PRACTICES, MOTIVATION, PERCEIVED BENEFITS AND BARRIERS TO OUTSOURCING BY HOSPITALS IN UGANDA

by

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submitted in accordance with the requirements for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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FEBRUARY 2016
DECLARATION

I declare that PRACTICES, MOTIVATION, PERCEIVED BENEFITS AND BARRIERS TO OUTSOURCING BY HOSPITALS IN UGANDA is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

10 February 2016

Paschal Nicholas Mujasi

Date
ABSTRACT

This study investigated practices, motivations, perceived benefits and barriers to outsourcing of support services by general hospitals in Uganda. The aim was to contribute to the evidence base to increase adoption and effectiveness of outsourcing by hospitals in Uganda.

An explanatory sequential mixed methods design was used. Quantitative data was collected from hospital managers in 32 randomly selected hospitals using a self-administered questionnaire. Qualitative data was collected through in-depth interviews from 8 purposively selected hospital managers using an interview guide. Quantitative data was statistical analysed (frequencies, contingency tables and Wilcoxon-Mann-Whitney tests) using SAS 9.3. Qualitative data was managed using ATLAS ti 7, coded manually and content analysis conducted to identify emerging themes, subthemes and categories. A cost benefit analysis was conducted for outsourcing cleaning services in a selected hospital using financial data provided by the managers.

Quantitative findings indicate that many (72%) hospitals were outsourcing some of their support services; many were satisfied with their outsourcing (>60%). The key motivation for outsourcing was to gain access to quality service (68%). Most hospitals have a system for monitoring outsourcing (71%). Managers perceive improved productivity and better services as the main benefit from outsourcing (90%). The main barrier to outsourcing is limited financing. A key challenge encountered during outsourcing was limited number of service providers (57%). Managers perceive regulatory violations as a key risk during outsourcing (87%). Hospital location is a determinant of outsourcing (p=0.0033). Managers’ perceptions towards outsourcing have no impact on outsourcing (p>0.05). These findings were confirmed and explained by the qualitative data. Qualitative findings reveal masquerading, impersonation and extortion of patients by
outsourced staff as an outsourcing risk. They reveal a concern that outsourcing may lead to job loss for community members. The cost benefit analysis indicates that outsourcing in the studied hospital for the year considered was cheaper than insourcing by UGX 669,575.00. The savings increase to UGX 48,753,689.94 when adjusted for quality differences between insourced and outsourced services. Sensitivity analysis shows that the assumptions used in the analysis were robust.

Recommendations, interventions and guidelines are proposed for increasing outsourcing and its effectiveness.

**Keywords:** Cost benefit analysis; general hospital; hospital services; outsourcing; outsourcing practices; Uganda
ACKNOWLEDGEMENTS

I would like to acknowledge a number of individuals who have played a pivotal role in the actualisation of this thesis.

Professor ZZ Nkosi, my supervisor, for her guidance, support, and encouragement throughout my study. She has been a constant inspiration to me during this journey and I have learnt a lot from her expertise and guidance.

Ms Rose Kityo Bosa of The Sciences Research Consortia (SRC) Uganda, for her guidance and assistance with statistical data analysis.

Ms Coetzer Rina, for professional technical editing of my thesis.

The University of South Africa (UNISA), the Uganda Ministry of Health (MOH), Uganda National Council for Science and Technology (UNCST) and Lacor Hospital Institutional review board for the ethical clearance of this study.

The Medical Superintendents and Hospital Administrators from the hospitals that participated in the study for their willingness to participate and for taking time off their busy schedules to participate in the various data collection interviews. Special thanks to the managers from the hospital that were willing to share detailed financial data for the cost benefit analysis conducted as part of this study.

Sincere thanks go to all my research assistants – William Mugenyi, Prossy and Agara Collins – for helping with data collection and tolerating the difficult travels that sometimes involved riding on “boda bodas” and crossing rivers. Special thanks to Dr Mwima Gerald and Mr Ditai James for assisting with the planning, logistics and coordination of the quantitative data collection.

Heartfelt thanks to my family for always supporting me, believing in me and being there for me. My father, mother, brothers and sisters and in-laws who have always been there to share in the ups and downs of life. Your presence is a reassuring constant in a rapidly ever changing world.

Finally, it would be remiss for me not to thank my beautiful wife Pauline Mujasi for her love, patience, understanding, and encouragement during this whole process.

The fear of God is the beginning of wisdom.
Proverbs 9:10
Dedication

To my wife Pauline, the Mwima Family and all the health managers in Uganda, who dedicate their lives working to improve the life of others and thus made this study necessary in an attempt to improve their efforts.
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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Outsourcing is a contractual relationship in which an organisation hires a third party, usually an external vendor or contractor, to perform and manage one or more internal functions previously done in-house. The organisation does this in order to maximise service, optimise expertise, minimise cost and to maintain or improve quality (Blouin & Brent 1999:18). Outsourcing involves using an outside company to provide a non-core service previously performed by staff (Gottschalk & Solli-Saether 2005:685). These outsiders are allowed to move in because the outsourcing organisation perceives this to have benefits.

Research shows that outsourcing, if properly planned, resourced and managed, can deliver significant competitive advantage to companies and organisations in all sectors (Willcocks 2010:62). Outsourcing has thus emerged as one of the popular and widely adopted business strategies in the current globalisation era. Many organisations are using outsourcing as a strategy to improve business focus, mitigate risks, build sustainable competitive advantage, and extend technical capabilities and free resources for core business purposes.

Benefits of such outsourcing efforts to the organisations have included high quality and low cost of service provision. Critics of outsourcing however claim that it has not consistently delivered on the promised high quality, low-cost service. A number of disadvantages and risks have been associated with outsourcing by organisations including reduction in wages or laying off of staff currently performing the outsourced activities, reduction in quality of service in an attempt to reduce costs and risks to data security and privacy due to admission of outsiders into the organisation (Jensen & Stonecash 2009:268).

Thus, the decision to outsource should be based on a careful evaluation of the advantages and disadvantages or risks of outsourcing in a given situation. This, in
addition, should be complemented by an assessment to determine whether outsourcing an activity is appropriate and feasible for the organisation. This assessment involves the consideration of issues such as the capability of the organisation in the activity relative to competitors, the importance of the activity to competitive advantage, the capability of suppliers to perform the activity, the level of risk in the supply market, potential workforce resistance and the impact upon employee morale.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Outsourcing is one of the practices promoted under the new public management in the public sector in Uganda. Numerous public sector organisations such as ministries, parastatals, commissions, and hospitals have adopted outsourcing to reduce costs, increase flexibility, access better expertise, improve quality of services, reduce capital investment, and improve internal user satisfaction (Public Procurement and Disposal of Assets (PPDA) 2009; National Integrity Survey (NIS) 2008).

Hospitals are particularly fertile environments for outsourcing, given their role as providers of a broad and complex array of services, many of which may be bought from other institutions (Yigit, Tengilimogle, Kisa & Younis 2007:86). Over the last decade, the hospital sector in developed countries has been under pressure both from demographic changes and increasingly scarce financial resources in social security. The hospital sector in these countries has tried to find some relief in outsourcing of services not belonging to its core competences like IT services, catering and cleaning (Augurzky & Scheuer 2007:272). Benefits of such outsourcing efforts have included lower costs, reduced number of personnel and higher levels of satisfaction with services provided by the hospital (Rahimi, Mizrahi & Magnezi 2011:58).

Given that many developing countries like Uganda are beginning to feel the very same pressures faced by industrialised countries (Ministry of Health of Uganda 2010:9-37), outsourcing is one strategy that hospitals can adopt to improve efficiency and management. In Uganda, the recently passed Government of Uganda policy on Public Private Partnership for Health (2009) and the Government of Uganda National Public Procurement and Disposal Act (2003) provide hospitals with an opportunity to use outsourcing as a strategic management tool.
This would enable the hospitals to improve their general services, reduce costs, and update equipment and installations, without having to use their limited resources which would then be devoted to providing healthcare which is the hospitals’ core business. However, efforts will be needed to encourage increased adoption of outsourcing by hospitals where feasible and appropriate through a number of interventions, for example through policy guidelines. The interventions, including any developed guidelines will need to be evidence-based.

A number of studies have focused on outsourcing and its various aspects such as the rationale for outsourcing, the various outsourcing practices by organisations in terms of nature and scope of activities outsourced, service delivery models and vendor location. Advanced industrialised economies such as the USA, China, and Europe are the principal candidates for the origin of outsourcing transactions (Koveos & Tang 2004:43-62). Hence, although various studies have addressed a wide array of aspects of outsourcing e.g. technical, motivational, cultural, organisational, strategic, operational and performance related (as reviewed by Lacity, Khan & Willcocks 2009:130-146), the studies are focused on understanding outsourcing from developed countries perspective. Few studies address outsourcing from the perspective of developing countries like Uganda. This gap in the literature is echoed by recent studies (Hansen, Muller & Pottenger 2008:210-229). Also, most studies have either been qualitative or quantitative without mixing the two through a mixed method approach. Research on outsourcing in the context of outsourcing among companies in a developing country such as Uganda using a mixed methods research approach can provide several new insights on outsourcing decisions and practices. These insights can be used to guide companies in deciding whether outsourcing is appropriate and feasible for their unique situation and to design interventions to encourage adoption of outsourcing by companies where appropriate.

Given the absence of sufficient academic research on outsourcing with special focus on the hospital sector in Uganda; coupled with the increased scope and opportunity for hospitals to adopt outsourcing in the future, this proposed mixed methods study intends to shed light on outsourcing in the hospital sector in Uganda. The study will address the practices, motivations, perceived benefits or advantages, disadvantages and barriers to outsourcing by hospitals in Uganda. The aim is to contribute to the evidence base to guide hospital managers in determining whether outsourcing is appropriate and feasible
for their hospitals and to increase adoption of outsourcing by hospitals where appropriate as a strategic management tool for improving hospital management in Uganda.

1.3  RESEARCH PROBLEM

A research problem is a situation in need of a solution, improvement, or alteration; a discrepancy between the way things are and the way they ought to be. It is an area of concern where there is a gap in the knowledge base needed for professional practice (Burns & Grove 2005:70; Polit & Beck 2008:765). These problematic situations stimulate research.

Through the Ministry of Health (MOH) Public Private Partnership Policy, 2009 (PPP) and the Public Procurement and Disposal of Assets Act, hospitals in Uganda have the opportunity to outsource services where appropriate based on a cost benefit analysis, feasibility analysis and value for money analysis.

There is, however, limited knowledge about the use of outsourcing by hospitals in Uganda as a strategic management tool for improving hospital performance. This limits any potential efforts to increase adoption of outsourcing by hospitals in Uganda where appropriate, as determined by an evaluation of advantages and disadvantages of outsourcing and its feasibility in a given hospital. Where appropriate and feasible, outsourcing has the potential to reduce costs of hospital service delivery through focusing hospitals on their core competencies, enable the hospitals develop new capabilities, improve their processes, service quality, and operational efficiency. This would have enormous economic benefits since hospital services account for about 25% of total health expenditure in Uganda (Ministry of Health of Uganda 2013). Also, outsourcing is always assumed to lead to economic benefits e.g. lower costs, but this can only be verified through an economic evaluation.

Thus, the need for a systematic study to provide knowledge to enable evaluation of the appropriateness and feasibility of outsourcing by hospitals; and to design interventions to increase adoption of outsourcing where appropriate is imperative. This is in addition to the need for economic evaluation of outsourced services by hospitals in order to ensure appropriate resource allocation for the outsourced services. This led to the
question about current outsourcing practices and processes, the cost benefit of the
outsourced services; in addition to motivations and barriers to outsourcing among
publicly funded hospitals in Uganda and what can be done to increase outsourcing by
the hospitals where appropriate and feasible.

1.4 AIM OF THE STUDY

1.4.1 Research purpose

This study addresses the practices, motivations, perceived benefits or advantages and
barriers or disadvantages to outsourcing by hospitals in Uganda. The aim is to increase
adoption and effectiveness of outsourcing by hospitals where appropriate and feasible
as a strategic management tool for improving hospital performance in Uganda.

An explanatory sequential mixed methods design was used, and it involved collecting
quantitative data and then explaining the quantitative results with in-depth qualitative
data. In the first, quantitative phase of the study, survey data was collected from
hospital managers (medical superintendents and hospital administrators) at sampled
general hospitals (both publicly funded and NGO owned) in Uganda. This data was
used to test the study’s attitudinal conceptual framework by assessing how outsourcing
in the sampled hospitals relates to management perceptions and attitudes to
outsourcing, management perception of the outsourced services, out sourced service
characteristics and the hospital’s characteristics. A cost benefit analysis was also
conducted for a selected outsourced service in one of the participating hospitals to test
if the economic argument for outsourcing (i.e. reduced costs) holds true for the selected
service in the selected hospital.

The second qualitative phase was conducted as a follow up to the quantitative results to
help explain the quantitative results. In this exploratory follow up, the motivations and
advantages of outsourcing and barriers and disadvantages to outsourcing were further
explored with selected hospital managers who participated in the first phase. Collecting
both quantitative and qualitative data provided greater insight into the research problem
than would have been provided by either type of data separately.
1.4.2 Research objectives

The study objectives were to:

- Describe the current outsourcing practices and processes by general hospitals in Uganda
- Identify perceived benefits or advantages and drawbacks or disadvantages of outsourcing by general hospital managers in Uganda
- Identify determinants and factors associated with outsourcing by general hospitals in Uganda
- Conduct a cost benefit analysis of an outsourced service in one of the study hospitals
- Identify interventions to increase adoption and effectiveness of outsourcing by hospitals in Uganda where appropriate and feasible
- Develop an outsourcing framework and guidelines for use by hospital managers during the outsourcing process

1.4.3 Research questions

1.4.3.1 Quantitative research questions

- What are the current outsourcing practices and processes by general hospitals in Uganda?
- What are the motivations, attitudes, perceived benefits and barriers to outsourcing by general hospital managers in Uganda?
- What is the relationship between the hospital managers’ attitudes, perception of benefits and barriers to outsourcing and their decision to outsource one or more hospital support services?
- What is the relationship between a hospital’s characteristics and its decision to outsource one or more of the support services it requires?
- What is the relationship between the hospital managers’ perception of the various support services characteristics and the decision of the hospital to outsource those services?
• What are the costs versus the benefits of an outsourced service in one of the study hospitals?

1.4.3.2 Qualitative research questions

• What are the motivations and perceived advantages of outsourcing by hospitals in Uganda?
• What are the barriers and perceived disadvantages to outsourcing by hospitals in Uganda?
• How do hospitals in Uganda decide whether or not to outsource, and which services to outsource?
• What processes do hospitals in Uganda use to outsource services and to continuously monitor effectiveness of their outsourcing?
• What interventions could be used to increase adoption and effectiveness of outsourcing by hospitals in Uganda where appropriate and feasible?

1.4.3.3 Mixed method research question

How does the qualitative data on the practices, motivations for and barriers to outsourcing by managers of general hospitals in Uganda help to explain the quantitative results about general hospitals outsourcing motivation, practices, and their determinants?

1.5 SIGNIFICANCE OF THE STUDY

The findings of this study add to the existing body of knowledge and understanding of the subject of outsourcing, particularly in the health sector in developing countries, and specifically in the context of hospitals in Uganda.

The study provides useful information on current outsourcing practices and processes, motivations and barriers to outsourcing by hospitals in Uganda, thereby generating awareness among health planners, policy makers and health services managers. The study findings support and enrich theories and models of outsourcing that take into account attitudes and perceptions of managers involved in making the outsourcing
decision. The study also adds to the number of studies that have used a mixed methods approach particularly in the Ugandan context.

The results will be useful to health planners, policy makers, health services managers and other stakeholders by contributing to the evidence base to guide hospitals in deciding whether outsourcing is appropriate and feasible for their unique situation. The results will also be useful in designing interventions to encourage adoption of outsourcing by hospitals and to increase effectiveness of outsourcing by hospitals. Specifically, the results are used by the researcher to develop an outsourcing framework and guidelines and to provide recommendations that can be used by policy makers to encourage outsourcing where appropriate and feasible as a strategic management tool for improving hospital performance; and to improve effectiveness of outsourcing by the hospitals. This makes the study useful not only in Uganda but also in other countries both within and outside Africa.

1.6 DEFINITION OF TERMS

1.6.1 Conceptual definitions

The following concepts are considered crucial in aiding understanding of the parameters of this research:

1.6.1.1 Outsourcing

According to *Cambridge Business English Dictionary Online* (2014), outsourcing refers to a situation in which a company employs another organisation to do some of its work rather than using its own employees to do it. It is the process of purchasing goods or services on specification from an external supplier that were previously produced in-house (Mol 2004:585).

In this study, a hospital will be considered to be outsourcing if it uses an external supplier to provide one of the hospital services.
1.6.1.2 Outsourcing practices

According to *Cambridge English Dictionary Online* (2014), practice refers to what people do or how they do it.

For purposes of this study, outsourcing practices refer to the types of services outsourced by the hospital, number of services outsourced, duration for which services have been outsourced and the process for outsourcing the service(s) by the hospital.

1.6.1.3 Determinants of outsourcing

According to *Cambridge English Dictionary Online* (2014), a determinant is something that controls or affects what happens in a particular situation.

For purposes of this study, determinants of outsourcing refer to factors that influence or are associated with the outsourcing decision by the hospital.

1.6.1.4 General hospital

According to *Cambridge English Dictionary Online* (2014), a hospital is a place where people who are ill or injured are treated and taken care of by doctors and nurses. The Uganda Ministry of Health defines a hospital as a health care facility, public or private organisation for profit or not, devoted to providing curative, preventive, promotive and rehabilitative care, through outpatient, inpatient, and community health services. It should have at least 60 beds, a high level of skilled medical personnel including doctors and be able to carry out major surgery and advanced investigative procedures including X-ray (Ministry of Health of Uganda 2004:5).

According to the *Cambridge English Dictionary Online* (2014), a general hospital is one that deals with all types of sick people. It does not specialise in the treatment of a particular illness or of patients of a particular sex or group.

The Ministry of Health in Uganda categorises hospitals as general, regional or referral hospital.
For purposed of this study, all non-referral or non-teaching hospitals in Uganda are regarded as general hospitals.

1.6.1.5 Hospital services

According to the Business Dictionary Online (2014), services are intangible products such as accounting, banking, cleaning, consultancy, education, insurance, expertise, medical treatment or transportation.

For purposes of this study, hospital services refer to health services (curative, preventive, promotive and rehabilitative care) offered by the hospital to its clients and the support services (including domestic, housekeeping and other management support) needed by the hospital to be able to offer quality care to its clients.

1.6.1.6 Strategic management

According to the Cambridge English Dictionary Online (2014), strategic management refers to the way that a company’s executives decide what they want to achieve and plan actions and use of resources over time in order to do this. The Business Dictionary Online (2014) defines strategic management as the systematic analysis of the factors associated with customers and competitors (the external environment) and the organisation itself (the internal environment) to provide the basis for maintaining optimum management practices.

In this study, outsourcing is considered as one of the optimum management practices that a hospital can adopt as part of strategic management.

1.6.1.7 Intervention

According to the Cambridge English Dictionary Online (2014), intervention is the involvement in a difficult situation in order to improve it or prevent it from getting worse, or an occasion when this is done. Intervention also refer to treatments, therapies, procedures or actions implemented by health care professionals to and with patients, in a particular situation, to move patients conditions towards desired health outcomes that are beneficial to them (Burns & Grove 2005:740).
For purposes of this study, intervention refers to any action, for example policy formulation, training, provision of information or any other action intended to increase the likelihood that a hospital will outsource one or more of its services where appropriate.

1.6.2 Operational definitions

1.6.2.1 Outsourcing

Outsourcing is the dependent variable in the quantitative phase of the study. A hospital is deemed to be outsourcing if it currently uses an outside company or group of individuals based on a contractual relationship to provide the hospital with one or more services (e.g. cleaning services) that were traditionally provided in-house by the hospital using its own staff and facilities.

1.6.2.2 Outsourcing practices

Outsourcing practices refer to the types of services outsourced by the hospital, number of services outsourced, duration for which services have been outsourced and the process for outsourcing the service(s) by the hospital.

The independent variables will be operationalised as below:

1.6.2.3 Management perceptions and attitudes

Hospital management perceptions and attitudes refer to the hospital superintendents’ or hospital administrators’ views, opinions and experiences regarding benefits of outsourcing, bottlenecks to outsourcing and the risks of outsourcing one or more of the hospital’s services.

1.6.2.4 Service characteristics

Hospital services characteristics refer to the hospital superintendents’ or hospital administrators’ views about attributes of the various services required by hospital to meet its mandate of providing health care to patients, including availability of external...
supplies for the service, how critical the service is for the hospital’s mandate of delivering health care, how frequently the service is needed by the hospital and how easy it is to measure an external supplier’s performance in delivering the service.

1.6.2.5 Hospital characteristics

Hospital characteristics refer to attributes of the hospital, including its location, size (in terms of beds), ownership and organisation or management strategy for effective service delivery.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

1.7.1 Research paradigm

The overall study was guided by the philosophy of pragmatism and was based on the belief that researchers should use the approach or mixture of approaches that work the best in a real world situation. A mixed method approach was used based on the fundamental principle that a researcher should use a mixture or combination of methods that have complementary strengths and non-overlapping weaknesses.

Mixed methods research is increasingly recognised as a third major research approach along with qualitative and quantitative research. Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purpose of breadth and depth of understanding and corroboration (Johnson, Onwuegbuzie & Turner 2007:123).

Thus, the study had two phases; a quantitative and qualitative phase; each having its ontological position, epistemological position, methodological position and axiological issues; but with both phases complementing each other.

The quantitative phase of the study was based on the positivist paradigm and outsourcing theory (both economic and business theories). The positivist paradigm is
the traditional paradigm underlying the scientific approach and assumes that there is a fixed orderly reality that can be objectively studied (Polit & Beck 2008:728).

Through the positivist paradigm lens, the quantitative phase of the research studied real life experiences by examining the way hospital managers decide whether to outsource and what to outsource and how they continuously monitor the cost effectiveness and feasibility of outsourcing in their hospitals.

The qualitative phase of the study was based on the interpretivism paradigm. According to the interpretivism paradigm, there exist multiple realities; there is no one objective universal reality. Realities are constructed by social actors in social interactions; they are subjective, multiple, mutable and context dependent (Burns & Grove 2005:52). Through the interpretivism paradigm lens, the qualitative phase of the research studied real life experiences by examining the way hospital managers think about and practice outsourcing.

A key aspect of mixed methods research is the decision about the approach for mixing the quantitative and qualitative aspects within the mixed methods design. Mixing can occur during the interpretation of the study findings, during data analysis, during data collection and at the design phase. Strategies for mixing include merging the two data sets, connecting from the analysis of one set of data to the collection of the second set of data, embedding one form of data within a larger design or procedure and using a framework (theoretical or program) to bind together the data sets (Creswell & Plano-Clark 2007:66-68).

In this study, mixing occurred at two points. During data collection, the qualitative data guided refinement of the qualitative tools and selection of participants for the qualitative phase. Also, during interpretation of the study findings conclusion and inferences were drawn from what was learnt from combining the results from the qualitative and quantitative phases of the study (Chapter 7). The qualitative data collected was used to explain and to contextualise the observations made during the quantitative strand based on outsourcing theory. Using data from this qualitative phase to complement data from the quantitative phase (based on a positivism paradigm lens) allows the researcher to better understand the details of outsourcing from the perspective of those participating in the study.
1.7.2 Theoretical framework

Based on the combination of the transaction cost economics, resource based view, contingency theory and agency theory of outsourcing and a literature review, an attitudinal model of outsourcing was used as the conceptual framework for the quantitative phase of the study.

According to this attitudinal model, management perceptions and attitudes towards outsourcing such as perceived benefits and advantages, perceived bottlenecks, disadvantages and risks of outsourcing, are factors that influence the outsourcing decision. Management attitudes towards outsourcing are also affected by organisational (hospital) characteristics for example, size of the hospital, location, ownership and organisational strategy. These also directly influence the outsourcing decision. Additionally, management’s perception of the service and characteristics of the service under consideration for outsourcing, such as criticality of the service, frequency of need for the service, availability of vendors to provide the service in addition to the programmability or measurability of the service also influence the outsourcing decision.
Management perceptions of outsourcing
- Perceived benefits/advantages
- Perceived bottlenecks
- Perceived risks/disadvantages

Management perception of service/service characteristics
- Criticality
- Frequency of needs
- Supplier environment
- Measurability

Hospital characteristics
- Location
- Size
- Ownership
- Organisational strategy

Outsourcing evaluation and monitoring
- Activity importance analysis
- Capability analysis
- Strategic sourcing options
- Relationship strategy
- Relationship establishment, management and evaluation

Outsourcing
- Attitudes
- Practices

Figure 1.1: Theoretical framework
1.8 RESEARCH DESIGN AND METHODS

A mixed methods approach was used for the study. This approach involves combining elements of qualitative and quantitative research approaches. In this study, qualitative and quantitative viewpoints, data collection, analysis and inference techniques were used for the purposes of breadth and depth of understanding and corroboration (Creswell 2012:4)

A mixed methods explanatory sequential design was used. Quantitative and qualitative methods were implemented sequentially starting with the quantitative phase. The study comprised of a major quantitative phase which was the dominant phase of the study with a minor qualitative phase (QUAN → qual). This enabled the researcher to use the qualitative findings to help interpret and contextualise the quantitative results.

1.8.1 Quantitative phase

A non-experimental cross sectional descriptive design using the survey approach was applied. Through a survey, data was collected to describe the current outsourcing practices by sampled hospitals and to explore the interrelationships among study variables without any active intervention by the researcher. The quantitative phase also included a cost-benefit analysis based on a case study design.

1.8.1.1 Population and sample

The population for this study was all hospitals in Uganda. The target population was the hospitals selected to participate in the study through application of the chosen sampling method.

The target population comprised of 92 general hospitals as established from the MOH health facility inventory. These were divided into two strata: government owned general hospitals (40) and non-government owned hospitals (52). The required sample size was 47, comprising of 20 government hospitals and 27 non-government hospitals as determined using the sample size calculation formula.
1.8.1.2 Sampling method and sample size

A proportionate to size, stratified random sampling method was used. Given the enormous cost of collecting data from 47 hospitals all over the country, a sample size of 32 was eventually decided upon. This is the minimum required sample size for any meaningful statistical analysis. The implied allocation for this sample size (based on proportionate stratum size) was 14 government hospitals and 18 non-government hospitals.

1.8.1.3 Data collection

The study applied a structured data collection approach using a self-administered questionnaire with closed-ended questions. Medical superintendents or hospital administrators in the sampled hospitals were the respondents. Trained research assistants distributed the questionnaires to the respondents.

1.8.1.4 Data management and analysis

Completed questionnaires were submitted by the research assistants to the researcher for verification, cleaning and data capture. After coding by the researcher, the data was entered into Excel to create an excel data base. This was then exported to Statistical Analysis System (SAS) software version 9.3 (SAS 9.3) for analysis. Frequencies, contingency tables and Wilcoxon-Mann-Whitney tests were used for statistical data analysis.

1.8.1.5 Measures to ensure validity and reliability

Validity is broadly concerned with the soundness of the study’s evidence; that is, whether the findings are cogent, convincing and well grounded. Another aspect of validity concerns the quality of the researcher’s evidence regarding the effect of the independent variable on the dependent variable.

The researcher ensured face validity by careful selection of items to be included in the questionnaire based on a thorough literature review. To ensure content validity, the researcher conducted an extensive literature review especially of journal articles and
publications addressing the concept of outsourcing generally and in the health or hospital sector specifically. Anticipated threats to internal and external validity were minimised through random stratified sampling to ensure a representative sample and using a standardised questionnaire that was administered by trained research assistants.

According to Polit and Beck (2008:452), reliability refers to the accuracy and consistency with which an instrument measures the target attribute. It is often associated with the method used to measure the research variables. Burns and Grove (2005:374) define the reliability of a measure as the consistency of measures obtained in the use of a particular instrument. The researcher, in consultation with a statistician, used the Cronbach’s alpha co-efficient to test reliability of the study instrument.

1.8.2 Cost benefit analysis case study

For a hospital that is currently outsourcing a selected service and was willing to share financial and other data about the outsourced service, the costs of out-sourcing the service were determined. In addition to the contract price for the out sourced service, the costs included the costs incurred in setting up and monitoring the out sourcing contract in addition to the opportunity costs the hospital may have incurred as a result of outsourcing. This was then compared with the costs the hospital would have incurred if it was providing the service in-house (in-sourcing), making it possible to determine if for the evaluated case outsourcing resulted in lower costs for the service.

1.8.2.1 Scope and perspective

The scope for the evaluation was one year using historical data. The perspective adopted for this economic evaluation was the organisational (hospital’s) perspective. Thus only those costs incurred by the hospital under study related to the in-house provision (in-sourcing) or outsourcing the given service were considered.

1.8.2.2 Approach

Through a discussion with the hospital managers, the resources used by the hospital to provide the service in-house before it was outsourced were identified. These included
staff time, and consumables. The costs involved in the outsourcing process were also identified. Besides the contract price for the outsourced services, organisational resources involved in setting up and monitoring the outsourcing contract (e.g. staff time,) were identified.

Through further discussions with the hospital managers and review of documents, the costs of the earlier identified resources expended by the hospital in providing the service for a one year period before it was outsourced were determined. Also, any changes in internal resource costs due to the outsourcing contract (e.g. reduction in number of hospital staff) were also identified. The contract price and the costs of internal resources expended by the hospital in setting up, implementing and monitoring the outsourcing contract were also determined.

A mixture of the micro and macro costing approaches was adopted, using micro costing for the direct costs of providing or outsourcing the service, and gross costing for other costs. The general costs categories included personnel costs, utilities, other recurrent costs and equipment costs where applicable.

1.8.2.3 Data collection, management and analysis

Data sources included the hospital managers themselves, in addition to various documents of the hospital. These included contract documents, pay roll, annual financial reports and equipment inventory. Data was collected through interviews with the hospital managers in addition to a review of the relevant documents.

The collected cost data was entered into a Microsoft Excel spreadsheet set up for this purpose and analysed using Microsoft Excel. The total costs of delivering the outsourced service over a one year period were compared with the total costs of delivering the service in-house by the hospital to determine if for the evaluated case, outsourcing resulted in lower costs service costs for the hospital.

1.8.3 Qualitative phase

An exploratory, descriptive design was applied. Through in-depth interviews, data was collected to paint a picture of current outsourcing by the hospitals and to gain insight
into the hospital’s outsourcing practices and processes and the motivations and barriers to outsourcing in the various hospitals based on findings from the quantitative phase of the study.

### 1.8.3.1 Population and sample

The population for the qualitative phase of the study was all hospitals in Uganda. The target population was hospitals that participated in the quantitative phase of the study. The sample was selected from hospitals that met the inclusion criteria and whose hospital management (Medical superintendent or hospital administrator) could be contacted and were willing to participate in a follow up interview to the quantitative data collection. This was the accessible population.

### 1.8.3.2 Sampling method and sample size

A purposive sample of participants was included in the study based on established eligibility criteria. The sample consisted of eight hospital managers (Medical superintendents and hospital administrators) from targeted hospitals in Uganda that participated in the quantitative phase of the study.

### 1.8.3.3 Data collection

Semi-structured one to one, face-to-face interviews were used to collect the qualitative data. The researcher used a topic guide for the semi structured interviews. The interviews took place at the selected hospitals and were recorded on an audio recorder with the permission of the participants.

### 1.8.3.4 Data management and analysis

The researcher’s observations were noted at the back of the topic guide. Each taped interview was typed by the researcher in the form of a verbatim transcript. Audio recorded data was transcribed verbatim and the resulting texts were analysed. The researcher used the qualitative analysis software ATLAS/ti version 7 (ATLAS/ti 7) to aid in the management of textual data, for storage and retrieval of information more quickly and accurately.
Data analysis was done using open coding. During the analysis, the collected data was broken up into manageable themes, patterns, trends and relationships. Content analysis was done to explore in detail the common themes which were then established into units of meaning or codes (Mouton 2001:198).

### 1.8.3.5 Measures to ensure trustworthiness

Trustworthiness refers to the confidence qualitative researchers have in their data. This is assessed using criteria of credibility, transferability, dependability and conformability (Polit & Beck 2008:511).

In this study, member checking was done by having the research participants' review, validate and verify the researcher’s interpretations and conclusion (Brink, Van der Walt & Van Rensburg 2011:124). There was also prolonged engagement with the participants; the researcher invested sufficient time collecting data to have an in depth understanding of the participants under study and to test for misinformation and distortions (Polit & Beck 2008:430). The researcher spent as much time as was necessary interacting with the participants during the qualitative data collection.

### 1.9 ETHICAL CONSIDERATIONS

Research ethics involves protecting the rights of the respondents and the institutions in which research is done, and maintaining scientific integrity (Burns & Grove 2005:181; Polit & Beck 2008:141; Tjale & De Villiers 2004:215).

Ethical considerations were adhered to by obtaining the required ethical clearance from the required institutions and by adhering to the ethical principles that guided the researcher.

The fundamental ethical principles as outlined by Burns and Grove (2005:180-181) were adhered to as below, in order to protect the participants in this study:
Permission to conduct the study

Permission to conduct the study was sought and received from the Higher Degrees Committee of the Department of Health Studies, University of South Africa (UNISA) (Annex K); a local institutional review board at Lacor Hospital in Uganda (Annex L); the Uganda National Council of Science and Technology (Annex M); and the Ministry of Health in Uganda (Annex O). Informed consent to participate in the study was also obtained from the individual participants (Annex H).

Autonomy and respect for persons

Participation in the study was voluntary and the participants were assured that they could withdraw from the study at any time if they so wished, without penalty.

Confidentiality and anonymity

Given the need to follow up some selected respondents from the quantitative phase of the study during the qualitative phase, some personal identification data needed to be collected making it impossible to maintain anonymity. This was explained to the participants and they were assured that their individual responses and identification information would be kept confidential and would not be shared with other people. However, the quantitative research findings from the study are reported in aggregate and cannot be connected to any respondent. In the qualitative phase of the study confidentiality and privacy were ensured by using a password, restricted access computer for the collected text data; and anonymity was guaranteed by assigning interviewees codes instead of names.

Act on findings and publishing

The work of others has been acknowledged and negative and positive findings have been reported. The findings of this study will be disseminated in the form of publications in accredited journals and presentation at the relevant gatherings such as conferences and workshops (Katzellenbogen, Joubert & Karim 2007:27-34).
1.10 SCOPE OF THE STUDY

The scope of the study was limited to general hospitals and did not include regional referral or teaching hospitals. Also, the study only covered publicly funded general hospitals (i.e. those that receive funding from the central government) and private not for profit hospitals (i.e. Non-governmental organisational hospitals). As such, the study did not cover private for profit hospitals. Additionally, the study only focused on outsourcing of non-clinical or support services (e.g. catering, laundry etc) and did not cover outsourcing of clinical services (e.g. laboratory services).

Thus, a key limitation of the study is that it did not cover private for profit hospitals; and yet these are more likely to engage in outsourcing as a way of increasing efficiency, given their profit motive. However, accessing data from these hospitals was deemed to be difficult as they may not readily share information about their operations for fear that such information may end up in the hands of their competitors. Also, the non-clinical or support services which were the focus of this study have different characteristics from clinical services e.g. laboratory services.

Thus the study is limited to as far as the findings cannot be generalised to all hospitals services, especially clinical services; and not to all hospitals in Uganda.

1.11 STRUCTURE OF THE DISSERTATION

Chapter 1: Orientation of the study (Introduction and overview)
Chapter 2: Literature review
Chapter 3: Research design and methods
Chapter 4: Analysis, presentation and description of the quantitative research findings
Chapter 5: Analysis, presentation and description of the qualitative research findings
Chapter 6: Analysis, presentation and description of the cost benefit analysis findings
Chapter 7: Integration of quantitative and qualitative findings (including outsourcing framework and guidelines)
Chapter 8: Conclusions, limitations and recommendations
1.12 CONCLUSION

In this chapter the introduction, purpose of the study, research problem, objectives and significance of research were outlined. Key concepts were defined and an overview of the research methodology for the various phases and components of the study were presented. In the next chapter a detailed review of research literature is presented.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is a written summary of the state of evidence on a research problem. The purpose of the review is to familiarise the researcher with the scope of the field of study (Polit & Beck 2008:137). It shares with the reader the results of other studies that are closely related to the one being undertaken. It relates a study to the larger, ongoing dialogue in the literature, filling in gaps and extending prior studies. It also provides a framework for establishing the importance of the study as well as a benchmark for comparing the results with other findings (Creswell 2009:25).

In a mixed methods study, the researcher uses either a qualitative or a quantitative approach to the literature review depending on the type of strategy being used (Creswell 2009:28). In this QUANTI-Qual sequential study design, the researcher decided to focus on a review of the literature that will help to establish the rationale for the research questions of the quantitative phase of the study.

Thus this chapter contains the literature review on outsourcing, covering theories of outsourcing; outsourcing practices in various countries and sectors (particularly the IT and Health sector); determinants, motivations/reasons for outsourcing and the benefits; in addition to the roadblocks to outsourcing and outcomes of outsourcing. It also reviews the outsourcing framework as proposed by McIvor (2000:22-26).

Several resources were consulted for the literature review including journal articles, books related to outsourcing, conference papers, various policy documents and past dissertations.

2.2 OUTSOURCING

Outsourcing is a management approach that allows delegation to specialised and efficient external agents, operational and management responsibility for components,
processes or services previously delivered by the enterprise. It involves the sourcing of goods and services previously produced internally within the sourcing organisation from external suppliers.

Outsourcing can involve the transfer of an entire business function to a supplier. Alternatively, outsourcing may lead to the transfer of some activities associated with the function whilst some are kept in-house. Outsourcing can also involve the transfer of both people and physical assets to the supplier. Outsourcing is not just a straightforward financial or purchasing decision. In many cases, outsourcing is a major strategic decision that has implications for the entire organisation. It involves re-drawing the boundaries between the organisation and its supply base.

A term often used in the context of outsourcing is vertical integration. Vertical integration refers to the level of ownership of activities either backward (for example, component manufacture or inbound logistics) into the supply chain or forward (for example, distribution or after-sales service) towards the customer or end user of the product or service. Vertical integration is similar to the outsourcing concept in that it is concerned with the decision on whether to perform an activity internally or source it from an external supplier. Another term that is often used in a manufacturing context is 'make-or-buy'. The term 'make-or-buy' is associated with the decision on whether to manufacture a component internally or buy it from an external supplier. The attraction of this term (make-or-buy) is that it implies that there should be an evaluation of the suitability of either internal or external supply whereas the term outsourcing implies that the decision to use an external supplier has already been made without any consideration of whether it is appropriate for the organisation.

2.3 CONTEXTUAL DRIVERS OF OUTSOURCING

The trend towards the increased use of outsourcing has been driven by a number of inter-related factors in the external business environment. These include:

2.3.1 Globalisation

Over the last few years the external business environment has become increasingly global for many industries. Many organisations are now competing on a global basis.
Increasingly, there has been a shift away from national markets as distinct entities, protected from each other by trade barriers and distance and time barriers, towards a system in which national markets are merging into a single global market (Hill & Jones 2001:112). This trend has led organisations to expand the geographical scope of their business operations in terms of the markets they serve and the production locations for the creation of their products and services. These changes have presented organisations with significant opportunities. For example, companies have been in a position to achieve greater economies of scale, share investments in research and development and marketing across their various markets, and access lower cost labour sources for both the manufacture of their products and delivery of their services.

2.3.2 Developments in information and communication technologies

Advances in telecommunications and information technology have facilitated the trend towards outsourcing. In recent decades ICTs have deeply affected the way business is performed and the way in which organisations compete (Porter 2001:63-78). Most organisations cannot compete effectively without employing information technology. Information technology (IT) can create efficiencies in a number of business areas ranging from design to marketing to finance, and furthermore IT and globalisation are closely linked. IT has greatly facilitated the ability of organisations to both globalise production and access new product markets.

2.3.3 Public sector reforms

The trend towards increased outsourcing has also been influenced by wide-ranging reforms occurring in public sector organisations in many countries. For example, successive governments in the US and UK have pursued radical public sector reforms which have placed the use of competitive market mechanisms at the heart of these reforms. Proponents of this philosophy argue that assets and activities should be transferred from the public sector to the private sector in order to improve performance. They also argue that the public sector should aspire to levels of performance attained in the private sector. In a study of public sector organisations carried out in a number of countries including the US, the UK, France, Germany, Japan and Australia, Domberger and Fernandez (1998:29-39) found that outsourcing has become a significant and increasing practice. Much of the force behind this trend has been the prevailing belief
that best value is achieved through the use of competitive market solutions for service provision.

The most prominent concept associated with using the market in the public sector has been the privatisation of publicly owned organisations. However, the introduction of internal markets and the outsourcing of public service services such as refuse collection, building, catering and cleaning have also become very prominent.

2.3.4 More demanding consumers

In many business sectors consumers have become more sophisticated and demanding as they have become more knowledgeable on issues such as price, reliability and availability. Consumers are demanding a more customised product and service at a lower price. Consumers are much more mobile in terms of ease of access to alternative sources of supply as a result of increased competition in many markets and the advent of the Internet. With consumers becoming more sophisticated and powerful they will no longer settle for whatever companies are offering. Organisations are now being forced to be more responsive to customer needs in a range of areas.

2.3.5 Evolving organisation structures

Changes in the business environment are having major implications for the way in which organisations are structured and managed. The level of change and uncertainty in many industries is likely to accelerate, as organisations have to deliver more with fewer resources. In order to compete effectively in this environment, organisations must not only continue to reduce costs, but also focus on innovative activities that can deliver customers value and create competitive advantage. Changes in the business environment are forcing companies to move away from earlier paradigms of structuring and managing organisations.

As a result of the changes in the business environment, organisations have begun to radically rethink their organisational structures. Historically, companies have chosen either a strategy of vertical integration (make internally) or outsourcing (source externally) to bring their products to the market, based on the relative benefits and disadvantages of each alternative. As a result, many organisations have been forced to
adopt more organic structures in order to achieve greater levels of efficiency and cost reductions. The adoption of new organisational structures has been a major driver behind the trend towards increased outsourcing. Competitive pressures and increased product complexity have led companies to create flatter, more flexible and responsive organisations in comparison with highly vertically integrated organisations. The emphasis on achieving greater efficiencies and lower costs has forced many organisations to increasingly focus in a limited number of core areas that drive competitive advantage.

2.4 THEORIES OF OUTSOURCING

Various theories have been adopted in the outsourcing literature. The theories can be combined into three categories: strategic, economic, and social/organisational (Lee & Kim 1999:29-61; Grover & Teng 1995:75-103).

Strategic theories focus on how firms develop and implement strategies to achieve a chosen performance goal (Dibbern, Goles, Hirschheim & Jayatilaka, 2004:6-102). Reference theories of this type include: Game Theory, Resource-Based View, Resource Dependency Theory, and Strategic Management Theories.

Economic theories focus on the coordination and governance of economic agents regarding their transactions with each other (Dibbern et al 2004:6-102). Agency Theory and Transaction Cost Economics are examples of economic theories.

Social/organisational theories focus on the organisations. These theories concentrate on the relationships between individuals, groups, and organisations (Dibbern et al 2004:6-102). Reference theories include social exchange theory, innovation diffusion theory, power politics theories, and relationship theories.

Each of the theories addresses different aspects of outsourcing. The conceptual framework for this study has been developed from the Transaction Cost Economics theory, Resource Based view theory, Contingency Theory and Agency Theory.
2.4.1 Transaction cost economics

The Transaction Cost Economics Theory (TCE) addresses outsourcing directly, as it deals primarily with firm boundaries (Williamson 1981:549). Assumptions underlying the Transaction cost Economics theory include bounded rationality (the rationality of human behaviour is limited by the ability of the actor to process information); opportunism (people are prone to behave opportunistically which leads to self-interest seeking with guile); small numbers bargaining (many bargaining situations are infrequent or involve small quantities where the cost of obtaining full information is prohibitive) and information impactedness (asymmetrical distribution of information among exchanging parties that means one party might have more knowledge than another).

Transaction cost economics deals with both the antecedents as well as the outcomes of outsourcing. The antecedents to outsourcing according to transaction cost economics are asset specificity, small numbers bargaining, and imperfect information. All three of these have a negative relationship to outsourcing, i.e. higher values of these constructs results in lower outsourcing activity. In terms of the outcomes of outsourcing, increase in outsourcing will result in lower production costs of the market, but increased coordination costs of sourcing the good from the market.

2.4.2 Resource-based view

The Resource-based view emphasises resources internal to the firm as the principal driver of firm profitability and strategic advantage (Wernerfelt 1984:172). On the antecedents to outsourcing, studies using this theory assume that a firm is not able to internalise more than a few resources (Gilley, McGee & Rasheed 2004:120; Gilley, Rasheed & Al Shammar 2006:25). The firm then decides between all the resources they need by comparing the attributes of the resources with each other. Resources with greater value and rareness and lesser imitability and substitutability are internalised while the other resources are outsourced.

In terms of the outcomes of outsourcing, the resource should be able to provide the ability to generate above normal returns. Obtaining above normal returns requires that the outsourced product is distinctive or available at a lower cost than identical products. Sustained competitive advantage may not be possible through outsourcing according to
the resource based view as this requires the resource to be rare, imperfectly imitable and non-substitutable. However, it may be achieved by a unique combination between the outsourced resource and other internal firm resources.

2.4.3 Contingency theory

Under this view, it is suggested that organisations that face a high degree of uncertainty in their environments; for example due to fluctuations in returns and/or prices; may seek to ensure some stability by entering into outsourcing contracts (Koberg & Ungson 1987:729). With regards to outsourcing, this can be viewed in the context of resources required by the organisation; whereby an organisation has selected, acquired and combined a set of resources that were available in the environment. However, these resources may not be sufficient for it to meet its goals. This causes the organisation to perceive a gap between its present capabilities and its intended capabilities. This gap may be also caused by the dynamics of the external environment. The changing environment may expose new opportunities and threats to the firm. This again causes the perception of a gap between the present resources of a firm and those needed to exploit opportunities and counter threats. The organisation seeks to achieve a fit between the resources of the firm and the competitive environment by acquiring the resources required to fill the gap either through outsourcing or internalising.

Contingency theory would predict the outsourcing decision to be a result of the fit between environmental and organisational-level factors. If the environment is uncertain, the organisation cannot predict whether the resource would be needed in the future. The resource may lose value and would no longer be able to generate returns, or imitations or substitutes of the resource may be available that may have higher value. In such a situation, the firm may decide that greater flexibility may be achieved through acquiring the resource through short-term outsourcing rather than by internalising through heavy investments. Therefore, from the perspective of contingency theory environmental uncertainty or dynamism is an antecedent to outsourcing.

2.4.4 Agency theory

Agency theory has several areas of overlap with transaction cost economics. Agency theory includes the assumption of opportunistic behaviour through the belief that the
agent will not behave in the principal’s best interests. Like the transaction cost economics theory, agency theory also includes the assumption of bounded rationality through the belief that it is not possible to write a complete contract.

There is also content overlap between the agency theory constructs of outcome uncertainty, span of control and programmability, and the transaction cost construct of imperfect information. Imperfect information is the condition that it is difficult for the principal to assess the performance of the agent, and a complete contingent contract is not possible, leaving open risk of opportunistic behaviour by the agent. This would include ability to assess that the desired outcome would occur (outcome uncertainty), ability to monitor and control the agent's behaviour (span of control) and the ability to write a complete contingent contract (programmability). From the perspective of agency theory, these are the main antecedents of outsourcing.

The lower the outcome uncertainty, the higher the span of control and the higher the programmability, the greater the likelihood to engage in outsourcing. An increase in the transaction cost economics constructs of asset specificity, small numbers bargaining, and imperfect information, may also result in higher risk of opportunistic behaviour by the agent, and therefore create increased costs for the principal to negotiate, monitor, and enforce a contract with the agent. This includes the costs predicted by agency theory, the costs of the agency problem and the costs associated with risk sharing (Schilling & Steensma 2002:391).

2.5 BENEFITS AND ADVANTAGES OF OUTSOURCING

Where outsourcing is evaluated and managed appropriately it can be a very powerful means for achieving performance improvements and contributing to the strategic development of an organisation. Organisations can benefit greatly from accessing the capabilities of suppliers in a range of areas including catering, security, design, manufacture, marketing, logistics and information technology. The literature provides several reasons why organisations decide to outsource. These are summarised below:
2.5.1 Better focus on the core business

Outsourcing of non-core activities eliminates the effort required to manage peripheral activities, except for the need to manage the relationship with the supplier. This it is claimed gives management the opportunity to concentrate on the important elements of the business (McIvor 2000:28; Kakabadse & Kakabadse 2000:672). This creates a need for providing greater attention to identifying what is a core competency (Kakabadse 2005:185). McIvor (2000:30) suggests that in a fast changing industry, the definition of core and non-core must be revisited on a continuous basis.

2.5.2 Cost reduction

Cost reductions can be obtained either through the savings of labour costs or from improved efficiency due to the application of more sophisticated technology or processes. The reduction in labour costs are based on the assumption that a supplier can provide a certain service more efficiently due to their expertise with fewer input resources (McIvor 2000:33; Kakabadse & Kakabadse 2000:681). Due to considerable economies of scale available to large outsourcing vendors, outsourcing can also provide a more cost effective solution for outsourcing customers. However, there are concerns that this cost reduction could be obtained at the expense of quality of the service provided.

2.5.3 Benefit from supplier investment and innovation

Henley (2006:117), through the review of emerging strategies for outsourcing the provision of software and IT enabled services to India, suggests that technological change is encouraging firms to outsource services based on the availability of leading edge technologies from the service provider. Collaboration with suppliers can provide access to high quality products and highly efficient services without the otherwise required investment in human capital, processes or information technology to obtain the required level of proficiency.
2.5.4 Increased flexibility and technology

Deavers (1997:507) suggests that outsourcing can provide greater flexibility, allowing organisations to incorporate the latest technology and respond to changes in the business environment more quickly and at a lower cost than vertically integrated organisations. Quinn (1999: 9-21) in his paper reviewing outsourcing, core competences and appropriate management techniques, also suggests that in-house functions may increase organisational commitment to a specific type of technology and may constrain flexibility in the long run. This is confirmed by Wang, Gwebu, Wang and Zhu (2008:125-159) whose study examined 120 companies’ performance after outsourcing IT.

2.5.5 Access to external competencies

Quelin and Duhamel (2003:651) suggest that through outsourcing, it is possible to achieve higher service levels, because firms can gain access to superior capabilities from their vendors. McIvor (2006:51) suggests in the case of offshore outsourcing, firms can benefit through access to skilled IT labour forces not available or very expensive in their own countries.

However, these are only potential benefits. Translating these potential benefits into actual ones requires a good understanding of the potential risks and possible approaches to managing them during the outsourcing process.

2.6 RISKS AND DISADVANTAGES OF OUTSOURCING

Many researchers have written about specific risks associated with outsourcing. These risks include:

2.6.1 Strategic risks

2.6.1.1 Not achieving the originally planned benefits

Adeleye, Annasingh, and Nunes (2004:167-180) who report the results of a questionnaire survey involving seven banks and 21 individual responses, note that the
less experienced both parties are, the higher the risk compared to traditional outsourcing. Willcocks and Lacity (1999:163-180) list unrealistic expectations about what can be achieved by outsourcing as a risk also.

2.6.1.2 The loss of core activities and competencies

Kakabadse and Kakabadse (2000:670-728) and Quinn and Hilmer (1994:43-55) suggest that excessive outsourcing can lead to considerable reduction of overhead so that the host organisation becomes a fraction of its former self, something they term the “hollow corporation”.

2.6.1.3 Loss of skills and corporate memory

Kakabadse and Kakabadse (2000:670-788) note that by contracting out goods and services traditionally produced in-house, the organisation loses skills, competences and collective knowledge, as both a producer and client of those services.

2.6.2 Operational risks

2.6.2.1 Dependency on the supplier

Quinn and Hilmer (1995:48-70) suggest that dependence on the supplier often finds its roots in: poor contracting, outsourcing into limited supply markets and high asset specificity.

2.6.2.2 Cost increases

Lacity and Hirschheim (1993:73-86) in their article and Lacity and Willcocks (1995:203-244) through analysis of 61 sourcing decisions and outcomes made in 40 U.S. and U.K. organisations from 145 interviews with case participants, suggest hidden costs emerge if managers incorrectly assume the depth and extent of activities included within the outsourcing contract. Levina and Ross (2003:331-364) who conducted a close examination of vendor strategy and practices in one long-term successful applications management outsourcing engagement, state that the pursued cost efficiency of (offshore) outsourcing is certainly not always achieved.
2.6.2.3 Transition and switching costs

Kakabadse and Kakabadse (2000:670-728) note that outsourcing requires a redefinition of organisational boundaries. This in turn induces possible further restructuring and dislocation of resources which induces a variety of costs in the process. Some of these transition costs could include unforeseeable set-up costs, redeployment costs, relocation costs or parallel-running costs.

2.6.2.4 Diminished quality of service

Aubert, Patry and Rivard (1998: 685-693) who in their paper propose a conceptual framework for risk assessment through empirical literature, note that reduction of quality may result from several factors: the interdependence between an outsourced activity and processes which remained in house, the lack of experience and expertise of the service provider with the outsourced activity and/or the situation where the service provider does not have the necessary resources.

2.6.2.5 Loss of management control

Quinn and Hilmer (1994:43-55) note loss of control over suppliers can occur when firms do not closely monitor suppliers and where suppliers assume leadership in their relationship. McIvor (2006:50) lists this as a major risk.

2.6.3 Commercial risks

2.6.3.1 Security breaches

Khalfan (2004:29-42) notes that a special issue in business process outsourcing (BPO) is the risk to data privacy as the service provider needs access to the client's sensitive data to be able to process it. Earl (1996:26-32) also warns of knowledge diffusion risk – the possibility of confidentiality leaks and loss of intellectual property rights by the vendor.
2.6.3.2 Customer lock-in

Quelin and Duhamel (2003:647-661) in their research through 25 semi-structured interviews in 20 large European manufacturing groups and a subsequent survey of 180 firms, note that this is mainly driven by two factors: (1) the level of standardisation and complexity of the process and (2) the level of market maturity. The more customer specific a process, the greater the difficulties associated with switching to another service provider.

2.6.4 Human resource and communication risks

2.6.4.1 Loss of internal coherence

Quinn and Hilmer (1995:48-70) note the possibility that external sourcing of certain activities will hamper the internal coherence of the company. McCarthy and Anagnostou (2004:61-71) in their paper looking at how the economic benefits of outsourcing alter the contribution that an organisation makes to a sector’s gross domestic product using an input–output method, note that employees’ morale, trust and productivity can be damaged due to job security issues related to outsourcing.

2.6.4.2 Communication mismatches

Earl (1996:26-32) and Willcocks, Lacity and Kern (1999:285-314) note that what initially seems to be clear and unquestionable to one side might result in disputes and litigation due to contrary interpretation by the other partner. This can be especially true for offshore outsourcing.

In terms of practitioner literature, surveys conducted by the strategic business advisory firm Op2i (specialising in strategic governance, sourcing and relationship management) between 2009 and 2010 find that:

- Selecting the right process and functions to outsource in the first place was seen as the best means of getting maximum return from the outsourcing investment – the core competence argument essentially.
• The greatest financial risk remains the possibility of not achieving the cost benefits, followed by cost of reintegration of processes on termination of the outsourcing agreement.
• The two largest sources of internal risks are identified as: (1) inadequate skills, proficiency and experience in outsourcing and (2) poorly constructed contracts and service level agreements (SLAs).

2.7 THE OUTSOURCING EVALUATION AND MANAGEMENT PROCESS

Successful application of the outsourcing concept involves an analysis of whether outsourcing is appropriate for the organisation and, if so, how the outsourcing process should be managed. This can be summarised in the figure below:

![Figure 2.1: The outsourcing evaluation and management framework](Adapted from McIvor 2000)

2.7.1 Determining the current boundary of the organisation

This stage in outsourcing evaluation and management is concerned with identifying the major activities that have to be performed in order to create and deliver the range of
products and services offered by the organisation to its customers. This involves identifying the major activities that have to be performed internally as well as those performed by external sources. This will provide an outline of the scope of the organisation both upstream into the supply chain and downstream towards end customers of the products and services. In effect, it is concerned with identifying the current boundary of the organisation.

Segmenting the organisation into activities allows an organisation to identify the activities that are a source of competitive advantage, activities in which it is equal to competitors and activities in which it is weaker in relation to competitors. In order to perform this analysis, the resources owned and deployed by the organisation must be identified as well as the activities that have to be carried out so that the organisation fulfils the needs of its customers.

Analysing the organisation in terms of activities allows outsourcing evaluation to be carried out in a number of contexts including: an organisation may undertake an evaluation of its entire business and identify potential opportunities for outsourcing from this analysis; an organisation may select certain parts of the business that it considers a suitable candidates for outsourcing; an organisation may consider outsourcing as an appropriate means of improving performance in certain activities that have been causing problems.

There are a number of frameworks that can be used to analyse an organisation as a collection of activities depending upon the type of organisation. These include the value chain, the value shop, the value network and the business process perspective.

The mapping of an organisation to a particular configuration and identifying its relationship with its environment is an important starting point in outsourcing evaluation. Adopting an activity perspective can assist in analysing outsourcing at the following levels:

- Perform the entire activity internally – this involves the sourcing organisation continuing to perform the activity internally. This may involve in investing and developing the activity in order to maintain and enhance any performance
superiority possessed by the sourcing organisation. This is sometimes referred to as in sourcing.

- **Outsource the entire activity** – this involves the sourcing organisation outsourcing the entire activity to an external supplier. This may involve staff and equipment being transferred from the sourcing organisation to the supplier. The supplier is responsible for performing the activity and delivering the associated product or service to the sourcing organisation.

- **Partial outsource** – this involves the sourcing organisation outsourcing a number of sub-activities that comprise the entire activity. In this case, the sourcing organisation has identified a number of competent suppliers to perform the relevant sub-activities. Pursuing this approach, the sourcing organisation avoids being overly dependent upon a single supplier. The sourcing organisation may also establish a relationship with each of the sub-suppliers in order to foster competition and obtain lower prices.

### 2.7.2 Activity importance analysis

This stage in outsourcing evaluation involves determining the level of importance of the activities that have to be performed in order to satisfy customer needs. It is crucial for an organisation to determine which activities are critical to competitive advantage. Identifying critical activities involves understanding the major determinants of competitive advantage in the markets or the industries in which the organisation competes or might wish to compete. An analysis of the competitive environment and customer needs can have an important role in identifying which activities are critical for success in the business environment. Critical activities will enable an organisation to differentiate itself from its competitors in the way in which it serves its customers. An understanding of critical activities is central to outsourcing evaluation. For example, if an organisation possesses a superior capability in a critical activity relative to competitors or suppliers, then it should continue to perform that activity internally. The organisation must also have a clear understanding of how sustainable this position is over time. Alternatively, where possible, activities that are not key influences on the ability of the organisation to achieve competitive advantage should be outsourced.

Critical activities are those that can be used to build sources of advantage that are difficult and costly for competitors to replicate. Focusing attention on customer needs
and competitive advantage will involve the organisation applying its distinctive capabilities to meet the needs identified in the context of outsourcing it is also important to determine the importance level of activities rather than segmenting the organisation into primary and support activities.

For outsourcing purposes, critical and non-critical activities are defined as follows.

- Critical activities – have a major impact upon the ability of an organisation to achieve competitive advantage either through the ability to reduce cost and/or create differentiation. Therefore, superior performance in such an activity relative to competitors offers customers a unique value proposition. Consequently, the activity is a source of competitive advantage. Critical activities can reside entirely within the organisation. However, a critical activity can also extend across organisational boundaries.

- Non-critical activities – have a limited impact upon the ability of an organisation to achieve competitive advantage. Although these activities are central to successfully serving the needs of customers in each market, any performance advantage obtained in such activities will not lead to a sustainable competitive advantage as competitors or suppliers can easily replicate this performance advantage.

Distinguishing between critical and non-critical activities in the context of outsourcing is important for the following reasons:

- Assessing the importance level of activities allows the organisation to determine whether outsourcing an activity will maintain the competitive position of the organisation or act as a source of competitive advantage. For example, outsourcing an activity such as catering or security that has limited or no impact upon why customers buy the products or services of the organisation is unlikely to have any impact upon competitive differentiation.

- The importance level of an activity is a valuable indicator of the level of resource and attention that should be given to managing that activity. Employing definitions of critical and non-critical activities in this context provides a valuable basis for determining the level of attention that should be given to managing the outsourcing process. For example, a higher level of attention should be given to
an outsourcing strategy that is designed to strengthen a critical activity than the outsourcing of a non-critical activity.

• The importance level of activities is linked to the factors in the external business environment that can create business success. These factors can also change over time due to changes in customer preferences or improved competitive offerings. For example, an organisation may decide to perform an activity internally because it is currently important in the eyes of the customer; i.e. one of the principal reasons why the customer purchases the product. However, over time that factor may diminish in importance in the eyes of the customer as suppliers become more proficient at performing the activity; i.e. it is no longer a source of differentiation. In this case, it will be more prudent to outsource the activity. Employing this approach allows outsourcing evaluation and management to be linked with the factors that create business success.

This analysis of the importance level of organisational activities serves as an introduction to the analysis of the capability of the sourcing organisation in relation to competitors and suppliers.

2.7.3 Capability analysis

A major part of outsourcing evaluation is determining whether an organisation can achieve superior performance levels internally in critical activities on an on-going basis. If the organisation can perform the activity uniquely well, then this activity should continue to be carried out internally. Many organisations assume that because they have always performed the activity internally, then it should remain that way. In many cases, closer analysis may reveal a significant disparity between their internal capabilities and those of the best suppliers and competitors.

Organisations considering outsourcing must rigorously evaluate their capabilities in relation to both their suppliers and competitors. This analysis can identify sources of competitive advantage that can be exploited more fully by further developing certain activities. It also assists in revealing weaknesses that need to be addressed – either through internal improvement or outsourcing – to become more competitive. It can allow an organisation to focus on whether it will be detrimental to their competitive position to outsource activities.
The benefits of carrying out this analysis are as follows:

- Organisations can focus resources on activities where they can achieve pre-eminence and provide unique customer perceived value. If an organisation has leadership in an activity considered to be a key source of competitive advantage then this activity should be held and further developed within the organisation in order to maintain and build upon this position.
- Activities for which the organisation has neither a critical strategic need nor distinctive capabilities are potential candidates for outsourcing. It is more appropriate for an organisation to use external suppliers that are more competent and have a lower cost base.

Determining the capability of an organisation in relation to competitors or suppliers in the context of outsourcing involves an analysis of the following:

- Cost analysis – part of this analysis involves comparing the costs of sourcing the activity internally and from an external supplier. An assessment of the relative cost position of the sourcing organisation in relation to both suppliers and competitors in the activities under scrutiny should also be undertaken. An assessment of costs can form a significant part of capability analysis. The major drivers of cost associated with each activity should be identified.
- Benchmarking – can assist in determining performance levels in the activities under scrutiny. Organisations considering outsourcing must rigorously evaluate their capabilities in relation to suppliers and competitors. This analysis involves a structured benchmarking approach to assessing the organisation’s capabilities relative to potential suppliers and competitors. Benchmarking also involves consideration of the cost position relative to competitors and suppliers.

As well as the importance of the activity under scrutiny, the manner in which capability analysis is undertaken will also be influenced by the priorities of the sourcing organisation. These priorities may have been determined on the basis of the following.

- The organisation may have identified a number of critical activities where it feels its performance is lacking in comparison to external sources. Therefore, urgent
action is required in order to determine the significance of this disparity in performance.

- The organisation may have identified a number of less important activities that it considers as potential candidates for outsourcing.
- Organisational difficulties in certain areas may require rapid performance improvements. For example, complaints about some aspect of customer service may have precipitated the need for action whether it be through improving the activity internally or outsourcing it to a supplier.

2.7.4 Strategic sourcing options analysis

The preceding analysis considered the dimensions of activity importance and organisational capability in the context of outsourcing. These two dimensions yield a number of strategic sourcing options as shown on the matrix in Figure 2.2.

![Figure 2.2: Strategic outsourcing options](Source: Mclvor 2000)
These options should be considered in the context of the following key determinants:

- **The disparity in performance** – this is concerned with determining the sustainability of superior performance in an activity – either by the internal or external source. Some of the insights gained from the capability analysis will assist at this stage. Having a clear understanding of the source of superior performance can provide a reliable indication of the sustainability of such a position.

- **Technology influences** – this is concerned with understanding the influence of technology on the choice of sourcing option. For example, if the environment is characterised by rapid advances in technology then any performance advantages the organisation possesses may be difficult to sustain over a long period of time.

- **External considerations** – factors in the external environment such as the political context, market growth rates, the level of competition and barriers to entry should also be considered. For example, in an industry characterised by high levels of growth and competitive rivalry, competitors can rapidly erode a superior performance advantage in an activity.

- **Behavioural considerations** – with outsourcing being considered as an option, there are likely to be a number of behavioural issues that will affect the freedom of the organisation to outsource. For example, there is the potential for significant workforce resistance to such a move particularly from employees that are going to be directly affected. In fact, in the case of an organisation that is highly unionised, workforce resistance will act as a powerful inhibitor to any form of outsourcing.

- **Supply market risk** – if outsourcing is being considered, then the level of risk associated with the relevant supply market has to be considered. For example, if analysis of the supply market reveals a high level of rivalry between potential suppliers in the supply market then this is a reliable indicator of low risk and the potential for outsourcing.

The Figure 2.3 below considers the implications of each of these strategic sourcing options shown on the matrix in Figure 2.2. Each of these options is considered in the context of the activity importance and capability analysis earlier discussed.
2.7.5 Developing the relationship strategy

Choice of relationship type and management of the outsourcing relationship is crucial to the development of an effective outsourcing strategy. The choice of the relationship type must reflect the overall objectives for outsourcing the activity.

The absence of clear objectives can create difficulties in managing the outsourcing process in a number of areas including selecting the most appropriate supply relationship, drawing up the contract and managing the relationship with the supplier.
Establishing clear objectives at the outset will assist in the management of a more effective outsourcing strategy.

Typical objectives for outsourcing can include reducing the costs of sourcing the activity, enhancing quality levels and obtaining higher levels of service in the provision of activity. The objectives set will reflect the underlying motives for the organisation considering outsourcing as an appropriate strategy.

The objectives for outsourcing are important from a number of perspectives.

- Selecting the supply relationship – the objectives established for outsourcing will assist in selecting the type of supply relationship that should be adopted. For example, if the organisation is focusing primarily on attaining the lowest price, then an adversarial relationship is likely to be the most appropriate. Alternatively, if the organisation wishes to access and integrate the knowledge and design skills of the supplier into its own products then a more collaborative relationship is required.

- Monitoring supplier performance – once the relationship is established the performance of the supplier must be assessed on an ongoing basis. The outsourcing objectives will inform the metrics used to assess supplier performance throughout the life of the relationship. For example, if enhanced service is the key objective for outsourcing, then clearly there must be a number of metrics used to measure performance in this area.

- Monitoring the nature of the supply relationship – the objectives of outsourcing influence how the relationship with the supplier is managed. It is important to monitor whether the relationship is meeting the overall outsourcing objectives. Conditions in the supply market can change which may affect the relationship with the supplier.

There are two key influences on the relationship type that should be chosen.

- Activity importance – the closer the activity impacts upon business success the greater the strategic importance of the activity being outsourced. The importance of the activity being outsourced is a reliable indicator of the attention that the sourcing organisation should give to managing the relationship with the supplier.
• Supply market risk – this refers to factors in the supply market that can create difficulties for the buyer in managing the relationship with the supplier. For example, the number of suppliers in the supply market, competitive demand for supply and the relative size of other buyers are key factors that should be considered at this stage. These factors are sound indicators of supplier power.

These factors will influence the way in which the sourcing organisation will manage the relationship with the supplier. For example, a high level of risk in the supply market will necessitate the development of a supply strategy to secure long-term supply and the employment of mechanisms to encourage the supplier to make investments that are specific to the needs of the buyer.

2.7.6 Establish, manage and evaluate the relationship

Many organisations lack the skills to implement an effective outsourcing strategy. Managing an external supplier requires a different set of skills than those associated with managing an internal business function. For example, the manager responsible for managing the activity when it was performed in-house may not have the range of skills or experience to manage an external provider of the activity. This lack of awareness of the effort involved in managing external relationships can be particularly serious in the outsourcing of critical activities.

2.7.6.1 Supplier selection

One of the most important activities in the outsourcing process is that of supplier selection. Organisations must have a supplier selection strategy, which enables them to achieve the objectives of the outsourcing strategy.

The objectives of the outsourcing strategy will influence the level of attention that the organisation will give to the supplier selection process. For example, in the case of outsourcing critical business activities, supplier selection is a strategic decision that will involve input from senior management. There are a number of steps in the supplier selection process.
2.7.6.2 Determine requirements

The starting point in the supplier selection decision involves the buyer determining what is required from the supplier. This will involve dissecting the activity involved in order to determine the skills and resources required to perform the activity. This will serve as the basis for the request for proposal (RFP), which consists of a purchase description of the product or service, information on quantities, service levels, special terms and conditions, and standard terms and conditions. The objectives of the outsourcing strategy will also assist in this phase.

2.7.6.3 Determine criteria for evaluation

Once the sourcing organisation has decided what is required from the supplier, it can then determine the criteria it wishes to employ to evaluate potential suppliers. This may include quantitative criteria such as price, quality, delivery and service. Also, depending on the model adopted, a new set of supplier selection criteria may come into consideration. Ellram (1990:8-14) uses the term ‘soft’ factors to describe this set of criteria. These soft factors can include issues such as top management compatibility, design capabilities, company culture and the strategic direction of the supplier firm. These factors are unique due to the collaborative nature of the buyer–supplier relationship and are similar to those identified by Ellram (1990:8-14) for a partnership relationship.

2.7.6.4 Evaluation

This phase involves evaluating potential suppliers against the criteria identified in the previous phase. The outsourcing strategy will fail if the supplier cannot meet the criteria identified.

In the case of standardised items, the evaluation will focus primarily on the quantitative criteria identified. The level of evaluation will be influenced by the buyer’s previous experience with suppliers identified. For example, the decision will be informed by the historical performance of the supplier. The depth of evaluation will be determined by how familiar the buyer is with the supplier in question. In many cases, the buyer will normally develop a collaborative relationship with a supplier which it has already done
business with. In fact, in-depth knowledge of the supplier’s capabilities and performance may have created the initial impetus for outsourcing an activity to the supplier.

In relation to the outsourcing of critical activities, the buyer will have to give significant attention to evaluating a supplier for a close collaborative relationship. This will involve a thorough review of potential suppliers by the buyer, usually involving visits to supplier facilities, interviews, presentations, and information sharing. This interaction will occur at both the operational and strategic level. Top management from the buyer and supplier must be involved in communicating the expectations of each party from the relationship. The involvement of top management indicates the importance of the decision to employees at lower levels in both organisations. Interaction at the operational level is also important in the evaluation phase. The success of the relationship will be largely determined at the operational level where the relationship is managed on a day-to-day basis. In effect, this analysis is concerned with evaluating the potential fit between the buyer’s and supplier’s management philosophy and commitment to the same values of improvements over time.

### 2.7.6.5 Selection

In the final selection decision, each supplier will be evaluated against their ability to meet the criteria identified. If the buyer cannot select a suitable supplier that meets the criteria, then this will clearly have significant implications for the outsourcing strategy. The failure to select a supplier may force the company to abandon the outsourcing of the activity and continue to perform the activity internally. Therefore, it is important that the buyer should identify a number of suitable suppliers at a very early stage in outsourcing evaluation in order to avoid this scenario.

Factors such as the relative importance of quality and service have become increasingly prominent in the selection decision. Although price is still the dominant selection criterion
2.8 CONTRACTING ISSUES

The importance of establishing clear objectives for outsourcing has already been emphasised. These outsourcing objectives can also be used as a basis for drawing up a contract for the outsourcing process.

DiRomualdo and Gurbaxani (1998:67-80) found that poor results from outsourcing are as a result of a failure to carry out the following: defining clearly specific objectives for outsourcing; aligning the contract and relationship with the strategic objectives set; making contracts flexible enough to adjust to changes in the business or technology; and ensuring that the supplier has the capabilities required to meet the strategic objectives for outsourcing.

However, clearly established objectives and a well-designed contract can compensate for many of these potential pitfalls. A well-designed contract can allow for most future contingencies and how these contingencies should be dealt with. It is better to have a clear idea of what is required in order to avoid any potential gaps in the contract. The type of activity being sourced and the level of risk in the supply market will influence the design of the contract. For example, in the case of a straightforward activity with a significant number of suppliers in the supply market, the objectives of outsourcing the activity and requirements of the supplier are well defined. Alternatively, if there is uncertainty about the requirements the contract must be designed to reflect this uncertainty. The performance measures incorporated into the contract must reflect the objectives of the outsourcing strategy. For example, it is unlikely that a contract which focuses primarily on securing price reductions from the supplier will lead to the development of a relationship which is designed to foster and encourage inter-firm innovation.

Organisations considering outsourcing must have an understanding of the complex business and legal issues associated with outsourcing and how some of these issues can be dealt with in a contract.

2.8.1 The outsourcing contract

An outsourcing contract will include some of the following aspects:
2.8.1.1 Service level agreement

A service level agreement (SLA) is an agreement between the customer and the supplier that quantifies the service levels required by the customer (Hiles 1994:14-16).

The service level agreement should describe, the types, scope, and nature of all the services required, the times when these services should be available, and the level of performance required. Clearly defined services and service levels are critical elements of an outsourcing contract. Larson (1998:128-132) argues that the key to successful outsourcing involves defining services and service levels that can be measured and managed; can be audited; can be provided at an economic price; and give maximum value to the users of the services. The SLA should also allow the buying organisation to measure the performance of the supplier through a number of mechanisms including regular progress meetings, inspection procedures, etc. The types of performance measures employed will depend upon the outsourcing context.

For example, in information technology context Larson (1998:128-132) has identified the following as dimensions of performance:

- availability – identifies the proportion of the time that the service is actually accessible and usable over a defined time period
- reliability – defines the frequency with which the service is withdrawn or fails over a defined time period
- serviceability – measures the length of available time lost between the point of service failure and service reinstatement
- response – measured as turnaround time or transfer time, for example in the case of a help desk call
- user satisfaction – related to perceived performance versus expectation

2.8.1.2 Transfer of staff

Outsourcing contracts often involve the transfer of staff from the customer organisation to the supplier. As part of outsourcing an activity, the supplier may agree to the transfer of all the employees from the customer organisation involved in that activity.
2.8.1.3 Asset transfer

A common feature of outsourcing is the transfer of assets from the sourcing organisation to the supplier. For example, the customer may transfer the in house equipment that it used to manufacture the equipment to the supplier. This asset transfer may be dealt with through a sale agreement in which the assets are formally transferred to the supplier.

2.8.1.4 Price and payment terms

The price and payment terms must be agreed in the contract. This will involve agreeing when, how and to whom the payments should be made along with the amounts and structure of the payments. A mechanism should be included to allow for any increases or decreases in costs to be built into the contract.

2.8.1.5 Liability

There is the potential for litigation in outsourcing if the supplier fails to meet the required service levels. However, litigation is normally a last resort because it is extremely time consuming with no guarantee of success. An alternative is to write express warranty into the agreement for the supplier to indemnify the company for, any losses, costs, and liabilities associated with the supplier breaching the contract (Lee 1996:15-20). For example, the customer organisation may suffer severe disruption to its operations and a loss of business due to supplier failure. It is therefore important to ensure that these losses are recoverable by explicitly providing for them in the contract.

2.8.1.6 Contract termination

There will normally be a number of conditions under which the contract should be terminated. These conditions can include the bankruptcy of either party, the refusal of either party to abide by the terms set out in the contract or non-payment by the sourcing organisation. There has to be clear agreement on these conditions when the contract is drawn up. It is important to establish at the outset that there is a minimum of disruption to operations in order to extricate either party from the contract. A reasonable time
should also be given to either party to seek to rectify any problems that may arise in the relationship.

2.8.1.7 Flexibility

A robust contract can be a significant determinant on the success of the outsourcing process. Contracts are an extremely effective mechanism in the case of activities for which complete information exists and future uncertainty is manageable. In some circumstances it is possible to incorporate some mechanisms into the contract to create flexibility and allow for future uncertainty. The rationale for building flexibility into an outsourcing contract is based on the premise that factors both internally and externally may change and thus impact the achievement of the desired objectives of the outsourcing.

There are a number of methods of incorporating flexibility into a contract through incomplete contracting.

- Price flexibility – allows prices to be renegotiated as circumstances change during the contract. Incorporating price flexibility means that all future contingencies do not have to be fully considered at the outset, as the buyer and supplier are aware that prices can be adjusted to reflect changes in circumstances.
- Renegotiation – mechanisms are incorporated into the contract that allow for renegotiation based upon changes in the business environment. The contract may include specific clauses under which renegotiation should occur including fixed calendar dates or changes in economic indices. Renegotiation often involves renegotiating more than price and can also focus on the terms of contract.
- Contract length – the employment of shorter contracts can be employed to achieve flexibility. At the end of the contract period a new contract can be negotiated that reflects the current circumstances both internally and externally.
- Early termination – a clause may be incorporated into the contract that sets out the conditions under which the contract may be terminated. The omission of such a clause can result in considerable penalties in the event of the contract being terminated prematurely.
2.8.2 Managing the interaction process

The direction and management of the buyer-supplier relationship will be influenced by the objectives of the outsourcing strategy. The importance of the activity and the level of risk in the supply market will also have determined the type of relationship adopted. However, the success of the relationship will be very much determined by how it is managed at the operational level. Therefore, it is critical that both the buyer and supplier have the necessary skills and resource to manage the interaction process at the operational level. The interaction process will differ considerably depending upon the type of relationship adopted.

2.8.3 Evaluation

2.8.3.1 Relationship performance evaluation

Much of the risk associated with outsourcing arises from the failure of suppliers to deliver and meet the requirements of the buyer. In order to reduce these risks and pre-empt supplier failure, the buying organisation must have a formal mechanism to determine whether the supplier is meeting the performance levels set and whether the objectives in its approach to relationship management are being achieved. There are a number of aspects that should be considered in this evaluation including supplier performance, the strength of the relationship and the level of dependency.

2.8.3.2 Supplier performance

Evaluation of supplier performance is concerned with determining whether the supplier is delivering to the required standards during the contract. This analysis will focus on performance metrics related to quality, delivery, service and ability to reduce costs. Having an effective mechanism of evaluating supplier performance can also serve as basis for comparing performance levels with that of other potential suppliers in the supply market. The approach to evaluation will depend upon the nature of the relationship.
2.8.3.3 The strength of the relationship

As well as evaluating supplier performance, the nature of the relationship with the supplier must be evaluated. Evaluation of the strength of the supply relationship will be guided by the initial objectives established for the outsourcing process. This evaluation is most appropriate in the context of collaborative relationships. For example, monitoring the strength of a close collaborative relationship will involve analysing the presence of intangible factors such as joint problem solving, high levels of information exchange and top management commitment from both the buyer and supplier.

2.8.3.4 The level of dependency

In the choice of relationship, the level of dependency was influenced by the importance of the activity being outsourced and the number of suppliers in the supply market. For example, in the case of a peripheral activity with a readily available number of suppliers, the most appropriate strategy was to create a low level of dependency on the supplier through employing an adversarial relationship. However, changes in the internal and external environment can have a positive or negative effect upon the level of dependency for the buyer over the lifetime of the relationship.

There are a number of factors that can influence the level of dependency:

- Supply market – changes in factors such as the number of available suppliers, competitive demand for supply and the performance of other suppliers can impact the level of dependency in the relationship. However, over time changes such as lower entry barriers and advances in technology can lead to more competent suppliers entering the supply market. In this case, the sourcing organisation will have to consider switching to another more competent supplier or altering the level of dependency with the existing supplier by reallocating some of the business to another supplier.

- Activity importance – the importance of the activity provides a reliable indication of the level of resource and attention that should be given to managing the supply relationship. Over time the importance of the outsourced activity can increase or diminish. The sourcing organisation will have to consider altering the level of dependency in the relationship to reflect changes in the importance of the
activity. Alternatively, the level of dependency can be altered by reducing the importance of the activity.

The evaluation of these aspects of relationship performance will be linked to the objectives of the outsourcing strategy. Evaluation of relationship performance should serve as a stimulus for action.

The following are potential actions that can result from this evaluation

- Maintain the relationship at its current level – in this case, the buyer maintains the relationship while not allocating additional business to the supplier.
- Further develop the relationship – in this case, the outsourcing of the activity has proved to be successful with the supplier having met and exceeded the performance objectives. As a result, the buyer may further strengthen the relationship through giving the supplier more business.
- Discontinue or reduce the scope of the relationship – the buyer may decide to discontinue the relationship with the supplier. If possible, the business should be switched to one or a number of other suppliers. As a last resort, the buyer may decide to bring the business back in-house – sometimes referred to as back-sourcing.

2.9 CONCLUSION

The literature review presented in this chapter has covered the concept of outsourcing, theories of outsourcing; outsourcing practices in various countries and sectors (particularly the IT and Health sector); determinants, motivations/reasons for outsourcing and the benefits; in addition to the roadblocks to outsourcing and outcomes of outsourcing. It also covered Mclvor outsourcing framework (Mclvor 2000:22-36) which provides a frame of reference for this study.
CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This study addresses the practices, motivations, perceived benefits or advantages and barriers or disadvantages to outsourcing by hospitals in Uganda. The aim is to increase adoption and effectiveness of outsourcing by hospitals where appropriate and feasible as a strategic management tool for improving hospital performance in Uganda.

This chapter describes the research design, sample, and techniques for data collection and analysis used for the study; as well as the strengths and weaknesses inherent in the study design. The process that was used to gain permission to conduct the study is outlined. Ethical considerations and issues pertaining to the rigor and trustworthiness of the study are also discussed.

3.2 RESEARCH DESIGN

A research design is a plan for collecting and utilising data or blueprint of how the researcher intends to conduct the research (De Vos, Strydom, Fouché & Delport 2007:132). It is a blue print for conducting a study that maximises control over the factors that could interfere with the validity of the findings (Burns & Grove 2005:734). Polit and Beck (2008:66) define research design as the overall plan for obtaining answers to the research question being studied including specifications for enhancing the study’s scientific integrity. It is essentially the architectural backbone of the study.

A mixed methods approach, with an explanatory sequential design was used for this study. The figure below summarises the overall research design for the study.
Figure 3.1: Research design
3.1.1 Mixed methods research

A mixed methods research design is a procedure for collecting, analysing, and “mixing” both quantitative and qualitative research and methods in a single study to understand a research problem (Creswell 2012:3).

Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixing of qualitative and quantitative approaches during the various phases in the research process. As a method, it focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone (Creswell & Plano-Clark 2007:5).

Specifically, in mixed methods research, the researcher or team of researchers combine elements of qualitative and quantitative approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purpose of breadth and depth of understanding and corroboration (Johnson, Onwuegbuzie & Turner 2007:112).

According to Polit and Beck (2008:309), the advantages of a mixed methods research approach include complementarity, incrementality, and enhanced validity.

*Complementarity:* Using mixed methods approach allows the researcher to use numbers (quantitative data) and words (qualitative data) in order to minimise the limitations of a single approach.

*Incrementality:* Using a mixed methods approach, progress of the research tends to be gradual, relying on feedback loops. By using qualitative findings one can generate hypotheses that can be tested quantitatively. Also, quantitative findings can be clarified through in-depth probing.
Enhanced validity: When a model is supported by multiple and complementary types of data, the researcher will be more confident about the validity of the results. Also, the research question will be answered from a number of perspectives.

It is for these merits that the researcher decided to use the mixed methods approach, in order to generate findings concerning outsourcing by hospitals in Uganda that are supported by both qualitative and quantitative research approaches, hence, enhancing the validity and credibility of the study.

3.1.1.1 Explanatory sequential design

In the explanatory sequential design, quantitative and qualitative methods are implemented sequentially starting with the quantitative phase. It is used when a researcher wishes to use qualitative findings to help interpret or contextualise quantitative results.

The quantitative phase of this study addressed the practices, perceived barriers, perceived benefits and determinants of outsourcing by hospitals in Uganda. Information from this first phase was explored further in a second qualitative phase. Qualitative data collection was used to explore important quantitative results with a few participants. The reason for following up with qualitative research in the second phase was to enable better understanding and explanation of the quantitative results. The findings from the second qualitative phase explain in greater depth the results from the initial quantitative phase of the study.

3.2 QUANTITATIVE RESEARCH PHASE

Quantitative research is an objective, systematic process used to describe and test relationships and to examine cause-and-effect interactions among variables. It involves investigation of phenomena that lend themselves to precise measurement and quantification often involving a rigorous and controlled design where the researcher is independent from what is being researched (Burns & Grove 2005:747; Polit & Beck 2008:763).
Quantitative research is characterised by the use of structured interviews, questionnaires or observations; scales; or physiological instruments to generate numerical data. Statistical analyses are conducted to reduce and organise data, determine significant relationships and identify differences among groups. Control, instruments and statistical analyses are used to render the research findings an accurate reflection of reality so that the study findings can be generalised (Burns & Grove 2005:25).

The quantitative approach is associated with advantages such as being systematic whereby research is through a logical process according to a pre specified plan of action; and control mechanisms are employed to minimise bias and maximise precision and validity and reliability. Empirical evidence gathered through this approach is the basis for knowledge. Findings are grounded in objective reality rather than in the researchers’ personal beliefs or expectations. Also, the numeric information gathered from formal measurements is easy to analyse with statistical procedures (Polit & Beck 2008:16-17).

Some of the disadvantages of the quantitative approach include inflexibility and the inability to answer the “how” and “why” of phenomena. Too much control of the research may sometimes obscure insights into complex environments and qualitative experiences of people (Polit & Beck 2008:16-17).

The quantitative approach is suitable for addressing the study questions related to the current practices, perceived barriers, perceived benefits and determinants of outsourcing by hospitals in Uganda. These call for a description and exploration of factors influencing outsourcing by the hospitals and are amenable to statistical analysis. Also, generalisation of the findings of these aspects of the study to the target population can be easily achieved with the quantitative approach.

For the quantitative phase of the study, which was the dominant phase, the researcher used a non-experimental correlational descriptive design using the survey approach. The quantitative phase also included a cost-benefit analysis based on a case study design.
3.2.1 Non-experimental research

Non-experimental research refers to studies in which the researcher collects data without introducing an intervention. In this study, no intervention was introduced.

3.2.2 Correlational design

Correlational research refers to research that explores the interrelationships among variables of interest without any active intervention by the researcher.

The study explored the relationship between various factors related to the hospital management perceptions regarding outsourcing, hospital characteristics, characteristics of the outsourced services and the hospital’s outsourcing decision and practices.

3.2.3 Descriptive design

Descriptive research is described by Burns and Grove (2005:239) as a research design that provides an accurate portrayal or account of characteristics of a particular individual, situation, or group. It is a way of describing what exists, discovering new meaning, determining the frequency with which something occurs and categorising information.

The purpose of descriptive studies is to observe, describe, and document aspects of a situation as it naturally occurs and sometimes to serve as a starting point for hypothesis generation or theory development (Burns & Grove 2005:26; Polit & Beck 2008:274).

Descriptive studies are usually conducted when little is known about a phenomenon. Currently little is known about outsourcing in Ugandan hospitals and so a descriptive design was appropriate. A descriptive design enabled the researcher to describe the current outsourcing practices by hospitals in Uganda, motivations for outsourcing, the perceived barriers and perceived benefits to outsourcing in addition to the factors that influence outsourcing by the hospitals in Uganda.
3.2.4 Survey approach

The survey approach is a technique of data collection in which questionnaires or personal interviews are used to gather data about an identified population; it is a design used to obtain information about the prevalence, distribution and interaction of variables within a population. It is a non-experimental research that obtains information about people’s activities, beliefs, preferences, and attitudes via direct questioning (Burns & Grove 2005:239; Polit & Beck 2008:323, 767).

The researcher chose a survey approach for the study because of its advantages such as its flexibility and broadness of scope which can be applied to large samples of populations. A further advantage is that it can focus on a wide range of topics and its information can be used for varied purposes like description, exploration and explanation of the phenomena. However, its main disadvantage is that the information obtained tends to be relatively superficial (Polit & Beck 2008:323-324). However, the collected data was probed further during the qualitative phase of the study hence enriching the quantitative findings.

3.2.5 Case study design

This involves exploration of a single unit of study such as a person, family, group, community or institution. A cost benefit analysis was conducted for an outsourced service in one of the participating hospitals that was willing to share financial data. The unit of analysis was the individual hospital for the specifically selected outsourced service (cleaning service).

3.2.5.1 Cost-benefit analysis

This is an analysis technique used in outcomes research that examines the costs and benefits of alternative ways of using resources as assessed in monetary terms and the use that produces the greatest net benefit (Polit & Beck 2008:228). It involves an evaluation of the monetary costs of a programme or intervention relative to the monetary gains attributable to it (Polit & Beck 2008:715).
In this study, for a hospital currently outsourcing a selected service, costs of providing the selected service through outsourcing were compared with the costs the hospital would have incurred if it was providing the service in house (in-sourcing).

3.3 QUALITATIVE RESEARCH PHASE

Qualitative research is the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit & Beck 2008:529). It is a systematic, interactive, subjective approach used to describe life experiences and give them meaning (Burns & Grove 2005:747). The purpose of qualitative research is to discover the essences, patterns, symbols, attributes and meanings of human and related phenomena under study with informants in their natural or familiar environments (Leininger & McFarland 2002:86). Qualitative research’s hallmark is the richness of information and the types of settings that are modified to enrich understanding (Mouton 2001:75).

The qualitative phase of the study, which was the minor phase, was exploratory and descriptive in nature.

3.3.1 Exploratory research

Exploratory research is conducted to gain insight into a situation, phenomenon, community or individual. Generally exploratory research has a basic research goal and researchers frequently use qualitative data (De Vos et al 2007:106).

In this study, the researcher attempted to gain insight into outsourcing by hospitals in Uganda by asking participants about their hospital’s outsourcing practices and the motivations and barriers to outsourcing in their various contexts based on findings from the quantitative phase of the study.

3.3.2 Descriptive research

Descriptive research presents a picture of the specific details of a situation, social setting or relationships. A descriptive study involves a more intensive examination of
phenomenon and their deeper meanings thus leading to a thicker description (De Vos et al 2007:106).

In this study the researcher attempted to get a deeper meaning of outsourcing by hospitals in Uganda by asking a pre-pared list of open ended questions, following up with probes depending on the answer given by the participants.

3.4 RESEARCH METHODS

Research methods refer to the techniques used to structure a study and to gather and analyse information in a systematic fashion (Polit & Beck 2008:731).

The research method outlines a logical process of the research and what processes and procedures are followed to answer the research question and achieve the research objectives (Mouton 2001:56). It includes the research context, study population, sample and sampling technique, data collection and the data analysis techniques, techniques for ensuring validity and reliability and ethical considerations.

3.5 QUANTITATIVE RESEARCH METHODS

3.5.1 Research context

According to Polit and Beck (2008:57), a research context is defined as a specific place where data collection occurs. The research context for this study was the general hospitals in Uganda selected to participate in the study.

3.5.2 Population

Babbie (2001:174) defines a population as an aggregation of elements from which a sample is selected. According to Polit and Beck (2008:337), the study population is defined as the entire aggregation of cases in which the researcher is interested. The population for this study was all general hospitals in Uganda.
3.5.2.1 Target population

Burns and Grove (2005:342) define a target population as the entire set of individuals or elements who meet the sampling criteria. Polit and Beck (2008:338), define it as the total group of subjects about whom a researcher is interested and to whom results could reasonably be generalised. For this study, the target population was the hospitals selected to participate in the study through application of the chosen sampling method.

3.5.2.2 Accessible population

According to Polit and Beck (2008:338), accessible population is the aggregate of cases that conform to designated criteria and are available as subjects for a particular study. Burns and Grove (2005:342) define it as the portion of the target population to which the researcher has reasonable access.

For this study, the accessible population was all sampled hospitals in Uganda that were willing to participate in the study.

3.5.2.3 Eligibility criteria

According to Burns and Grove (2005:342), eligibility criteria refer to a list of characteristics essential for membership or eligibility in the study population.

Polit and Beck (2008:338) refer to it as the criteria that designate the specific attributes of the target population by which people are selected for inclusion in a study.

The following inclusion criteria were used to identify the study population:

• government owned/public sector hospital or private not profit hospital i.e. NGO hospital
• non-referral and non-teaching hospital i.e. not affiliated to any university
3.5.3 Site sample and sampling technique

A sample is a subset of the study population that is selected for a particular study. Members of the sample are then referred to as respondents. Burns and Grove (2005:41) define sampling as the process for selecting a group of people, events, behaviour or other elements with which to conduct a study. A sampling technique is the method used to select a sample from the study population.

3.5.3.1 Mixed methods sampling strategy

The overall sampling strategy for the study was sequential mixed methods sampling, designed to generate a sample that would address the research questions. In sequential mixed models studies, information from the first sample is often required to draw the second sample.

In this study, sequential sampling involved the selection of study hospitals through the initial use of probability sampling techniques for the quantitative study phase followed purposive sampling techniques for the qualitative study phase (QUAN-Qual).

3.5.4 Quantitative phase sampling

In the quantitative phase of the study a stratified random sampling technique was used.

3.5.4.1 Random sampling

Random sampling is the selection of a sample such that each member of a population has an equal probability of being included (Polit & Beck 2008:340). It is a selection process in which each element in the population has an equal, independent chance of being selected.

In probability sampling, every element of the population has an equal opportunity of being included in the sample. Probability sampling increases the likelihood of obtaining samples that are representative of their target population. However, probability sampling has limitations of being inconvenient and complex more especially when the study population is not clearly defined (Burns & Grove 2005:346, 350).
The quantitative phase of the study used a probability random sampling approach so as to obtain a representative sample and also to be able to perform inferential statistics during data analysis. The specific random sampling technique applied was stratified random sampling.

### 3.5.4.2 Stratified random sampling

Stratified random sampling is the random selection of study participants from two or more strata of the population independently (Polit & Beck 2008:733). Strata are subdivisions of the population according to some characteristics e.g. males and females (Polit & Beck 2008:733). Stratified random sampling is used when the researcher knows some of the variables in the population which are critical to achieving representativeness. These identified variables are used to divide the sample into strata or groups (Burns & Grove 2005:752).

In this study, the general hospitals were divided into two strata based on ownership (i.e. government owned or NGO hospital). Random samples were then selected from each stratum taking into consideration the size of each stratum.

The advantage of stratified random sampling is that it enabled the researcher to sharpen the precision and representativeness of the final sample.

### 3.5.4.3 Sample size determination

For stratified sampling with proportionate to stratum size allocation, the formula for sample size termination is as below:

\[
n = \left( \frac{\sum_{h=1}^{L} N_h \sigma_h^2}{N^2 q^2 + \sum_{h=1}^{L} N_h \sigma_h^2} \right) \left( \frac{\sum_{h=1}^{L} N_h \sigma_h^2}{N^2 q^2 + \sum_{h=1}^{L} N_h \sigma_h^2} \right)
\]
Where:
\( n = \text{required sample size} \)
\( N = \text{Total Population size} \)
\( d = \text{difference in the parameter of interest to be detected} \)
\( N_h = \text{Population size per stratum} \)
\( z = \text{value at required confidence level} \)
\( \sigma^2 = \text{variance} \)

Hence for the study population of 92 hospitals (40 government and 52 non-government), the required sample size was 47, comprising of 20 government hospitals and 27 non-government hospitals as indicated in the sample calculation table below:

### Table 3.1: Sample size calculation

<table>
<thead>
<tr>
<th>Code</th>
<th>Source</th>
<th>Number</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td></td>
<td>92</td>
<td>Total population size</td>
</tr>
<tr>
<td>( N_h )</td>
<td>Government Hospitals</td>
<td>40</td>
<td>Population per stratum</td>
</tr>
<tr>
<td></td>
<td>Non-government</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>( \Sigma )</td>
<td></td>
<td>5</td>
<td>Estimated variance</td>
</tr>
<tr>
<td>( Z )</td>
<td></td>
<td>1.96</td>
<td>z-value for 95% confidence</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td>1</td>
<td>Estimated difference</td>
</tr>
</tbody>
</table>

**Calculation:**

\[
\text{Numerator} = \frac{N^2 \sigma^2}{d^2} = \frac{211600}{6} = 35266.66666
\]

| \( N_h \sigma^2 \) | Government Hospitals | 1000 | Non-government | 1300 |

**Table 3.1: Sample size calculation**

<table>
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</tr>
</tbody>
</table>

**Calculation:**

\[
\text{Numerator} = \frac{N^2 \sigma^2}{d^2} = \frac{211600}{6} = 35266.66666
\]

| \( N_h \sigma^2 \) | Government Hospitals | 1000 | Non-government | 1300 |
\[
\begin{array}{|c|c|}
\hline
\Sigma Nh \sigma^2 & 2300 \\
\hline
\text{Denominator} & 4503.249 \\
\hline
\text{Implied sample size } n & 47 \\
\hline
\text{Sample/stratum} & \begin{array}{c} 20 \\ 27 \end{array} \\
\hline
\text{Proposed Sample Size} & 32 \\
\hline
\text{Proposed Sample Size/Stratum} & \begin{array}{c} 14 \\ 18 \end{array} \\
\hline
\end{array}
\]

However, given the enormous cost of collecting data from 47 hospitals all over the country, a sample size of 32 was eventually decided upon. This is the minimum required sample size for any meaningful statistical analysis. The implied allocation for this sample size (based on proportionate stratum size) was 14 government hospitals and 18 non-government hospitals.

3.5.4.4 Sample selection

A sample frame for all hospitals in Uganda was established from the Ministry of Health. According to Polit and Beck (2008:344), a sampling frame is a list of the elements from which the sample will be chosen. Babbie (2001:174) defines it simply as a list of the study population. The sampling frame contained 92 general hospitals. The hospitals in the sampling frame were divided into two strata based on hospital ownership. The sample frame comprised of 40 government owned general hospitals and 52 non-government hospitals (excluding private for profit hospitals).

A sample proportionate to the number of hospitals in each stratum was then selected randomly using systematic sampling to achieve the determined sample size of 32 general hospitals. The final sample comprised of 14 government owned general hospitals and 18 non-government general hospitals.

According to Polit and Beck (2008:347-348), systematic sampling involves the selection of every \( k^{\text{th}} \) case from a list or group and ensures that an essentially random sample is drawn.

In the study, the hospital population comprising 92 general hospitals was divided into two strata according to ownership (40 government owned and 52 non-government hospitals). The hospitals in each stratum were then listed in alphabetical order and
numbered. To draw the sample from each stratum, the starting point was determined by generating a random number between 0 and the population size in each stratum. To draw the target sample of 14 government hospitals from a population of 40 government hospitals, starting at the randomly generated starting number and every 3rd (40/14) hospital in the list was chosen until the target sample was obtained. For the non-government hospitals, to draw the target sample of 18 hospitals out of 52, once the starting point was determined using random numbers, every 3rd (52/18) hospital on the list was chosen until the target sample was obtained. In both cases, if the end of the list was reached before the targeted sample size had been reached, the counting continued from the end to the start of the list. Figure 3.2 below shows the location of the various hospitals included in the final sample.

![Figure 3.2: Map of Uganda showing location of hospitals in the study sample](source: Researcher)
3.6 QUANTITATIVE DATA COLLECTION

According to Burns and Grove (2005:42), data collection is defined as the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypotheses of a study.

3.6.1 Data collection approach and method

The study used a structured data collection approach using a questionnaire with close-ended questions that were administered to respondents in the sampled hospitals.

According to Polit and Beck (2008:371), structured data collection involves a fixed set of questions to be answered in a specified sequence and with pre-designated response options. Fisher, Foreit, Laing, Stoeckel and Townsend (2002:74) define it as an approach that uses a standard questionnaire or interview schedule to ensure that all respondents are asked exactly the same set of questions in the same sequence. While Katzenellenbogen, Joubert and Abdool Karim (2007:83), define this approach as one whereby interviewers follow a well-defined structure to prevent them from placing their own interpretation on the question.

Burns and Grove (2005:398) define a questionnaire as a printed self-report form designed to elicit information that can be obtained through the written responses of the respondent. The questionnaire can be designed to determine facts about the respondent or persons known by the respondent. Examples of such facts can be about events or situations known by the respondent; or beliefs, attitudes, opinions, levels of knowledge, or intentions of the respondent.

The use of a questionnaire is associated with advantages such as less cost, respondent anonymity, absence of interviewer bias, ease of administration and data yielded are easy to analyse. However, it has disadvantages including low response rates, the questions tend to have less depth especially if they are closed-ended questions and the respondent is unable to elaborate on the responses or ask for clarification of the questions (Burns & Grove 2005:398-399; Polit & Beck 2008:423-424).
In the quantitative phase of the study a structured questionnaire was used so as to focus the research process and also be able to quantify the results of the study phenomenon (outsourcing).

3.6.2 Development of the questionnaire

The questionnaire titled “Hospital support services outsourcing questionnaire” was developed using the conceptual framework as a point of reference and taking into consideration the literature review. The items on the questionnaire were close-ended and worded in such a way that respondents were limited to specified mutually exclusive response options. The questionnaire was reviewed and approved by the study supervisor. The questionnaire was in English, the officially used language in all institutions in Uganda. The questionnaire is included in Annex A.

3.6.2.1 Characterisation of the questionnaire

The questionnaire comprised of several sections as below:

- The facility identification section that elicited data on the name, location, ownership, size, budgetary information and past performance of the hospital. The section also collected identification information of the respondents from the hospital who participated in the survey.
- A section introducing the study and requesting the respondents' consent to participate in the study.
- A section about the hospital's strategic planning process and the respondent’s opinion and knowledge about some aspects of outsourcing. This section had nine (9) items. The section also elicited data on the importance of certain services that the hospital needs to deliver health care to its patients. Responses to questions in this section were arranged in form of a Likert scale.
- A section about the hospitals current outsourcing practices and the advantages/benefits or disadvantages/drawbacks that the hospital has experienced from their outsourcing practices. This section with fourteen (14) items comprised of questions to which respondents were to select their response from a provided list.
• A section about the hospitals outsourcing process that consisted of questions about the process the hospital went through before deciding to outsource any currently outsourced services; and how the hospital manages and monitors the outsourcing process. The section comprised of seven (7) items to which respondents were to select their response from a provided list.

• A section for hospitals that were not currently outsourcing, comprising of seven (7) items with questions about why the hospital was not currently outsourcing, if they intended to outsource in the future and the likely support services they would outsource.

• A section on the perceived benefits/advantages of outsourcing, comprising of a ten (10) items with a list of statements about the potential benefits/advantages of outsourcing as identified from the literature. Respondents were required to indicate their level of agreement or disagreement with the statements based on responses on a Likert scale.

• A section on the perceived risks/disadvantages of outsourcing, comprising of seven (7) items with a list of statement about the potential risks/disadvantages of outsourcing as identified from the literature. Respondents were required to indicate their level of agreement or disagreement with the statements based on responses on a Likert scale.

• A section on the perceived barriers/roadblocks to outsourcing comprising of five (5) items with a list of statements about potential bottlenecks that organisations may face regarding the decision to outsource as identified from the literature. Respondents were required to indicate to what extent they perceived those barriers to apply to their hospitals based on responses on a Likert scale.

• A section on the respondent’s perception about the characteristics of outsourced services. This section comprised of four (4) items with statements regarding characteristics of services that the hospital could ideally outsource based on a review of the literature. Respondents were required to indicate their level of agreement with the statements based on responses on a Likert scale.

3.6.3 Pre-test

According to Polit and Beck (2008:380, 762), a pre-test is a trial administration of a newly developed instrument to identify flaws or assess time required to complete the
questionnaire. During the pre-test, it is possible to identify questions that are ambiguous or that respondents may find objectionable or difficult to understand and for the researcher to determine whether the sequencing of the questions is sensible or not.

After the approval of the questionnaire by the supervisor, a small scale pilot study was conducted to pre-test the questionnaire with respondents from three hospitals that meet the eligibility criteria for the main study. This was done to identify gaps in the questionnaire. The hospitals that participated in the pre-test were not included in the main study. Based on the pre-test, any required changes were made to the questionnaire. The pre-test also helped the researcher to identify training needs for the research assistants who helped with data collection. A report of the pre-testing of the initially developed questionnaire is included in Annex B.

3.6.4 Data collection process

The researcher used three research assistants to distribute and administer the questionnaire to the respondents at the various hospitals. The research assistants were trained and equipped with the knowledge of obtaining consent from respondents, administrating the questionnaire, interacting with respondents, data collection techniques and issues of confidentiality and anonymity during the process of conducting the research. A training manual was developed by the researcher for this purpose to ensure a comprehensive and standardised training for all research assistants.

After introducing the study and presenting an introduction letter from the Ministry of Health, the research assistants requested permission to collect data from management of the various hospitals in the study sample. A separate quiet room was used by the research assistants to administer the questionnaires to the selected respondents. Respondents included either the hospital medical superintendent or hospital administrators. These are the top managers of the hospitals. The managers were provided with and requested to fill in the questionnaires. After administering the questionnaires for their allocated hospitals, the research assistants passed on the filled questionnaires to the researcher.
3.6.5 Data management and analysis

After completing the questionnaires, the research assistants submitted the questionnaires to the researcher for verification, cleaning and data capture. The responses were coded by the researcher and entered into Excel to create an excel database. This was then exported to SAS 9.3 for statistical analysis. An experienced statistician assisted with the statistical analysis. A confirmation letter from the statistician who helped with data analysis is included in Annex C.

Outsourcing was dichotomised on the basis of whether a hospital outsources one or more of the services it provides. Descriptive statistics including mean, standard deviations, range, frequency distributions, contingency tables and percentages were obtained for the different study variables as appropriate. The different study variables related to the outsourcing practices of the hospital, hospital manager’s attitudes and perceptions towards outsourcing, characteristics of the outsourced services and hospital characteristics were used in the analysis of data to describe and make inferences. Wilcoxon-Mann-Whitney tests were used for statistical data analysis.

3.7 VALIDITY AND RELIABILITY

Validity and reliability are important concepts and of concern throughout the research process. They are important to the researcher during the research process and to those who read the study report as they provide a basis for making decisions as they consider using the findings in their practice.

3.7.1 Validity

According to Polit and Beck (2008:457-458), validity is defined as the degree to which an instrument measures what it is supposed to measure. On the other hand Burns and Grove (2005:376) define the validity of an instrument as the extent to which the instrument actually reflects the abstract construct being examined.

Validity is a concept that broadly concerns the soundness of the study’s evidence; that is, whether the findings are cogent, convincing and well grounded. Another aspect of validity concerns the quality of the researcher’s evidence regarding the effect of the
independent variable on the dependent variable. It is an important criterion for assessing the methods of measuring the variables. Validity varies from one sample to another and from one situation to another; therefore, validity testing actually validates the use of an instrument for a specific group or purpose rather than the instrument itself.

In this study, the degree of face, content, internal and external validity of the instrument were determined or ensured by the researcher using various approaches for the intended purpose and the context where the study was conducted. (Burns & Grove 2005:377).

### 3.7.1.1 Face validity

Face validity refers to whether the instrument looks like it is measuring the appropriate construct or not. It verifies that the instrument looks like it is valid or gives the appearance of measuring the content. It is an important aspect of the validity of the instrument because the willingness of respondents to complete the instrument is related to their perception that the instrument measures the content they agreed to provide (Burns & Grove 2005:379; Polit & Beck 2008:458).

In this study, the researcher ensured face validity by careful selection of items to be included in the questionnaire based on a thorough literature review. The items included reflected the concept of outsourcing and the factors that influence the outsourcing decision, in addition to the roadblocks to outsourcing. Face validity was also established by consulting colleagues of the researcher and study supervisor to provide some input in the questionnaire design.

### 3.7.1.2 Content validity

Burns and Grove (2005:377) define content validity as the extent to which the method of measurement includes all the major elements relevant to the construct being measured. Polit and Beck (2008:458) define it as the degree to which an instrument has an appropriate sample of items for the construct being measured.

To ensure content validity, the researcher conducted an extensive literature review especially of journal articles and publications addressing the concept of outsourcing
generally and in the health or hospital sector specifically. With a thorough conceptualisation of the construct from literature review and based on the study’s theoretical framework a questionnaire that captures the entire content domain was designed.

To enhance content validity, the developed questionnaire was presented for review to a statistician, senior colleagues and the study supervisor to make an input because of their experience in practice and quantitative research. This helped in refining the questions for better meaning, clarity and conceptualisation.

3. 7.1.3 Internal and external validity

Internal validity refers to the extent to which it is possible to make an inference that the independent variable is truly causing or influencing the dependent variable and the relationship between the two is not the spurious effect of an extraneous variable.

For this study the dependent variable was the decision to outsource and the independent variables were the various factors related to hospital management perceptions/ attitudes towards outsourcing; characteristics of the outsourced service and hospital characteristics.

External validity is defined as the generalisability of the research findings to other settings or samples. In other words, it is the degree to which the conclusions in the proposed study would hold for other persons in other contexts and at other times (Polit & Beck 2008:287, 295, 301).

In this study, anticipated threats to internal and external validity included sample selection, expectancy effect, instrumentation and researcher effect. To enhance the internal and external validity the researcher used stratified proportionate to stratum size random sampling to draw a sample that was representative of the study population. Efforts were made to ensure that the accessible population was as much as possible similar in characteristics to the target population by increasing response rates through visiting the respondents to administer the questionnaire as opposed to just mailing questionnaires to respondents and asking them to answer the questions and mail back the questionnaire.
Researcher effect refers to a situation where by the hypothesis held by the researcher can lead him or her to unintentionally alter his or her behavior toward the research participants in such a way as to increase the likelihood that participants will respond so as to confirm the investigators hypothesis or expectations. To minimise this, research assistants who do not know about the hypothesis underlying the study were used to collect data. The researcher developed a data collection manual to guide and standardise the interaction between the research assistants and the respondents during data collection. The research assistants were trained according to the developed manual.

Instrumentation, a situation whereby data collectors may unconsciously change the criteria they use to collect data, was minimised by only using the trained research assistants to collect data and using the same questionnaire for data collection in all study sites. This ensured that any differences in responses received from the various study sites were actual and not due to variations in the data collection process across the different study sites.

However, the expectancy effect, a situation where participants in the study discover what the study is about and act differently could not be completely avoided as the respondents’ participation in the study could not be hidden since their consent to participate needed to be sought. However, the expectancy effect was minimised by emphasising to the respondents before the interview the importance of the research and reiterating the importance of the respondents giving correct answers to the questions asked most especially about their perceptions or attitudes related to outsourcing.

3.7.2 Reliability

According to Polit and Beck (2008:452), reliability refers to the accuracy and consistency with which an instrument measures the target attribute. It is often associated with the method used to measure the research variables. Burns and Grove (2005:374) define the reliability of a measure as the consistency of measures obtained in the use of a particular instrument.
Reliable instruments enhance the power of the study to detect significant differences or relationships actually occurring in the population under study. Reliability exists in degrees and is usually expressed as a form of correlation coefficient with 1.00 indicating perfect reliability and 0.00 indicating no reliability.

Reliability testing is concerned with characteristics such as dependability, consistency, precision and comparability. The researcher, in consultation with a statistician, used the Cronbach’s alpha co-efficient to test reliability of the study instrument.

3.8  CASE STUDY: COST BENEFIT ANALYSIS OF OUTSOURCED SERVICE

A cost benefit analysis is an evaluation of the monetary costs of a programme or intervention relative to the monetary gains attributed to it (Polit & Beck 2008:714).

One of the reported benefits of outsourcing in the hospital sector is lower costs of outsourced services in addition to reduced number of personnel and higher levels of satisfaction with outsourced services (Rahimi et al 2011:58). It should thus be possible to compare costs of offering the service in house (in-sourcing), versus the costs of outsourcing the service. The difference in the two costs would thus be the monetary gain or cost saving attributed to outsourcing a given service.

In a cost benefit analysis, the actual costs associated with an activity (outsourcing and in-house service provision in this case) and not prices (e.g. the outsourcing contract price) must be used. Costs are a measure of the actual use of resources rather than the price charged (Burns & Grove 2005:298). The costs should include opportunity costs in addition to any other costs for example third party payments.

In this study, for a hospital that is currently outsourcing a cleaning services, the costs of providing the service through out-sourcing was determined. In addition to the contract price for the out sourced service, the costs included the costs incurred in setting up and monitoring the out sourcing contract in addition to the opportunity costs the hospital may have incurred as a result of outsourcing. This was then compared with the costs the hospital would have incurred if it was providing the outsourced service in house, making it possible to determine if for the evaluated case outsourcing resulted in lower costs for the service.
3.8.1 Scope and perspective

The scope for the economic evaluation in this study was one year using historical data. Thus costs for providing the contracted service in-house by the hospital were compared with the costs of having the service provided through an outsourcing contract for a one year period.

The perspective of an economic evaluation (societal or confined to some organisation) affects the range of both outcomes and costs that should be included. The perspective adopted affects the “resource frame” of the study. It determines the point of view from which costs are measured.

The perspective adopted for this economic evaluation was the organisational (hospital’s) perspective. Thus only those costs incurred by the hospital under study related to the in-house provision or outsourcing the given service were considered.

3.8.2 Resource identification

Identification consists of listing the likely resource effects of the intervention as comprehensively as possible so that decisions can be made about the frame of the study.

Through a discussion with the hospital managers, the resources used by the hospital to provide the cleaning service in-house before it was outsourced were identified. These included staff time, utilities and consumables. The costs involved in the outsourcing process were also identified. Besides the contract price for the outsourced services, organisational resources involved in setting up and monitoring the outsourcing contract (e.g. staff time) were also identified.

3.8.3 Resource measurement and valuation

Two strategies can be used in measuring and valuation: micro costing and gross costing. Micro costing refers to detailed analysis of the changes in resource use due to a particular intervention. Such detailed, bottom up, collection of data on resource use
may be necessary when changes are being made to existing services. With micro costing, valuation is likely to require customised work as prices are unlikely to be available. It thus tends to be costly and runs the risk of being specific to particular contexts. Gross or top down costing allocates a total budget to specific services such as hospital stays or doctors' visits according to rules. The simplicity of top down costing may be offset by a lack of sensitivity, which in turn depends on the type of routine data available.

In this study, a mixture of the two approaches was adopted, using micro costing for the direct costs of providing or outsourcing the service, and gross costing for other costs. The general costs categories included personnel costs, utilities, other recurrent costs and equipment costs where applicable.

### 3.8.3.1 Resource measurement

Measurement refers to the determination of the changes in the quantity of resources included in the study.

Through a discussion with the hospital managers and document review an attempt was made to determine the quantities of the earlier identified resources expended by the hospital in providing the service for a one year period before it was outsourced. Also, any changes in internal resource use due to the outsourcing contract (e.g. reduction in number of hospital staff) were also identified. Whereas this was possible for some of the resources (e.g. hospital staff), it was not possible for others, especially the utilities and consumables. The contract price and the amount of internal resources expended by the hospital in setting up and monitoring the outsourcing contract were also determined.

### 3.8.3.2 Resource valuation

This involved assigning a value to the resources used. The resource effects earlier identified and measured were valued in order to establish their monetary value. The quantity of each resource (e.g. hospital staff) was multiplied by the relevant units (e.g. monthly salary) to yield total costs. For the resources like the utilities and consumables for whom quantities had not been determined, the hospital managers provided
aggregate costs of the hospital’s spending during the in-sourcing and outsourcing of the cleaning service.

3.8.4 Data sources and data collection

Data sources included the hospital managers themselves, in addition to various documents of the hospital. These included contract documents, pay roll, annual financial reports and equipment inventory. Data was collected through interviews with the hospital managers in addition to a review of the relevant documents. Hospital managers were sent a data collection sheet with some contextual questions and a table to input cost data. This is shown in Annex D.

3.8.5 Data management and analysis

The collected resources and cost data was entered into a Microsoft Excel spreadsheet set up for this purpose and analysed using Microsoft Excel. The total costs of delivering the cleaning service over a one year period were compared with the total costs of delivering the service in-house by the hospital (in-sourcing) to determine if for the evaluated case, outsourcing resulted in lower costs cleaning costs for the hospital.

3.9 QUALITATIVE RESEARCH METHODS

3.9.1 Population

The population is the entire set of individuals having some common characteristic. The accessible population comprises the individuals who conform to the eligibility criteria and are available for a particular study (Burns & Grove 2005:342; De Vos 2002:198).

The population for the qualitative phase of the study was all hospitals in Uganda. The target population was hospitals that participated in the quantitative phase of the study. The sample was selected from hospitals that met the inclusion criteria and whose hospital management (Medical superintendent or hospital administrator) could be contacted and were willing to participate in a follow up interview to the quantitative data collection. This was the accessible population.
3.9.2 Setting

Setting is defined as a quiet environment that is private, comfortable, non-threatening and easily accessible to facilitate the interview process (De Vos et al 2007:294-295).

The research setting was the general hospitals in Uganda selected to participate in the study, this being where outsourcing decisions are made and implemented.

3.9.3 Sample and sampling method

Sampling is the process of selecting a portion of the population to represent the entire population. The selected elements are then referred to as the sample (Polit & Beck 2008:340).

A sample is defined as a set of individuals selected from a population for analysis to yield estimates of the whole population or a subset of the population that is selected to represent the population (Brink et al 2011:214).

Sampling approach (design) refers to decision making on whether probability (random) or no probability (non-random) sampling will be done (Polit & Beck 2008:340). Sampling method refers to the approach used to obtain a sample which can be probability or random sampling and non-probability sampling (Brink et al 2011:134).

The sample consisted of managers (Medical superintendent or hospital administrators) from targeted hospitals in Uganda that participated in the quantitative phase of the study.

A purposive sample of participants was selected and included in the study based on the established eligibility criteria. Purposive sampling is a non-probability sampling method in which the researcher selects participants based on personal judgement about which ones will be most representative or informative (Polit & Beck 2008:729).

A purposive sample was used because it was an easy and economical way of identifying information rich cases that would help achieve the qualitative research
objectives. The sample size depended on the saturation of information during data collection.

3.9.3.1 **Eligibility criteria**

The term eligibility criteria refers to criteria used by a researcher to designate the specific attributes of the target population, and by which subjects are included or excluded from participation in a study (Burns & Grove 2005:342; Polit & Beck 2008:290).

Specific criteria were used to decide which hospital managers would form part of the sample (Brink et al 2011:133). The eligibility criteria were as follows:

**Inclusion criteria:**

- Participation in the quantitative phase of the study/data collection
- Currently outsourcing or insourcing one or more support service
- Could be contacted and willing to participate in a follow on interview from the quantitative data collection

**Exclusion criteria:**

Those hospitals that were not willing to participate in a follow on interview or those that could not be contacted by any means (e.g. by telephone) to set up a follow up interview.

3.10 **QUALITATIVE DATA COLLECTION**

Data collection refers to the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study (Burns & Grove 2005:732). It is the gathering of information to address a research problem (Polit & Beck 2008:716). Data may be gathered by a variety of data collection methods. These methods correspond with data sources (Mouton 2001:104).

Interviewing is the predominant mode of data or information collection in qualitative research (De Vos et al 2007:287). Interviews are structured or unstructured verbal
communication between the researcher and subject during which information is obtained for a study (Burns & Grove 2005:740). They are a method of data collection in which one person (an interviewer) asks questions of another person (respondent). Interviews can be conducted either face to face or by telephone (Polit & Beck 2008:721).

3.10.1 Data collection approach

In the qualitative phase of the study, semi structured one to one, face-to-face interviews were used. A semi structured interview is an interview in which the researcher has listed topics to cover rather than specific questions to ask (Polit & Beck 2008:732).

Semi structured interviews were used to ensure that a specific set of topics was covered based on findings from the quantitative phase of the study. At that time in the study process, the researcher knew what to ask but was not able to predict what the answers from the participants would be. During the interviews, the function of the researcher was to encourage participants to talk freely about all topics on the list and to share their experiences in their own words. This ensured that the researcher obtained all the information required and provided the respondents freedom to respond in their own words, providing as much detail as they wished and offering illustrations and explanations.

3.10.2 Data collection instrument

The researcher used an interview guide for the semi structured interviews. An interview guide is a list of questions to be covered in a semi-structured interview or focus group interview (Polit & Beck 2008:734).

Prior to development of the interview guide the researcher reviewed the quantitative findings to identify areas that needed further exploration or explanation. The topic guide contained a list of questions arranged in a logical sequence from general to specific questions based on findings from the quantitative phase of the study. The list of questions included suggestions for follow up questions designed to elicit more detailed information. The questions were shared with the study supervisor for their review and input. The topic guide is included Annex E.
3.10.3 Data collection process

The interviews took place at the selected hospitals and were recorded on an audio recorder with the permission of the participants (Katzellenbogen et al 2007:177).

Key informants (Medical superintendents or hospital administrators) identified during the quantitative phase of the study were interviewed. A key informant is a person well-versed in the phenomenon of research interest and who is willing to share the information and insights with the researcher.

The researcher took notes during the interview and used the notes during the transcription to capture the researcher's own observations. The observations made during data collection assisted the researcher during data analysis in providing additional insight into emergent themes and subthemes.

3.10.4 Data management

The researcher’s observations were noted at the back of the interview guide. Each taped interview was typed by the researcher in the form of a verbatim transcript. The researcher typed the transcripts within two days of the interview and completed the transcripts of one day’s interview before the next day of interviews. A sample transcript from the interviews is shown in Annex F.

3.10.5 Qualitative data analysis

Data analysis was done using open coding. During the analysis, the collected data was broken up into manageable themes, patterns, trends and relationships. The analysis aimed at understanding the various constitutive elements of the collected data through inspection of the relationships between concepts, constructs or variables and to see whether there were any patterns or trends that could be identified or isolated to establish themes in the data (Mouton 2001:108).

Content analysis was done to explore in detail the common themes which were then established into units of meaning or codes (Mouton 2001:198).
Audio recorded data was transcribed verbatim and the resulting texts were analysed. The researcher will use a computer analysis ATLAS/ti to aid in the coding and management of textual data, for storage and retrieval of information more quickly and accurately. A sample output from the ATLAS/ti software is included in Annex G.

Creswell’s (1998) analytic spiral as described by Marshall and Rossman (1999:150) was utilised to analyse data as follows:

1. Planning for recording of data
2. Data collection and preliminary analysis
3. Managing or organising data
4. Reading and writing memos
5. Generating categories, themes and patterns
6. Coding the data
7. Testing the emergent understandings
8. Searching for alternative explanations
9. Representing, visualising (i.e. writing report)

3.11 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness refers to the confidence qualitative researchers have in their data. This was assessed using the criteria of credibility, transferability, dependability and conformability (Polit & Beck 2006:511).

3.11.1 Credibility

Credibility is a criterion for evaluating data quality in qualitative studies, referring to confidence in the truth of the data (Polit & Beck 2008:539). The following strategies were used by the researcher to enhance credibility of the study:

**Member checking:** During the face to face interviews with the participants during the process of data collection, member checking was carried out by the researcher occasionally rephrasing the participants’ responses to check if the responses had been interpreted correctly by the researcher. Participants were encouraged to provide critical feedback about factual or interpretive errors or inadequacies.
**Prolonged engagement** was achieved through investment of sufficient time collecting data to have an in depth understanding of the information provided by the participants and to test for misinformation and distortions (Polit & Beck 2008:545). The researcher spent as much time as necessary interacting with the participants during data collection.

**Reflexivity:** During the process of conducting interviews, the researcher was aware of the interaction between himself and the data. Acknowledgement and analysis of this process is termed reflexivity (Lietz, Langer & Furman 2006:441).

**Peer debriefing and examination** which involved a session with the hospital superintendent or hospital administrator for peer review and to explore various aspects of the inquiry (Polit & Beck 2008:544). However, due to time constraints, it was not possible to give back the findings to the participants after data analysis for confirmation or modification.

Throughout the phase of data collection and data analysis, the researcher worked in close collaboration with the supervisor referring samples of interview transcripts and coded analysis for comments and guidance. This further enhanced the credibility of the research.

### 3.11.2 Dependability

Dependability is a criterion for evaluating data quality in qualitative data, referring to the stability of data over time and over conditions (Polit & Beck 2008:539). Dependability is enhanced by taking steps to ensure that the findings are consistent if the study is replicated with the same informants or in a similar context.

In this study, dependability was achieved by applying strategies to enhance the credibility of the study and by establishing an audit trail. Lietz et al (2006:451) describe audit trail as keeping track of the decisions which led to the choice of particular steps in the research procedure. Reasons for the choice of research design, sampling type and sample size and methods of data collection and analysis are described in the study report. This provides others who intend to replicate the research project in another context with the necessary methodological information.
3.11.3 Confirmability

Confirmability is a criterion for evaluating data quality with qualitative data, referring to the objectivity or neutrality of the data (Polit & Beck 2008:539). It refers to documented verbatim statements and direct observational evidence from informants, situations and other people who firmly and knowingly confirm and substantiate the data or findings (Leininger & McFarland 2002:88).

During this study, confirmability was enhanced through the following strategies:

- **Member checking** whereby, during the data collection, confirmation was sought from the participants that the data collected was a true reflection of their narratives regarding outsourcing in their hospitals.

- **Creating an audit trail** that can be used independently to establish both the dependability and confirmability of the data. This was done through a systematic collection of materials and documentation that could allow an independent auditor to come to conclusions about the data. The materials included the raw data including field notes; interview transcripts and the data reduction and analysis products.

3.11.4 Transferability

Transferability refers to the extent to which findings can be transferred to other settings or groups (Polit & Beck 2008:539). It refers to whether the findings from a completed study have similar (not necessarily identical) meanings and relevance to be transferred to another similar situation, context or culture (Leininger & McFarland 2002:88). Data from this study are transferable to their sources only.

3.12 ETHICAL CONSIDERATIONS

According to De Vos et al (2005:57), ethics means preferences that influence behaviour in relations. Ethics is mostly associated with morality, to deal with issues of right and wrong among societies. Polit and Beck (2008:753) describe ethics as a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations of the participants. Ethical considerations in research should
uphold fairness, honesty, openness, disclosure of methods, and the purpose for which the research is being carried out.

For any study, the research process starting with identification of the study to publication of the findings should adhere to ethical standards of research which means that the respondents’ rights and the rights of the institution should be protected. Scientific integrity should also be maintained.

Research ethics including protecting the rights of the respondents and the institutions in which research is done, and maintaining scientific integrity (Burns & Grove 2005:181-206; Polit & Beck 2008:188-207; Tjale & De Villiers 2004:215-235) were observed in this study as below:

3.12.1 Protecting the rights of the participants

The study involved human subjects as respondents thus the following was done to protect their rights:

3.12.1.1 Informed consent

Obtaining informed consent from human subjects is essential for the conduct of ethical research. It involves the transmission of essential ideas and content of the research from the investigator to the prospective subject and then the prospective subject’s agreement to participate in the research as a subject is reached after assimilation of the essential information. Informed consent consists of four elements i.e. disclosure of essential information, comprehension, competency and voluntarism (Burns & Grove 2005:193).

To ensure adherence to this stated ethical standard, the questionnaire used for the quantitative data collection contained introductory text providing information about the study and informing the respondents that their participation was voluntary; specifically asking them if they wanted the data collection to continue. For the qualitative data collection, a written informed consent form explaining the objectives, the benefits and potential risks of the study was developed and administered to each respondent. The respondents were requested to sign the consent form as a way of confirming their
acceptance to participate in the study. The qualitative data collection form is included in Annex H.

3.12.1.2 Confidentiality and anonymity

Confidentiality is defined as the management of private data so that subjects’ identities are not linked with their responses and are never publicly disclosed whereas anonymity is when the subject’s identity cannot be linked even by the researcher with his or her individual responses (Burns & Grove 2005:728, 731).

To ensure confidentiality, respondents were assured that all their individual responses and information obtained from them during the study would not be disclosed to anyone. Also, quantitative research findings from the study are reported in aggregate and cannot be connected to any respondent. However, given the need to follow up some selected respondents from the quantitative phase of the study during the qualitative phase, some personal identification data needed to be collected making it impossible to maintain anonymity. This was explained to the participants and they were assured that their identification information would be kept confidential and would not be shared with other people. In the qualitative phase of the study confidentiality and privacy were ensured by using a password, restricted access computer for the collected text data; and anonymity was guaranteed by assigning interviewees codes instead of names.

Data collected for the cost benefit analysis case study included financial data. This kind of data is usually sensitive and most institutions may not be comfortable sharing such data. A confidentiality binding form was signed between the researcher and the hospital managers providing the financial data. This was to ensure confidentiality of the provided data and to assure the data managers that the provided data was to only be used for purposes of the study. The confidentiality binding form is included in Annex I.

3.12.2 Respect for human dignity

Respect for human dignity includes the right for self-determination and the right for full disclosure. A respondent’s right to self-determination includes freedom from any explicit or implicit threats of penalty from failing to participate in a study or excessive rewards from agreeing to participate. Full disclosure means that the researcher has fully
described the nature of the study; the person’s right to refuse to participate, the researcher’s responsibilities, and the likelihood of risks and benefits (Polit & Beck 2008:171-172).

To ensure respect and dignity for the respondents, all respondents were briefed about the study objectives, their rights, the benefits and potential risks before being asked to participate in the quantitative phase of the study. For the qualitative phase of the study, participants were requested to sign the consent form after the briefing as a sign that they agreed to participate. Data was collected in a socially conducive environment and secluded venue. Respondents were not coerced to participate in the study and no excessive rewards were given to those who accepted to participate in the study. Respondents who participated in the qualitative phase of the study were informed beforehand that there was a likelihood that they would be approached by the researcher in future during the second phase of the study (qualitative phase) to provide some additional information related to their responses.

3.12.3 Right to withdraw from the study

Prospective respondents in a study have a right to self-determination i.e. they have a right to ask questions, refuse to give information, ask for clarification and discontinue participation or withdraw from a study at any time without penalty or loss of benefits (Burns & Grove 2005:194, Polit & Beck 2008:172).

In this study, the respondents were informed of their right to withdraw from the study at any time they wished to do so or if they felt uncomfortable.

3.12.4 Protecting the rights of the institutions

Permission to conduct the study was obtained from the UNISA Scientific committee (see Annex J) and Higher Degrees Ethics Committee of the Department of Health Studies at UNISA (see Annex K); the ethical review committee of Lacor hospital in Uganda (see Annex L) and the Uganda Council of Science and Technology (see Annex M). The researcher also requested for permission from the Ministry of Health in Uganda to conduct the study (see Annex N) which was granted with provision of an introduction letter for the researcher to be presented to the study hospitals (see Annex O). Finally,
informed consent to participate in the study was obtained from the selected individual participants in the various hospitals.

3.12.5 Scientific integrity of the research

When carrying out the study, the researcher avoided any form of plagiarism by ensuring that all the sources of the scientific information quoted in the study are acknowledged and correctly referenced. The researcher used objective methods to collect, analyse and report study findings. The methodology used was selected based on the research objectives and not any other reason. The collected data was interpreted according to methodological standards and not the researcher’s preferences. The researcher maintained honesty when writing and reporting the findings. Both positive and negative findings were accurately reported.

3.12.6 Dissemination of the research findings

The findings of this study will be disseminated in the form of publications in accredited journals and presentation at the relevant gatherings such as conferences and workshops (Katzellenbogen et al 2007:27-34).

3.13 CONCLUSION

This chapter discussed the research design and methodology for the various phases and components of the study. The data collection method and data analysis for each phase or component were explained. Ethical issues surrounding the study were also elaborated. The next chapter will present the data analysis and findings of the study.
CHAPTER 4

ANALYSIS, INTERPRETATION AND DISCUSSION OF QUANTITATIVE DATA

4.1 INTRODUCTION

This chapter discusses the quantitative data analysis and interpretation of the findings.

According to Kruger, De Vos, Fouché and Venter (2005:218), the purpose of quantitative data analysis is to categorise, order, manipulate, and summarise data to an intelligible and interpretable form in order to provide answers to the research objectives and be able to draw conclusions from the data.

The objectives of this study were to:

- Describe the current outsourcing practices and processes by general hospitals in Uganda.
- Identify perceived benefits or advantages and drawbacks or disadvantages of outsourcing by general hospital managers in Uganda.
- Identify determinants and factors associated with outsourcing by general hospitals in Uganda.
- Conduct a cost benefit analysis of an outsourced service in one of the study hospitals.
- Identify interventions to increase adoption and effectiveness of outsourcing by hospitals in Uganda where appropriate and feasible.
- Develop an outsourcing framework and guidelines for use by hospital managers during the outsourcing process.

Specifically, the study sought to answer the following quantitative research questions:

- What are the current outsourcing practices and processes by general hospitals in Uganda?
• What are the motivations, attitudes, perceived benefits and barriers to outsourcing by general hospital managers in Uganda?
• What is the relationship between the hospital managers’ attitudes, perception of benefits and barriers to outsourcing and their decision to outsource one or more hospital support services?
• What is the relationship between a hospital’s characteristics and its decision to outsource one or more of the support services it requires?
• What is the relationship between the hospital managers’ perception of the various support services characteristics and the decision of the hospital to outsource those services?
• What are the costs versus the benefits of an outsourced service in one of the study hospitals?

The collected quantitative data was analysed according to the objectives of the study.

Thus, the results are not necessarily presented or discussed in the sequence of the theoretical framework or that of the questionnaire.

This chapter is organised as follows: response rate, data analysis including testing of the reliability of the scale used. The descriptive and inferential statistics that were used are briefly discussed. This is followed by the presentation of the sample characteristics and the research findings. Finally the chapter summary is presented.

The findings related to the cost benefit analysis are presented in a separate chapter (Chapter 6).

4.2 RESPONSE RATE

The response rate is the rate of participation in a study. According to Polit and Beck (2008:765), the response rate is calculated by dividing the number of persons participating in the study by the number of persons sampled.

The response rate for this study based on the initial sample list was 90% which is considered to be very good. This good participation is probably an indication that the study was interesting to the participants given that there were many questionnaire
items. However, given the conservative sample, the non-responding hospitals were replaced with other similar hospitals in order to ensure the minimum sample size of 32 for statistical analysis purposes.

4.3 DATA ANALYSIS

Polit and Beck (2008:751) describe data analysis as the systematic organisation, synthesis of research data, and testing of the hypothesis using those data.

The purpose of data analysis is to provide answers to the research questions or objectives. The plan for data analysis comes from the research objectives, the research design, the methods of data collection used, and the level of measurement of data (Wood & Ross-Kerr 2006:243).

4.3.1 Statistical analysis programme

The SAS version 9.3 software was used to analyse the data for this study. The researcher collaborated with an experienced statistician to analyse data. Data analysis was conducted using both descriptive and inferential statistics. The researcher set the p-value at less than 0.05 (p<.05) as the level of statistical significance for the tests performed.

4.3.2 Reliability of the data collection instrument

Reliability is the degree of consistence with which a research instrument measures a given attribute (Polit & Beck 2008:764). Hence, reliability test measures how consistent the participants were in answering a group of related questions.

The Cronbach alpha is the most widely used reliability index that estimates the internal consistency of a measure composed of several subscales. The Cronbach alpha ranges from 0.00 to 1.00. A measure of 1.00 signifies a perfect reliability.
George and Mallery (2003:231) provide the following rule of thumb for interpreting the Cronbach alpha: “>.90 – Excellent; >.80 – Good; >.70 – Acceptable; >.60 – Questionable; >.50 – Poor; and <.50 – Unacceptable”. Ideally, an alpha of .70 and above is acceptable and is considered a reasonable goal.

Table 4.1 below present a summary of the reliability coefficients of some of the main constructs used in this study.

### Table 4.1: Reliability coefficients for the main constructs in the study

<table>
<thead>
<tr>
<th>Domain</th>
<th>What it measures</th>
<th>Constructs/variable</th>
<th>Number of items</th>
<th>Cronbach Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived benefits</td>
<td>The impact of perceived benefits on the attitude towards outsourcing decisions</td>
<td>Cost management</td>
<td>3</td>
<td>0.802</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater focus</td>
<td>2</td>
<td>0.895</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flexibility</td>
<td>2</td>
<td>0.908</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to external expertise/investment or innovation</td>
<td>3</td>
<td>0.844</td>
</tr>
<tr>
<td>Perceived risks</td>
<td>The impact of perceived risks on the attitude towards outsourcing decisions</td>
<td>Strategic risks</td>
<td>2</td>
<td>0.856</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Operational risks</td>
<td>3</td>
<td>0.826</td>
</tr>
<tr>
<td>Barriers to outsourcing</td>
<td>The impact of perceived roadblocks on the attitude towards outsourcing decisions</td>
<td>Organisational barriers</td>
<td>3</td>
<td>0.739</td>
</tr>
<tr>
<td></td>
<td></td>
<td>External/contextual barriers</td>
<td>2</td>
<td>0.742</td>
</tr>
</tbody>
</table>

Table 4.1 shows that considered constructs have Cronbach alpha (α) greater than 0.7 indicating that the questionnaire used in the study was reliable.

#### 4.3.3 Descriptive statistics

Descriptive statistics are the various methods used to describe and summarise data. The descriptive statistics include the means, median, and percentages. For the purpose of this study, the researcher presented data in terms of frequencies and percentages. All the percentages are expressed to one decimal place in the text and in the tables. For some questions, participants could select more than one option from a list of options in the questionnaire. In such instances, the percentages add up to more than 100%.
Responses to a number of questions were presented in form of a Likert scale with five response categories (e.g. strongly agree, agree, neither agree nor disagree, disagree and strongly disagree) provided to enable the participants respond to a specific statement according to their personal views. For some of the analysis, the categories were grouped together e.g. strongly agree and agree were grouped together to form a category called “agree”.

4.3.4 Inferential statistics

According to Polit and Beck (2008:755), inferential statistics is that type of statistics that permit deductions about whether the results observed in a sample are likely to occur in the larger population.

In this study, since the data was ordinal and not normally distributed, the association between two variables was investigated using non-parametric tests (Wilcoxon-Mann-Whitney tests).

4.4 SAMPLE CHARACTERISTICS

This section presents a description of the hospitals and hospital managers that participated in the study. This information includes the ownership and location of the hospitals in addition to the titles of the various hospital managers who participated in the study. This section also presents information on hospital size (in terms of number of beds), staffing and budget. Also included is information about strategic planning by the sampled hospitals.

Table 4.2 presents a summary of the sample characteristics:
Table 4.2: Sample characteristics (N=32)

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals surveyed</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Hospital ownership/type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH</td>
<td>14</td>
<td>44%</td>
</tr>
<tr>
<td>NGO</td>
<td>18</td>
<td>57%</td>
</tr>
<tr>
<td>Hospital location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>19</td>
<td>59%</td>
</tr>
<tr>
<td>Urban</td>
<td>13</td>
<td>41%</td>
</tr>
<tr>
<td>Total number of respondents</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Title of respondents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Superintendent</td>
<td>17</td>
<td>53%</td>
</tr>
<tr>
<td>Hospital Administrator</td>
<td>15</td>
<td>47%</td>
</tr>
<tr>
<td>Availability of business/strategic plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>70%</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Strategic plan includes outsourcing (n=18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>72%</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>28%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>Average</th>
<th>Maximum</th>
<th>Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Beds (N=31)</td>
<td>137</td>
<td>284</td>
<td>25</td>
</tr>
<tr>
<td>Hospital staff (N=30)</td>
<td>135</td>
<td>254</td>
<td>46</td>
</tr>
<tr>
<td>Staff break down</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical (N=29)</td>
<td>82</td>
<td>166</td>
<td>7</td>
</tr>
<tr>
<td>Non-clinical (N=29)</td>
<td>54</td>
<td>188</td>
<td>13</td>
</tr>
<tr>
<td>Annual budget for 2013-UGX (N=25)</td>
<td>1,007,536,98</td>
<td>3,509,805,896</td>
<td>131,000,000</td>
</tr>
</tbody>
</table>

Table 4.2 shows that the majority of the 32 hospitals that participated in the study were NGO owned hospitals (57%). Additionally, most of the hospitals were located in rural areas (59%). The majority of the questionnaire respondents were Medical Superintendents (53%).

Most of the hospitals (70%) mentioned that they had a business/strategic plan for the hospital. Of those hospitals with a strategic plan 72% mentioned that the strategic plan included outsourcing.
The average hospital in the study sample had 137 hospital beds, 135 total staff; 82 clinical and 54 non clinical; and had an average annual budget of 1,007,536,983 Uganda Shillings in 2013.

There were however variations in the actual number of hospital beds, staff and annual budget within the study sample as indicated by the maximum and minimum values for each of these.

### 4.5 OBJECTIVE 1: OUTSOURCING PRACTICES AND PROCESSES

The first objective of this study was to describe the current outsourcing practices and processes by general hospitals in Uganda. The outsourcing practices were conceived to relate to the extent of outsourcing among the hospitals, the motivation for outsourcing, the services outsourced, duration of outsourcing, value of the outsourcing contract and the level of satisfaction with the outsourced services.

The outsourcing processes were conceived to relate to actions undertaken by the hospital before deciding to outsource, the procurement method used and challenges faced during the outsourcing process. The outsourcing processes also include monitoring of outsourcing by the hospital.

#### 4.5.1 Extent of outsourcing

As can be seen from table 4.3, most of the hospitals surveyed (n=23; 72%) reported to be outsourcing one or more of the support services required to run the hospitals. Similar studies in other contexts have found outsourcing of support services by hospitals to be common. In a study conducted in Turkey, for example, 84% of hospitals were found to be outsourcing at least one support service (Yigit et al 2007:87). In a Taiwanese study, 95% of studied hospitals were found to be outsourcing support services (Hsiao, Pai & Chiu 2009:[3]). In an Israel study, 94% of hospitals were found to be outsourcing (Rahimi et al 2011:57). However, it is important to note that these studies were conducted in a different context than this study (out of Africa). However, in Botswana, a 2015 study indicates that seven selected regional and district hospitals were outsourcing some of the hospital support services as part of the roll out of MOH
outsourcing strategy in line with the government of Botswana privatisation policy (Cogswell, Buzwani, Myers, Ohadi, Todini & Avila 2015).

Table 4.3: Extent of outsourcing

<table>
<thead>
<tr>
<th>Services currently being outsourced (N=23)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently outsourcing any of the services needed to run the hospital</td>
<td>23</td>
<td>72%</td>
</tr>
<tr>
<td>Laundry</td>
<td>4</td>
<td>17%</td>
</tr>
<tr>
<td>Security</td>
<td>8</td>
<td>35%</td>
</tr>
<tr>
<td>Cleaning</td>
<td>18</td>
<td>78%</td>
</tr>
<tr>
<td>IT Services</td>
<td>12</td>
<td>52%</td>
</tr>
<tr>
<td>Catering</td>
<td>5</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>22%</td>
</tr>
<tr>
<td>Approximate annual value (in Uganda shillings) of the outsourcing contract (N=23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1,000,000</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>1,000,001-10,000,000</td>
<td>10</td>
<td>44%</td>
</tr>
<tr>
<td>10,000,001-50,000,000</td>
<td>12</td>
<td>52%</td>
</tr>
<tr>
<td>50,000,0001-100,000,000</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>&gt;100,000,000</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Duration of outsourcing for various services (months)</td>
<td>Max</td>
<td>Min</td>
</tr>
<tr>
<td>Laundry (n=4)</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Security (n=8)</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Cleaning (n=15)</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>IT Services (n=7)</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td>Catering (n=4)</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

The most frequently outsourced service was cleaning services (n=18; 78% of hospitals) followed by IT services (n=12; 52% of hospitals). The least outsourced service was laundry services (n=4; 17% of hospitals).

Just like this study, other studies have found cleaning services to be one of the most outsourced services. A study of teaching hospitals in Iran found that all the hospitals (100%) were outsourcing cleaning/housekeeping services (Karimi, Agharahimi & Yaghoubi 2012:25). In a study of outsourcing by Taiwanese hospitals, cleaning services including management of common trash were the most frequently outsourced with 95% of hospitals reporting to be outsourcing these services (Hsiao et al 2009:3). In a Turkish study on outsourcing by hospitals, cleaning services were the second most
frequently outsourced with 81% of hospital reported to be outsourcing cleaning services (Yigit et al 2007:88). In a study in Botswana, all the seven hospitals participating in the MOH outsourcing programme were outsourcing cleaning services (Cogswell et al 2015).

Based on the economic theories of outsourcing the popularity of outsourcing cleaning services may be related to the ready availability of service providers, ease of monitoring the quality of service and the none core nature of this service in the hospital setting.

Most of the outsourced services contract (n=12, 52% of outsourcing contracts) ranged in value from 10,000,000-50,000,000 Uganda Shillings. This is about 1% to 5% of the average budget of the hospitals included in the study. Similar to this study, a study on outsourcing by hospitals in Israel shows that 42% of the hospitals assign 0-5% of their annual budget for outsourcing contracts (Rahimi et al 2011:58).

Regarding the duration of outsourcing, on average IT services and security services had been outsourced the longest duration (average 45 months) while catering services had been outsourced for the shortest duration on average (average 18 months).

4.5.2 Motivation for outsourcing and satisfaction with current outsourcing

Table 4.4 presents the hospitals managers motivation or reasons for outsourcing and their level of satisfaction with the outsourced services.

Among the hospitals that were outsourcing, the most frequently reported reason for outsourcing was to gain quality service from another firm’s expertise (n=15; 68% of managers), followed by the need to enable the hospital focus on its core mandate of serving patients (n=12; 55% of managers). The least frequently reported reason for outsourcing was the need to reduce employee size (n=6; 22% of managers).

As revealed by this study in Uganda, studies in other contexts also identify key motivations for outsourcing by hospitals to be a concern with cost and quality of services. In a study on outsourcing by Turkish hospitals, the sampled hospitals indicate that they chose to outsource services in order to decrease costs (78.8%) and increase the quality of services rendered (65.5%) (Yigit et al 2007:89). Similarly a study on outsourcing by hospitals in Israel identifies the factors driving outsourcing as cost
restrictions (82.8%), operational flexibility (77%), and focus on the core business (74.2% (Rahimi et al 2011:57.) In further support of the cost reduction motivation for outsourcing by hospitals, in a case study of outsourcing by a rural hospital in Australia, the hospital managers indicated that food services were not outsourced because there was a lack of evidence that costs could be reduced (Young 2003:129).

For the services being outsourced, most hospitals reported being satisfied with their outsourcing services, with at least 60% of hospital manager managers reporting that they were strongly satisfied or satisfied with their outsourced service. Hospital managers reported most satisfaction with IT services, with 92% of managers reporting that they were very satisfied or satisfied with their outsourcing. This was followed by cleaning services (89% very satisfied or satisfied). Interestingly 11% of hospital managers reported being dissatisfied with their cleaning services.

The most frequently reported reason for satisfaction with the outsourced services was that the anticipated improvement in quality of the outsourced service had been realised (n=20; 87% of managers). For the managers not satisfied, the most frequently reported reason for dissatisfaction was that anticipated cost reduction from outsourcing had not been realised.

A study on outsourcing by Greek hospitals found that most of the surveyed managers were satisfied with the performance of the outsourced companies and believed that there would be an increase in the usage of outsourced services in the future (Moschuris & Kondylis 2006:10). Similarly, a high level of satisfaction with outsourced services was found in an outsourcing study in Israel (Rahimi et al 2011:59). However, the literature also documents instances where, there has been dissatisfaction with outsourcing. In a case study that investigates in depth the outsourcing decision in Australia for a health program, Young (2008:446-464) finds that the outsourcing contract produced problems with service quality, sharing of culture, relationships between contract and internal staff, and in managing the contract and staff; and reductions in trust and morale of both internal and contract staff. The study identifies inadequate contract specifications and subsequent under-pricing as the cause of contract termination, poor quality, and difficulties in contract management (Young 2008: 446-464). Another case study in Australia documents negative outcomes and dissatisfaction with hospital outsourcing due to the short length of relationships and
accompanying difficulties with trust, commitment and loyalty; poor quality; and excessive monitoring and the measurement of outsourcing outcomes (Young 2007:140-149).

Table 4.4: Reasons for outsourcing and satisfaction with outsourcing

<table>
<thead>
<tr>
<th>Reason for hospital decision to begin outsourcing (n=22)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To save costs</td>
<td>10</td>
<td>45%</td>
</tr>
<tr>
<td>To enable the hospital focus on servicing patients</td>
<td>12</td>
<td>55%</td>
</tr>
<tr>
<td>Gain quality service from another firms’ expertise</td>
<td>15</td>
<td>68%</td>
</tr>
<tr>
<td>To increase flexibility by using a contracted work force</td>
<td>7</td>
<td>32%</td>
</tr>
<tr>
<td>Wanted to reduce employee size</td>
<td>6</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall level of management satisfaction with current outsourcing for various services</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Very Satisfied (1)</td>
</tr>
<tr>
<td>Laundry (n=4)</td>
<td>25%</td>
</tr>
<tr>
<td>Security (n=8)</td>
<td>12.5%</td>
</tr>
<tr>
<td>Cleaning (n=18)</td>
<td>22%</td>
</tr>
<tr>
<td>IT Services (n=12)</td>
<td>25%</td>
</tr>
<tr>
<td>Catering (n=5)</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for satisfaction with outsourced services (n=23)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated reduction in costs has been realised</td>
<td>8</td>
<td>35%</td>
</tr>
<tr>
<td>Good relationship with supplier</td>
<td>11</td>
<td>48%</td>
</tr>
<tr>
<td>Anticipated improvement in quality of service has been realised</td>
<td>20</td>
<td>87%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for dissatisfaction with outsourced services (n=18)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated cost reduction has not been realised</td>
<td>8</td>
<td>44%</td>
</tr>
<tr>
<td>Contract management with the supplier has been problematic</td>
<td>6</td>
<td>33%</td>
</tr>
<tr>
<td>Reduction in quality of service</td>
<td>4</td>
<td>22%</td>
</tr>
<tr>
<td>Complaints by staff about laying off staff</td>
<td>3</td>
<td>17%</td>
</tr>
<tr>
<td>Complaints from clients</td>
<td>3</td>
<td>17%</td>
</tr>
</tbody>
</table>
4.5.3 Outsourcing process and challenges encountered

Table 4.5 presents data on the outsourcing process for hospitals that were currently outsourcing and the challenges the hospitals encountered during outsourcing.

Before deciding to outsource, majority of hospital managers surveyed (n=16; 73%) report to have conducted an internal analysis of the relative capability of the hospital to provide the service vs outside suppliers. Additionally, slightly more than half of the hospital managers (n=12; 55%) reported conducting an internal analysis of the importance level of the activity to be outsourced to the hospital’s mandate.

However, less than half of the hospital managers reported conducting an analysis of the market for the service to be outsourced or determining the strategic outsourcing options or the relationship strategy to be adopted and how to manage, monitor or evaluate the relationship with the supplier.

It is also interesting to note that 14% of the managers (n=3) indicate that no analysis was conducted and the decision to outsource was made intuitively.

The most frequently used method for identifying and selecting a vendor for the outsourced service was through open domestic bidding, with 60% of hospital managers (n=12) reporting to have used this method. The least frequently used method was a request for proposals with 10% of surveyed managers (n=2) reporting to have used this method.

The surveyed managers report that during the outsourcing process, the most frequently encountered challenge was the limited number of service providers (n=12; 57% of managers).

Slightly less than half of the surveyed hospital managers (n=10; 48%) report having encountered challenges with contractual issues during the outsourcing process. An equal proportion of managers (n=8; 38%) report limited in-house capacity to outsource and political interference as challenges encountered during the outsourcing process.
The least encountered challenge was the law or the hospital owning authority not permitting outsourcing (n=1; 5%). This is not surprising given that the PPDA act that provides guidelines for procurement by government entities can be used as a basis for outsourcing. Also, as earlier noted, a high proportion of hospitals (72%) reported having outsourcing in their strategic plan.

Table 4.5: Outsourcing process and challenges encountered

<table>
<thead>
<tr>
<th>Internal process before deciding to outsource (n=22)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, decision was made intuitively</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>Analysis of the importance level of the activity to the hospital's mandate</td>
<td>12</td>
<td>55%</td>
</tr>
<tr>
<td>Analysis of the relative capability of the hospital to provide the service Vs outside suppliers</td>
<td>16</td>
<td>73%</td>
</tr>
<tr>
<td>Market analysis for the services to be outsourced</td>
<td>8</td>
<td>36%</td>
</tr>
<tr>
<td>Determination of the appropriate strategic sourcing options</td>
<td>8</td>
<td>36%</td>
</tr>
<tr>
<td>Determination of the relationship strategy with supplier</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>Determination of how the relationship with supplier will be established, managed, monitored and evaluated</td>
<td>6</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procurement method used to select outsourcing vendor (n=20)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open domestic bidding</td>
<td>12</td>
<td>60%</td>
</tr>
<tr>
<td>Restricted domestic bidding</td>
<td>3</td>
<td>15%</td>
</tr>
<tr>
<td>Through a request for proposals</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Direct procurement</td>
<td>3</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges faced during the outsourcing process (n=21)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited in house capacity to outsource</td>
<td>8</td>
<td>38%</td>
</tr>
<tr>
<td>Limited number of service providers</td>
<td>12</td>
<td>57%</td>
</tr>
<tr>
<td>Contractual issues</td>
<td>10</td>
<td>48%</td>
</tr>
<tr>
<td>Law/owning authority could not allow it and had to negotiate</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Political interference in the outsourcing process</td>
<td>8</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>19%</td>
</tr>
</tbody>
</table>

4.5.4 Monitoring of outsourcing

Table 4.6 provides data on monitoring of outsourcing by the hospitals that were outsourcing one or more support services.

Many of the surveyed hospitals that were outsourcing (n=15; 71%) reported having in place systems to continuously monitor the outsourcing program. Of those with a
monitoring system, majority of the hospital managers (n=13; 87%) reported to be monitoring supplier performance, while 80% (n=12) of the managers reported to be monitoring cost effectiveness of the outsourcing program. The continued feasibility of outsourcing was the least monitored aspect of the outsourcing programme (n=4; 27% of managers).

The most frequently utilised monitoring strategy was regular meetings with the supplier to review performance (n=14; 93% of managers). The next frequently utilised monitoring strategy was tracking costs of the outsourced services (n=10; 67%).

One of the least employed monitoring strategies was market surveys to determine changes in supplier availability and capabilities (n=6; 40% of managers). This is not surprising because as indicated earlier, only 36% of hospital managers reported conducting a market analysis as part of pre-sourcing evaluation. A similarly low proportion of managers (n=6; 40%) reported employing benchmarking of their outsourced service quality with quality of the service in the best or other hospitals in the country.

Also, less than half of the managers (n=7; 47%) reported to be continuous monitoring or analysing their internal capability to deliver the outsourced service. This may be because once they begin outsourcing, hospitals no longer actively build their internal capacity in the providing the outsourced service since they perhaps do not intend to bring back provision of the service in-house due to the perceived benefits of outsourcing.
Table 4.6: Outsourcing monitoring (N=23)

<table>
<thead>
<tr>
<th>Availability of a system to continuously monitor the outsourcing program</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15</td>
<td>71%</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspects of outsourcing programme being monitored (n=15)</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplier performance</td>
<td>13</td>
<td>87%</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Continued feasibility of outsourcing</td>
<td>4</td>
<td>27%</td>
</tr>
<tr>
<td>Continued need for outsourcing</td>
<td>6</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring strategies employed (n=20)</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular meetings with supplier to review performance</td>
<td>14</td>
<td>93%</td>
</tr>
<tr>
<td>Regularly tracking the costs of the sourced services</td>
<td>10</td>
<td>67%</td>
</tr>
<tr>
<td>Regular satisfaction surveys without sourced services among staff and clients</td>
<td>9</td>
<td>60%</td>
</tr>
<tr>
<td>Market surveys to determine changes in supplier availability and capabilities</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Benchmarking our outsourced service quality with quality of the service in the best hospitals in the country</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Continuous internal analysis regarding importance of the outsourced service to hospital performance</td>
<td>8</td>
<td>53%</td>
</tr>
<tr>
<td>Continuous internal capability analysis to deliver the outsourced service</td>
<td>7</td>
<td>47%</td>
</tr>
</tbody>
</table>

4.5.5 Outsourcing practices per hospital characteristics

The researcher conducted an analysis to determine if there is a difference in outsourcing practices depending on the hospital characteristics. Contingency tables with Odds Ratios were used for this analysis. The hospital characteristics were divided into extrinsic factors (location, ownership) these being beyond the immediate control of the hospital managers, and intrinsic factors (hospital size and staffing) these being within some control of the hospital managers. The hospital size was related to the bed capacity of the hospital and only non-clinical staff members were considered.
4.5.5.1 Extrinsic hospital characteristics

As can be seen from Table 4.7a, there are no significant differences in the reasons for outsourcing between MOH and NGO hospitals and the procurement method used (p>0.05 for all items). Similarly, there is no significant difference in the internal process before deciding to outsource between MOH and NGO hospitals.

However, there were significant differences in some of the reported challenges in the outsourcing process depending on hospital ownership and location. Rural hospitals were more likely to report challenges with the available number of suppliers during the outsourcing process compared to their urban counterparts (p= 0.0152).

On the other hand, urban hospitals were more likely to report challenges with contractual issues during the outsourcing process compared to their rural peers (p=0.0056).

Hospitals owned by MOH were more likely to report political interference in the outsourcing process compared to NGO hospitals (p= 0.0065).

Regarding outsourcing monitoring, there was no significant difference in availability of a monitoring system and the monitoring strategies employed between the studied hospitals based on the extrinsic hospital characteristics considered. However, rural hospitals were more likely to monitor the continued need for outsourcing compared to their urban counterparts (p=0.0358). This may be related to the earlier reported fact that rural hospitals were more likely to report a challenge of limited number of service providers and so would be more motivated if continuously assess if indeed outsourcing is still required to justify any continued effort and cost of seeking out the few available suppliers who are more likely to be expensive.

4.5.5.2 Intrinsic hospital factors/characteristics

As can be seen from Table 4.7b, there were no significant differences in outsourcing practices based on hospital size and staffing (p>0.05 for all items).
Table 4.7a: Difference in outsourcing practices based on extrinsic hospital characteristics

<table>
<thead>
<tr>
<th>Responses</th>
<th>Ownership</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NGO (N (%))</td>
<td>MOH (N (%))</td>
</tr>
<tr>
<td></td>
<td>OR (P)</td>
<td>Rural (N (%))</td>
</tr>
<tr>
<td></td>
<td>P (OR)</td>
<td>Urban (N (%))</td>
</tr>
<tr>
<td></td>
<td>P (OR)</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for hospital decision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To save costs n=22</td>
<td>8 (67%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td></td>
<td>8.000</td>
<td>0.0344</td>
</tr>
<tr>
<td></td>
<td>4 (44%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td></td>
<td>1.0714</td>
<td>0.3344</td>
</tr>
<tr>
<td>To enable the hospital focus on servicing patients n=22</td>
<td>6 (50%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td></td>
<td>0.6667</td>
<td>0.3001</td>
</tr>
<tr>
<td></td>
<td>5 (56%)</td>
<td>7 (54%)</td>
</tr>
<tr>
<td></td>
<td>0.9333</td>
<td>0.3344</td>
</tr>
<tr>
<td>Gain quality service from another firms’ expertise n=22</td>
<td>11 (92%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td></td>
<td>16.500</td>
<td>0.0148</td>
</tr>
<tr>
<td></td>
<td>5 (56%)</td>
<td>10 (77%)</td>
</tr>
<tr>
<td></td>
<td>2.6667</td>
<td>0.2113</td>
</tr>
<tr>
<td>To increase flexibility by using a contracted work force n=22</td>
<td>2 (17%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td></td>
<td>0.2000</td>
<td>0.0975</td>
</tr>
<tr>
<td></td>
<td>3 (33%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td></td>
<td>0.8889</td>
<td>0.3522</td>
</tr>
<tr>
<td>Wanted to reduce employee size n=22</td>
<td>2 (17%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td></td>
<td>0.3000</td>
<td>0.1858</td>
</tr>
<tr>
<td></td>
<td>3 (33%)</td>
<td>3 (23%)</td>
</tr>
<tr>
<td></td>
<td>0.600</td>
<td>0.3220</td>
</tr>
<tr>
<td><strong>Internal process before deciding to out source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None, decision was made intuitively n=22</td>
<td>0 (0%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td></td>
<td>0.000</td>
<td>0.0779</td>
</tr>
<tr>
<td></td>
<td>2 (22%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td></td>
<td>0.2917</td>
<td>0.3039</td>
</tr>
<tr>
<td>Analysis of the importance level of the activity to the hospital’s mandate n=22</td>
<td>8 (67%)</td>
<td>4 (10%)</td>
</tr>
<tr>
<td></td>
<td>3.000</td>
<td>0.1608</td>
</tr>
<tr>
<td></td>
<td>5 (56%)</td>
<td>7 (54%)</td>
</tr>
<tr>
<td></td>
<td>0.9333</td>
<td>0.3344</td>
</tr>
<tr>
<td>Analysis of the relative capability of the hospital to provide the service Vs outside suppliers n=22</td>
<td>9 (75%)</td>
<td>7 (70%)</td>
</tr>
<tr>
<td></td>
<td>1.2857</td>
<td>0.3538</td>
</tr>
<tr>
<td></td>
<td>6 (67%)</td>
<td>10 (73%)</td>
</tr>
<tr>
<td></td>
<td>1.6667</td>
<td>0.3220</td>
</tr>
<tr>
<td>Market analysis for the services to be outsourced n=22</td>
<td>6 (50%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td></td>
<td>4.000</td>
<td>0.1300</td>
</tr>
<tr>
<td></td>
<td>4 (44%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td></td>
<td>0.5556</td>
<td>0.2817</td>
</tr>
<tr>
<td>Determination of the appropriate strategic sourcing options n=22</td>
<td>5 (42%)</td>
<td>3 (30%)</td>
</tr>
<tr>
<td></td>
<td>1.6667</td>
<td>0.2972</td>
</tr>
<tr>
<td></td>
<td>3 (33%)</td>
<td>5 (38%)</td>
</tr>
<tr>
<td></td>
<td>1.2500</td>
<td>0.3381</td>
</tr>
<tr>
<td>Determination of the relationship strategy with supplier n=22</td>
<td>1 (8%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td></td>
<td>0.3636</td>
<td>0.3506</td>
</tr>
<tr>
<td></td>
<td>1 (11%)</td>
<td>2 (15%)</td>
</tr>
<tr>
<td></td>
<td>1.4545</td>
<td>0.4558</td>
</tr>
<tr>
<td>Determination of how the relationship with supplier will be established, managed, monitored and evaluated n=22</td>
<td>4 (33%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td></td>
<td>2.000</td>
<td>0.2985</td>
</tr>
<tr>
<td></td>
<td>2 (22%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td></td>
<td>1.5556</td>
<td>0.3450</td>
</tr>
<tr>
<td><strong>Procurement method used to select out sourcing vendor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open domestic bidding n=20</td>
<td>6 (55%)</td>
<td>6 (67%)</td>
</tr>
<tr>
<td></td>
<td>0.600</td>
<td>0.3081</td>
</tr>
<tr>
<td></td>
<td>5 (56%)</td>
<td>7 (64%)</td>
</tr>
<tr>
<td></td>
<td>1.400</td>
<td>0.3301</td>
</tr>
<tr>
<td>Restricted domestic bidding n=20</td>
<td>1 (9%)</td>
<td>2 (22%)</td>
</tr>
<tr>
<td></td>
<td>0.350</td>
<td>0.3474</td>
</tr>
<tr>
<td></td>
<td>1 (11%)</td>
<td>2 (18%)</td>
</tr>
<tr>
<td></td>
<td>1.7778</td>
<td>0.4342</td>
</tr>
<tr>
<td>Through a Request for Proposals n=20</td>
<td>1 (9%)</td>
<td>1 (11%)</td>
</tr>
<tr>
<td></td>
<td>0.800</td>
<td>0.5211</td>
</tr>
<tr>
<td></td>
<td>0 (0%)</td>
<td>2 (18%)</td>
</tr>
<tr>
<td></td>
<td>0.2895</td>
<td></td>
</tr>
<tr>
<td>Responses</td>
<td>Ownership</td>
<td>Location</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>NGO</td>
<td>MOH</td>
</tr>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td><strong>Direct procurement</strong></td>
<td>N (%)</td>
<td>1 (11%)</td>
</tr>
<tr>
<td><strong>Challenges faced during the outsourcing process</strong></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Limited in house capacity to outsource n=21</td>
<td>4 (36%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Limited number of service providers n=21</td>
<td>8 (73%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Contractual issues n=21</td>
<td>4 (36%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>Law/owning authority could not allow it and had to negotiate n=21</td>
<td>1(9%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Political interference in the outsourcing process n=21</td>
<td>1 (9%)</td>
<td>7 (70%)</td>
</tr>
<tr>
<td><strong>Availability of a system to continuously monitor the outsourcing programme</strong></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Yes</td>
<td>9 (82%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td><strong>Aspects of outsourcing programme being monitored</strong></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Supplier performance n=20</td>
<td>8 (73%)</td>
<td>5 (55%)</td>
</tr>
<tr>
<td>Cost effectiveness n=20</td>
<td>6 (55%)</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>Continued feasibility of outsourcing n=20</td>
<td>3 (27%)</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Continued need for outsourcing n=20</td>
<td>4 (36%)</td>
<td>2 (22%)</td>
</tr>
<tr>
<td><strong>Monitoring strategies employed</strong></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Regular meetings with supplier to review performance n=20</td>
<td>7 (64%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>Regularly tracking the costs of the sourced services n=20</td>
<td>5 (45%)</td>
<td>5 (56%)</td>
</tr>
<tr>
<td>Regular satisfaction surveys without sourced services among staff and clients n=20</td>
<td>6 (55%)</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>Market surveys to determine changes in supplier availability and capabilities n=20</td>
<td>3 (27%)</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>Benchmarking our out sourced service quality with quality of the service in the best hospitals in the country(n=20)</td>
<td>2 (18%)</td>
<td>4 (44%)</td>
</tr>
<tr>
<td>Responses</td>
<td>Ownership</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>NGO</td>
<td>MOH</td>
</tr>
<tr>
<td>Continuous internal analysis regarding importance of the outsourced service to hospital performance</td>
<td>4 (36%)</td>
<td>4 (44%)</td>
</tr>
<tr>
<td>Continuous internal capability analysis to deliver the outsourced service (n=20)</td>
<td>3 (27%)</td>
<td>4 (44%)</td>
</tr>
</tbody>
</table>

*p<0.05
Table 4.7b: Difference in outsourcing practices based on extrinsic hospital characteristics

<table>
<thead>
<tr>
<th>Reason for hospital decision</th>
<th>Small</th>
<th>Large</th>
<th>OR</th>
<th>P</th>
<th>Lowly staffed</th>
<th>Highly staffed</th>
<th>OR</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;100 beds</td>
<td>&gt;100 beds</td>
<td></td>
<td></td>
<td>&lt;50 staff</td>
<td>&gt;50 staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To save costs n=22</td>
<td>3 (75%)</td>
<td>7 (39%)</td>
<td>0.2121</td>
<td>0.1969</td>
<td>7 (47%)</td>
<td>3 (43%)</td>
<td>0.8571</td>
<td>0.3483</td>
</tr>
<tr>
<td>To enable the hospital focus on servicing patients n=22</td>
<td>2 (50%)</td>
<td>10 (56%)</td>
<td>1.2500</td>
<td>0.406</td>
<td>9 (60%)</td>
<td>3 (43%)</td>
<td>0.500</td>
<td>0.2709</td>
</tr>
<tr>
<td>Gain quality service from another firms’ expertise n=22</td>
<td>4 (100%)</td>
<td>11 (61%)</td>
<td>0.000</td>
<td>0.1866</td>
<td>11 (73%)</td>
<td>4 (57%)</td>
<td>0.4848</td>
<td>0.2801</td>
</tr>
<tr>
<td>To increase flexibility by using a contracted work force n=22</td>
<td>0 (0%)</td>
<td>7 (39%)</td>
<td>0.1866</td>
<td>-----</td>
<td>6 (40%)</td>
<td>1(14%)</td>
<td>0.2500</td>
<td>0.2054</td>
</tr>
<tr>
<td>Wanted to reduce employee size n=22</td>
<td>1 (25%)</td>
<td>5 (28%)</td>
<td>1.1538</td>
<td>0.4593</td>
<td>4 (27%)</td>
<td>2 (29%)</td>
<td>1.100</td>
<td>0.3842</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal process before deciding to out source</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None, decision was made intuitively n=22</td>
<td>0 (0%)</td>
<td>3 (17%)</td>
<td>-----</td>
<td>*</td>
<td>2 (13%)</td>
<td>1 (14%)</td>
<td>1.0833</td>
<td>0.4773</td>
</tr>
<tr>
<td>Analysis of the importance level of the activity to the hospital’s mandate n=22</td>
<td>4 (100%)</td>
<td>8 (44%)</td>
<td>0.000</td>
<td>0.0677</td>
<td>7 (47%)</td>
<td>5 (71%)</td>
<td>2.8571</td>
<td>0.2090</td>
</tr>
<tr>
<td>Analysis of the relative capability of the hospital to provide the service Vs outside suppliers n=22</td>
<td>3 (75%)</td>
<td>13 (72%)</td>
<td>0.8667</td>
<td>0.4593</td>
<td>10 (67%)</td>
<td>6 (86%)</td>
<td>3.000</td>
<td>0.2817</td>
</tr>
<tr>
<td>Market analysis for the services to be outsourced n=22</td>
<td>3 (75%)</td>
<td>5 (28%)</td>
<td>0.1282</td>
<td>0.1072</td>
<td>4 (27%)</td>
<td>4 (57%)</td>
<td>3.6667</td>
<td>0.1494</td>
</tr>
<tr>
<td>Determination of the appropriate strategic sourcing options n=22</td>
<td>1 (25%)</td>
<td>7 (38%)</td>
<td>1.9091</td>
<td>0.3981</td>
<td>5 (33%)</td>
<td>3 (43%)</td>
<td>1.5000</td>
<td>0.3287</td>
</tr>
<tr>
<td>Determination of the relationship strategy with supplier n=22</td>
<td>0 (0%)</td>
<td>3 (17%)</td>
<td>-----</td>
<td>*</td>
<td>1 (7%)</td>
<td>2 (29%)</td>
<td>5.600</td>
<td>0.2045</td>
</tr>
<tr>
<td>Determination of how the relationship with supplier will be established, managed, monitored and evaluated n=22</td>
<td>2 (50%)</td>
<td>4 (22%)</td>
<td>0.2857</td>
<td>0.2461</td>
<td>3 (20%)</td>
<td>3 (43%)</td>
<td>3.000</td>
<td>0.2134</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procurement method used to select out sourcing vendor</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Open domestic bidding n=20</td>
<td>1 (33%)</td>
<td>11 (65%)</td>
<td>3.6667</td>
<td>0.2947</td>
<td>7 (54%)</td>
<td>5 (71%)</td>
<td>2.1429</td>
<td>0.2861</td>
</tr>
<tr>
<td>Restricted domestic bidding n=20</td>
<td>0 (0%)</td>
<td>3 (17%)</td>
<td>-----</td>
<td>*</td>
<td>0.5965</td>
<td>2 (15%)</td>
<td>0.9167</td>
<td>0.4789</td>
</tr>
<tr>
<td>Through a Request for Proposals n=20</td>
<td>1 (33%)</td>
<td>1 (6%)</td>
<td>0.125</td>
<td>0.2684</td>
<td>2 (15%)</td>
<td>0 (0%)</td>
<td>0.000</td>
<td>0.4105</td>
</tr>
<tr>
<td>Challenges faced during the outsourcing process</td>
<td>N (%)</td>
<td>%</td>
<td>OR</td>
<td>P</td>
<td>N (%)</td>
<td>%</td>
<td>OR</td>
<td>P</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------</td>
<td>---</td>
<td>----</td>
<td>---</td>
<td>-------</td>
<td>---</td>
<td>----</td>
<td>---</td>
</tr>
<tr>
<td>Direct procurement</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14%</td>
<td>0.3544</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited in house capacity to outsource n=21</td>
<td>2</td>
<td>67%</td>
<td>0.2500</td>
<td>0.2737</td>
<td>5</td>
<td>36%</td>
<td>0.3443</td>
<td></td>
</tr>
<tr>
<td>Limited number of service providers n=21</td>
<td>3</td>
<td>100%</td>
<td>0.000</td>
<td>0.1654</td>
<td>7</td>
<td>50%</td>
<td>2.500</td>
<td>0.2452</td>
</tr>
<tr>
<td>Contractual issues n=21</td>
<td>2</td>
<td>67%</td>
<td>0.400</td>
<td>0.3722</td>
<td>7</td>
<td>50%</td>
<td>0.7500</td>
<td>0.3406</td>
</tr>
<tr>
<td>Law/owning authority could not allow it and had to negotiate n=21</td>
<td>0</td>
<td>0%</td>
<td><strong>a</strong></td>
<td>0.8571</td>
<td>1</td>
<td>7%</td>
<td>0.000</td>
<td>0.6667</td>
</tr>
<tr>
<td>Political interference in the outsourcing process n=21</td>
<td>0</td>
<td>0%</td>
<td><strong>a</strong></td>
<td>0.2150</td>
<td>7</td>
<td>50%</td>
<td>0.1667</td>
<td>0.1181</td>
</tr>
<tr>
<td>Availability of hospital strategies to continuously monitor the feasibility and cost effectiveness of outsourcing program</td>
<td>3</td>
<td>100%</td>
<td>12</td>
<td>67%</td>
<td>0.000</td>
<td>0.3421</td>
<td>9</td>
<td>64%</td>
</tr>
<tr>
<td>Aspects of outsourcing programme being monitored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplier performance n=20</td>
<td>3</td>
<td>100%</td>
<td>0.000</td>
<td>0.2509</td>
<td>8</td>
<td>57%</td>
<td>3.7500</td>
<td>0.2324</td>
</tr>
<tr>
<td>Cost effectiveness n=20</td>
<td>3</td>
<td>100%</td>
<td>0.000</td>
<td>0.1930</td>
<td>7</td>
<td>50%</td>
<td>5.000</td>
<td>0.1635</td>
</tr>
<tr>
<td>Continued feasibility of outsourcing n=20</td>
<td>1</td>
<td>33%</td>
<td>0.4286</td>
<td>0.4211</td>
<td>1</td>
<td>7%</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td>Continued need for outsourcing n=20</td>
<td>1</td>
<td>33%</td>
<td>0.8333</td>
<td>0.4789</td>
<td>3</td>
<td>21%</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td>Monitoring strategies employed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular meetings with supplier to review performance n=20</td>
<td>3</td>
<td>100%</td>
<td>11</td>
<td>65%</td>
<td>0.000</td>
<td>0.3193</td>
<td>9</td>
<td>64%</td>
</tr>
<tr>
<td>Regularly tracking the costs of the sourced services n=20</td>
<td>2</td>
<td>67%</td>
<td>8</td>
<td>47%</td>
<td>0.4444</td>
<td>0.3947</td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td>Regular satisfaction surveys without sourced services among staff and clients n=20</td>
<td>2</td>
<td>67%</td>
<td>7</td>
<td>42%</td>
<td>0.3500</td>
<td>0.3474</td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td>Market surveys to determine changes in supplier availability and capabilities n=20</td>
<td>1</td>
<td>33%</td>
<td>5</td>
<td>29%</td>
<td>0.8333</td>
<td>0.4789</td>
<td>4</td>
<td>29%</td>
</tr>
<tr>
<td>Benchmarking our outsourced service quality with quality of the service in the best hospitals in the country (n=20)</td>
<td>Hospital size (&lt;100 beds)</td>
<td>N (%)</td>
<td>Staffing (non-clinical)</td>
<td>Lowly staffed (&lt;50 staff)</td>
<td>N (%)</td>
<td>Highly staffed (&gt;50 staff)</td>
<td>N (%)</td>
<td>OR</td>
</tr>
<tr>
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<td>---</td>
</tr>
<tr>
<td>Small</td>
<td>Large</td>
<td>OR</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100 beds</td>
<td>&gt;100 beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (33%)</td>
<td>5 (29%)</td>
<td>0.8333</td>
<td>0.4789</td>
<td>5 (36%)</td>
<td>1 (17%)</td>
<td>0.3600</td>
<td>0.3099</td>
<td></td>
</tr>
<tr>
<td>Continuous internal analysis regarding importance of the outsourced service to hospital performance (n=20)</td>
<td>Hospital size (&lt;100 beds)</td>
<td>N (%)</td>
<td>Staffing (non-clinical)</td>
<td>Lowly staffed (&lt;50 staff)</td>
<td>N (%)</td>
<td>Highly staffed (&gt;50 staff)</td>
<td>N (%)</td>
<td>OR</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Small</td>
<td>Large</td>
<td>OR</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100 beds</td>
<td>&gt;100 beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (33%)</td>
<td>5 (29%)</td>
<td>1.4000</td>
<td>0.4632</td>
<td>4 (29%)</td>
<td>4 (67%)</td>
<td>5.000</td>
<td>0.1192</td>
<td></td>
</tr>
<tr>
<td>Continuous internal capability analysis to deliver the outsourced service (n=20)</td>
<td>Hospital size (&lt;100 beds)</td>
<td>N (%)</td>
<td>Staffing (non-clinical)</td>
<td>Lowly staffed (&lt;50 staff)</td>
<td>N (%)</td>
<td>Highly staffed (&gt;50 staff)</td>
<td>N (%)</td>
<td>OR</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Small</td>
<td>Large</td>
<td>OR</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100 beds</td>
<td>&gt;100 beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 (0%)</td>
<td>7 (41%)</td>
<td>----&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.2509</td>
<td>3 (21%)</td>
<td>4 (67%)</td>
<td>7.3333</td>
<td>0.0704</td>
<td></td>
</tr>
</tbody>
</table>

---<sup>a</sup> Odds Ratios could not be computed due to small numbers
4.5.6 Reasons for not outsourcing and future outsourcing intentions

Table 4.8 presents the reasons for not outsourcing by hospitals currently not outsourcing and their future intention to outsource one or more support services.

Slightly more than a quarter (n=9; 28%) of the hospital managers surveyed indicated that their hospitals were not outsourcing any of the hospital support services, but were using their own staff to deliver the services (in-sourcing).

Reasons for not outsourcing included lack of expertise, lack of confidence that outsourcing would benefit the hospital, the managers thinking that outsourcing is risky and thus prefer to use in-house staff and prohibition by hospital policy or law. An equal proportion of managers (n=2; 22%) from the hospitals that were not outsourcing cited these reasons. However, none of the hospital managers cited non availability of qualified suppliers as a reason for not outsourcing.

Slightly more than half (n=5; 56%) of the hospital managers indicated that their hospitals intend to outsource one of more hospital support services in the near future.

The managers report the most likely services to be outsourced in the future as cleaning and security services with an equal proportion of hospital managers currently not outsourcing (n=4; 80%) reporting that they would definitely, very probably or probably be outsourcing these in the future. However of the two, cleaning services are more likely to be outsourced in the future, with 60% (n=3) of managers indicating that they will definitely or very probably be outsourcing cleaning services, compared to 20% (n=1) of managers saying the same for security.

The managers report catering as the least likely service to be outsourced in the future with 75% of managers (n=3) indicating that they would not probably or very not probably outsource this service in the future. Half of the managers (n=2; 50%) indicate that they would very probably not outsource laundry services.

The outsourcing intentions of hospitals that are currently not outsourcing are congruent with currently observed practice by hospitals that are currently outsourcing. The hospital managers report cleaning and security services as likely services to be outsourced in
the future with cleaning services being the most likely to be outsourced. As earlier reported, for hospitals that are currently outsourcing, these services are among the most frequently outsourced services with cleaning services being the most frequently outsourced (78%). Similarly, the hospital managers report laundry and cleaning services as the least likely to be outsourced. This is congruent with currently observed practice where these two services are the least frequent services being outsourced by the hospitals that are currently outsourcing.

Table 4.8: Reasons for not outsourcing and future intention to outsource (N=9)

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently NOT outsourcing any of the support services needed to run the hospital</td>
<td>9</td>
<td>28%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for NOT outsourcing (n=9)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital policy/law does not allow it</td>
<td>2</td>
<td>22%</td>
</tr>
<tr>
<td>Don’t have the expertise</td>
<td>2</td>
<td>22%</td>
</tr>
<tr>
<td>Don’t think it would be of benefit to the hospital</td>
<td>2</td>
<td>22%</td>
</tr>
<tr>
<td>No qualified service providers</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Think it’s quite risky and prefer to provide service in-house</td>
<td>2</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>22%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have plans/intention to outsource in the near future (n=9)</th>
<th>Number (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>56%</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services likely to be outsourced</th>
<th>Definitely</th>
<th>Very probably</th>
<th>Probably</th>
<th>Probably not</th>
<th>Very probably not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laundry (n=4)</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
<td></td>
<td></td>
<td>2 (50%)</td>
</tr>
<tr>
<td>Security (n=5)</td>
<td>1 (20%)</td>
<td>3 (60%)</td>
<td>1 (20%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning n=5</td>
<td>2 (40%)</td>
<td>1 (20%)</td>
<td>1 (20%)</td>
<td></td>
<td>1(20%)</td>
</tr>
<tr>
<td>IT Services</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
<td>2 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering (n=4)</td>
<td>1 (25%)</td>
<td></td>
<td>2 (50%)</td>
<td>1 (25%)</td>
<td></td>
</tr>
</tbody>
</table>

4.6 OBJECTIVE 2: OPINIONS ABOUT OUTSOURCING, PERCEIVED BENEFITS/ADVANTAGES AND DISADVANTAGES OF OUTSOURCING

The second objective of this study was to identify perceived benefits/advantages and drawbacks/disadvantages of outsourcing by hospital managers in general hospitals in Uganda. As part of this objective, the researcher also sought to identify the opinions of
the hospital managers towards outsourcing and their perceptions towards the various services. Identifying the hospital managers’ opinion about outsourcing, their perception about the services, and their perceived advantages and disadvantages of outsourcing is critical to understanding the hospital managers outsourcing decisions and practices.

4.6.1 Opinions and knowledge about outsourcing

Majority of the surveyed managers (94%) strongly agreed or agreed with the statement that outsourcing is one approach that can be used by hospital management to improve hospital performance. Similarly, majority of the surveyed managers (90%) strongly agreed or agreed that they knew at least one hospital that is currently outsourcing one or more of the support services it requires. Also, a large proportion (80%) of the surveyed hospital managers agreed or strongly agreed that the Public Procurement and Disposal Act (2003) and the MOH public private partnership (PPP) policy 2009, can be used as a basis for outsourcing.

Hence it can be concluded that majority of the managers had a favorable opinion about outsourcing and knew the available policies that are favorable towards outsourcing. Additionally the managers knew of peers from whom they could learn lessons or benchmark for their own outsourcing programme.

4.6.2 Perceptions about service importance, characteristics and outsourcing

Certain characteristics make some services suitable for outsourcing. Ideally, services suitable for outsourcing should be.

Table 4.9 below shows the hospital managers perception about the support services considered in the study. The table also shows their attitude towards the characteristics that makes a service suitable for outsourcing. Understanding these perceptions is important to understanding the hospital managers outsourcing decisions and practices.

Table 4.9 indicates that the hospital managers consider cleaning services to be critical to the hospitals efforts of offering quality health care with 94% of managers indicating that they consider cleaning services to be very important or important to health care delivery in the hospital. An almost similar percentage (93%) consider security to be very
important or important to health care delivery in the hospital. As earlier indicated, cleaning and security services are among the most frequently outsourced services with 78% and 35% of hospitals outsourcing these services respectively. Thus, it can be concluded that the more important the managers perceive a support service to be important to hospital care delivery the more likely they are to outsource the service. This may be explained by the fact that by doing so, the hospital managers hope to get quality service; as earlier indicated, this is the most reported reason for outsourcing (68% of managers).

The surveyed hospital managers consider catering services the least important to quality health care delivery in the hospital with only 45% of managers indicating that catering is very important or important for hospital health care delivery. Also, 10% of hospital managers report catering services to be of little importance or unimportant for hospital health care delivery, this being the highest percentage for all the services considered on this combination of measures. And as earlier indicated, catering services were among the least frequently outsourced services with only 22% of hospitals reporting to be outsourcing catering services. This is further support of the earlier assertion that the more important managers see a service as being important to hospital service delivery, the more they are likely to outsource the service.

Table 4.8 indicates that generally, most (at least 78%) of the majors agree or strongly agree that for services to be outsource they must be critical to the hospital’s mandate of health care delivery, they must be frequently needed by the hospital, there must be sufficient number of suppliers and that the outputs of the service must be easy to measure. The majority (91%) of managers agrees or strongly agrees that for services to be outsourced by the hospital, they should be services for which there are enough competent suppliers for the hospital to be able to get competitive prices. It is interesting to note that most of the hospital managers’ report limited supplier availability as a key challenge faced during outsourcing (57% of managers).

The least agreed to characteristic is frequency of need, with a still high proportion of managers (78%) strongly agreeing or agreeing that for services to be outsourced, they should be services that are frequently needed by the hospital for example on a daily basis.
### Table 4.9: Perception about services and their outsourcing

#### Importance of individual support services to hospital health care delivery

<table>
<thead>
<tr>
<th>Service</th>
<th>Very Important (1)</th>
<th>Important (2)</th>
<th>Moderately Important (3)</th>
<th>Of Little Importance (4)</th>
<th>Unimportant (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT Services</td>
<td>21 (68%)</td>
<td>5 (16%)</td>
<td>5 (16%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Catering</td>
<td>0 (0%)</td>
<td>13 (43%)</td>
<td>7 (23%)</td>
<td>7 (23%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Security</td>
<td>24 (77%)</td>
<td>5 (16%)</td>
<td>0 (0%)</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Cleaning</td>
<td>26 (84%)</td>
<td>3 (10%)</td>
<td>2 (6%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

#### Perception of characteristics of services to be outsourced (n=32)

<table>
<thead>
<tr>
<th>Feature</th>
<th>Strongly Agree (1)</th>
<th>Agree (2)</th>
<th>Not sure (3)</th>
<th>Disagree (4)</th>
<th>Strongly Disagree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRITICALITY-For services to be outsourced by the hospital, they should be core/critical to the hospital’s mission of delivering health services</td>
<td>16 (50%)</td>
<td>10 (32%)</td>
<td>0 (0%)</td>
<td>3 (9%)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>FREQUENCY OF NEED-For services to be outsourced, they should be services that are frequently needed by the hospital for example on a daily basis</td>
<td>15 (47%)</td>
<td>10 (31%)</td>
<td>1 (3%)</td>
<td>5 (16%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>SUPPLIER AVAILABILITY-For services to be outsourced by the hospital, they should be services for which there are enough competent suppliers for the hospital to be able to get competitive prices</td>
<td>14 (44%)</td>
<td>15 (47%)</td>
<td>0 (0%)</td>
<td>2 (6%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>MEASUREBILITY-For hospital services to be outsourced, they must be services whose output is easy to measure so that a tight contract can be written and the performance/output of the vendor can be easily monitored</td>
<td>14 (44%)</td>
<td>14 (44%)</td>
<td>1 (3%)</td>
<td>2 (6%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>
4.6.3 Perceptions about benefits of outsourcing

The literature documents a number of benefits of outsourcing. However, most of these benefits are based on studies in other fields like IT, etc. Table 4.10 shows the level of agreement of the various hospital managers with the perceived benefits of outsourcing.

The literature broadly categories outsourcing benefits under cost management, greater focus for management, flexibility and access to external expertise/investment or innovation.

Generally, the hospital managers strongly agree or agree with the various documented benefits of outsourcing, with at least 79% of the managers agreeing or strongly agreeing with the each of the indicated benefits.

Regarding cost management, the benefit that most managers agree with is that outsourcing can be used by a hospital to achieve improvement in productivity of its operations with 90% of surveyed managers strongly agreeing or agreeing with this statement.

Regarding greater focus for management, the benefit that most managers agree with it that outsourcing can be used by a hospital to be able to deliver improved service to the patients with 90% of surveyed managers strongly agreeing or agreeing with this statement.

About flexibility, the benefit that most managers agree with it that outsourcing can enable the hospital to improve its internal process through restructuring, re-engineering, standardisation of processes service with 82% of surveyed managers agreeing or strongly agreeing with the statement.

Regarding access to external expertise/investment or innovation ,the benefit that most managers agree with is that Outsourcing enables the hospital to gain quick and continuous access to the latest technological developments e.g. equipment with 90% of surveyed managers strongly agreeing or agreeing with this statement.
The least agreed to benefit by the hospital managers was is that outsourcing enables the hospital to convert fixed costs to variable costs linked with predefined outputs by the contractor, with (a still high) 79% of the managers agreeing or strongly agreeing with this statement.

The most disagreed to benefit of outsourcing was that outsourcing can be used by a hospital to achieve cost saving and to control costs, with 11% of managers disagreeing with this statement. The next most disagreed to benefit was that outsourcing can be used by the hospital to be innovative, expand service and rapidly develop new ways of delivering services, with 7% of managers disagreeing with this statement.

Indeed some studies have documented instances where outsourcing has had negative benefits. In their study, Boardman and Hewitt (2004:917-929) found that the contracting out of the orderly/porter/courier service at Sir Charles Gairdner Hospital in Western Australia showed negative results. The result was poor in terms of cost, quality and externalities.
Table 4.10: Hospital managers’ agreement with various benefits of outsourcing

<table>
<thead>
<tr>
<th>Domain</th>
<th>Level of agreement with perceived benefits of outsourcing</th>
<th>Number and (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost management</td>
<td>Out sourcing can be used by a hospital to achieve cost saving and to control costs (n=28)</td>
<td>Strongly Agree 13 (46%)</td>
</tr>
<tr>
<td></td>
<td>Outsourcing enables the hospital to convert fixed costs to variable costs linked with predefined outputs by the contractor (n=28)</td>
<td>5 (18%)</td>
</tr>
<tr>
<td></td>
<td>Outsourcing can be used by a hospital to achieve improvement in productivity of its operations (n=30)</td>
<td>10 (33%)</td>
</tr>
<tr>
<td>Greater focus on core functions</td>
<td>Out sourcing enable hospital Management to focus resources on the core business of looking after patients (n=)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outsourcing can be used by a hospital to be able to deliver improved service to the patients (n=30)</td>
<td>12 (40%)</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Outsourcing can enable the hospital to improve its internal process through restructuring, re-engineering, standardisation of processes service (n=30)</td>
<td>11 (37%)</td>
</tr>
<tr>
<td></td>
<td>Outsourcing provides hospital management with flexibility and convenience for scaling up services reducing risk of poor service and limited or over capacity (n=30)</td>
<td>7 (23%)</td>
</tr>
<tr>
<td>Access to external expertise/investment or innovation</td>
<td>Outsourcing enables the hospital to gain quick and continuous access to the latest technological developments eg equipment (n=30)</td>
<td>10 (33%)</td>
</tr>
<tr>
<td></td>
<td>Outsourcing can be used by the hospital to be innovative, expand service and rapidly develop new ways of delivering services (n=30)</td>
<td>9 (30%)</td>
</tr>
<tr>
<td></td>
<td>Out sourcing allows the hospital to bring in vendors with newer capabilities and knowledge which can provide competitive advantage over other hospitals (n=30)</td>
<td>9 (30%)</td>
</tr>
</tbody>
</table>
4.6.4 Perception about barriers to outsourcing

Table 4.11 shows the surveyed hospital managers perceptions of the various barriers to outsourcing. The barriers were classified into organisational/internal barriers which are due to factors within the hospital and external/contextual barriers which are due to factors within the hospital’s operating environment.

From the hospital managers’ perception, the biggest barrier to their outsourcing was external. More than half of the hospital managers (69%) indicated that to a great or to some extent, absence of a matured vendor market reflected by non-availability of quality outsourcing vendors which makes it difficult for the hospital to outsource. Interestingly and in support of this, as earlier indicated, the surveyed managers report that during the outsourcing process, the most frequently encountered challenge was the limited number of service providers (57% of managers). Confirming the effect of supplier availability on outsourcing by hospitals, a study of outsourcing by Iranian hospitals finds a high propensity of managers to outsource support and logistic services because of their relative simplicity and the large number of contractors for providing these services. This finding was in contrast to the finding for nursing, radiology, and laboratory services for which the managers indicated that the number of contractors who can provide these services is not high (Karimi et al 2012:25).

The next most frequently cited barrier was internal /organisational and relates to lack of the required infrastructure (e.g. low level of computerisation, financial data management, process standardisation) and the management skills to effectively outsource; 60% of surveyed managers indicated that this applied to them to a great or to some extent. From the hospital managers’ perspective, the least cited barrier was regulatory and policy restrictions (e.g. Procurement regulations, MOH policy, hospital board policy etc.) under which the hospital operates make it difficult to outsource, with about a third (33%) of hospital managers indicating that this applies to them to a great or to some extent.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Perceived bottle necks to outsourcing</th>
<th>To a great Extent (1)</th>
<th>To Some Extent (2)</th>
<th>Not at all Extent (3)</th>
<th>To a little Extent (4)</th>
<th>To a very little Extent (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational/internal barriers</td>
<td>My hospital lacks the required infrastructure (e.g. low level of computerisation, financial data management, process standardisation,) and the management skills to effectively outsource (n=30)</td>
<td>6 (20%)</td>
<td>12 (40%)</td>
<td>7 (23%)</td>
<td>3 (10%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td></td>
<td>The size and scale of our hospital operations/organisation make it difficult for the hospital to outsource (n=29)</td>
<td>5 (17%)</td>
<td>7 (24%)</td>
<td>12 (41%)</td>
<td>3 (10%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td></td>
<td>Resistance from current employees and employee unions due to fear of staff changes (e.g. layoffs) which may result from outsourcing make it difficult for the hospital to outsource (n=30)</td>
<td>3 (10%)</td>
<td>11 (37%)</td>
<td>10 (33%)</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>External/contextual barriers</td>
<td>Regulatory and policy restrictions (e.g. Procurement regulations, MOH policy, hospital board policy etc.) under which the hospital operates make it difficult to outsource (n=30)</td>
<td>6 (20%)</td>
<td>4 (13%)</td>
<td>13 (43%)</td>
<td>5 (17%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td></td>
<td>Absence of matured vendor market reflected by non-availability of quality outsourcing vendors makes it difficult for the hospital to outsource (n=29)</td>
<td>3 (10%)</td>
<td>17 (59%)</td>
<td>6 (21%)</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>
4.6.5 Perceived risks of outsourcing

From the surveyed managers perspective, the highest risk to outsourcing is strategic and is related to the fact that outsourcing could lead to regulatory violations (e.g. violation of procurement act, corruption) and creation of legal obligations which may not be favourable to the hospital, with 87% of managers agreeing or strongly agreeing with this. Interestingly however, only about 38% of managers report political interference as one of the challenges encountered during the outsourcing process.

From the hospital manager’s perspective, the lowest risk to outsourcing is operational and relates to the fact that outsourcing by the hospital creates complexity in vendor relationship management; slightly less than half (45%) of managers agreed or strongly agreed with this.
Table 4.12: Hospital managers’ perceptions about risks to outsourcing

<table>
<thead>
<tr>
<th>Domain</th>
<th>Level of agreement with perceived risks of outsourcing</th>
<th>Number and (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>Strategic risks</td>
<td>Outsourcing could lead to regulatory violations (e.g. violation of procurement act, corruption) and creation of legal obligations which may not be favourable to the hospital <em>(n=31)</em></td>
<td>6 (19%)</td>
</tr>
<tr>
<td></td>
<td>Outsourcing by the hospital can lead to over reliance on vendors which may be risky to the hospital in case the vendor performs poorly <em>(n=31)</em></td>
<td>15 (49%)</td>
</tr>
<tr>
<td>Commercial risks</td>
<td>Out sourcing can lead to loss of confidentiality and possible breach of privacy since the contractor gets to know the internal operations of the hospital <em>(n=31)</em></td>
<td>11 (36%)</td>
</tr>
<tr>
<td>Operational risk</td>
<td>Outsourcing by the hospital creates complexity in vendor relationship management <em>(n=29)</em></td>
<td>2 (7%)</td>
</tr>
<tr>
<td></td>
<td>Out sourcing by the hospital leads to increased management complexities since it requires special skills to successfully outsource and manage the vendor <em>(n=31)</em></td>
<td>8 (26%)</td>
</tr>
<tr>
<td></td>
<td>Sometimes outsourcing by the hospital may not lead to the expected deliverables/benefits <em>(n=31)</em></td>
<td>11 (36%)</td>
</tr>
</tbody>
</table>
4.7 OBJECTIVE 3: DETERMINANTS/FACTORS ASSOCIATED WITH OUTSOURCING BY GENERAL HOSPITALS IN UGANDA

4.7.1 Hospital characteristics and outsourcing

Table 4.13 shows the proportion of hospitals outsourcing and those not outsourcing (insourcing) by hospital characteristics. The hospital characteristics considered include hospital ownership, location, hospital size (use number of beds as a proxy), hospital staffing (considering the number of non-clinical staff) and hospital budget for the year 2013. Results of the analysis using contingency tables with Odds Ratios are also shown in Table 4.13 below.

Table 4.13: Outsource status per hospital characteristics (N=23)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Outsourcing number (Percentage)</th>
<th>Odds Ratios</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH</td>
<td>11 (79%)</td>
<td>0.5455</td>
<td>0.2409</td>
</tr>
<tr>
<td>NGO</td>
<td>12 (67)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>10 (53%)</td>
<td>----a</td>
<td>0.0033*</td>
</tr>
<tr>
<td>Urban</td>
<td>13 (100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large (&gt;100 beds)</td>
<td>18 (69%)</td>
<td>0.5625</td>
<td>0.3875</td>
</tr>
<tr>
<td>Small (&lt;100 beds)</td>
<td>4 (80%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing (Non clinical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly staffed (&gt;50 staff)</td>
<td>7 (53%)</td>
<td>0.2188</td>
<td>0.0593</td>
</tr>
<tr>
<td>Lowly staffed (&lt;50 staff)</td>
<td>16 (84%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Budget (2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High budget (&gt;500M UGX)</td>
<td>7 (54%)</td>
<td>----a</td>
<td>0.2188</td>
</tr>
<tr>
<td>Low budget &lt;500M UGX</td>
<td>16 (84%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*P<0.05

----a Odds ratios could not be calculated due to small numbers

The results indicate that there is a significant difference in the proportion of hospitals outsourcing and those not outsourcing between rural and urban hospitals (p=0.0033). Thus it can be concluded that hospital location has a significant influence on
outsourcing. The impact of the other considered hospital characteristics like ownership is not significant (p>0.05). However, in contrast with this finding, a study in Taiwan found that not for profit hospitals (NGO hospitals) had a higher tendency to outsource the services considered in the study (utility maintenance and guard services) than private and public hospitals (Hsiao et al 2009:[5]).

4.7.2 Management perceptions and outsourcing

Table 4.14 below shows the number of managers who agree or strongly agree with statements related to benefits of outsourcing, outsourcing risks, characteristics of services that need to be outsourced and outsourcing barriers per outsourcing status (outsourcing or not outsourcing).

Some of the items in the table are Likert scale items derived from a combination of various Likert items whereas others are standalone Likert items.

For the analysis, non-parametric tests, the Wilcoxon-Mann-Whitney tests were used to calculate the z statistic and the associated p-values (two sided p-values). The analysis was based on the null hypothesis that “there is no difference in the distribution of combined scores between the two sides of the independent variable- outsourcing/not outsourcing”
Table 4.14: Managers perception about outsourcing benefits, risks and barriers to outsourcing by outsourcing status

<table>
<thead>
<tr>
<th>Perception about outsourcing benefits</th>
<th>Outsourcing</th>
<th>Not Outsourcing</th>
<th>Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Management (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>0.3906</td>
<td>0.6990</td>
</tr>
<tr>
<td>Greater focus (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>0.4720</td>
<td>0.6405</td>
</tr>
<tr>
<td>Flexibility (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>0.0000</td>
<td>1.0000</td>
</tr>
<tr>
<td>Access to external expertise/investment or innovation (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>0.3691</td>
<td>0.7147</td>
</tr>
<tr>
<td>Perception about outsourcing risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic risks (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>1.9213</td>
<td>0.0642</td>
</tr>
<tr>
<td>Commercial risks (Likert item)</td>
<td>22</td>
<td>9</td>
<td>1.5763</td>
<td>0.1150</td>
</tr>
<tr>
<td>Operational risks (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>0.2194</td>
<td>0.8279</td>
</tr>
<tr>
<td>Perception about service characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticality (Likert item)</td>
<td>23</td>
<td>9</td>
<td>-0.4563</td>
<td>0.6482</td>
</tr>
<tr>
<td>Frequency of need (Likert item)</td>
<td>23</td>
<td>9</td>
<td>-1.1727</td>
<td>0.2409</td>
</tr>
<tr>
<td>Availability (Likert item)</td>
<td>23</td>
<td>9</td>
<td>-1.0454</td>
<td>0.2958</td>
</tr>
<tr>
<td>Measurability (Likert item)</td>
<td>23</td>
<td>9</td>
<td>-0.7807</td>
<td>0.4350</td>
</tr>
<tr>
<td>Perception about outsourcing barriers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational/ internal barriers (Likert scale)</td>
<td>21</td>
<td>9</td>
<td>-0.2975</td>
<td>0.7682</td>
</tr>
<tr>
<td>External/ Contextual barriers (Likert item)</td>
<td>21</td>
<td>9</td>
<td>0.7252</td>
<td>0.4683</td>
</tr>
</tbody>
</table>

The results indicate that there are no significant differences (p>0.05) in the hospital managers perceptions about the benefits of outsourcing, outsourcing risks, characteristics of services that need to be outsourced and outsourcing barriers per outsourcing status (outsourcing or not outsourcing).

Further analysis of the variations in management opinions and perceptions among outsourcing and non outsourcing hospitals using Likert items (instead of Likert scales) confirms that there are no significant differences in hospital managers opinion and perceptions towards outsourcing based on outsourcing status (Table 4.15).

It can thus be concluded that the hospital managers’ perceptions have no impact on the hospital’s outsourcing decision.
Table 4.15: Variations in management opinions and perceptions regarding various aspects of outsourcing among outsourcing and non outsourcing hospitals

<table>
<thead>
<tr>
<th>Opinion and knowledge about outsourcing</th>
<th>Out sourcing (n=32)</th>
<th>Not Outsourcing (n=29)</th>
<th>Odds Ratio</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree/Strongly agree (%)</td>
<td>22 (96%)</td>
<td>8 (89%)</td>
<td>0.3636</td>
<td>0.4173</td>
</tr>
</tbody>
</table>

Know at least one hospital that is currently outsourcing one or more of the services it requires (n=29)

| Agree/Strongly agree (%)                | 20 (100%)          | 8 (89%)                | 0.0000     | 0.3103|

The Public Procurement and Disposal Acts (2003) and the MOH Public Private Partnership (PPP) policy 2009, can be used as a basis by hospitals to outsource (n=25)

| Agree/Strongly agree (%)                | 16 (100%)          | 8 (89%)                | 0.0000     | 0.3600|

Perception about outsourcing benefits

| Agree/Strongly agree (%)                | 16 (89%)           | 8 (89%)                | 1.0000     | 0.4708|

Outsourcing enables the hospital to convert fixed costs to variable costs linked with predefined outputs by the contractor (n=23)

| Agree/Strongly agree (%)                | 16 (94%)           | 6 (100%)               | ----a      | 0.7391|

Outsourcing can be used by a hospital to achieve improvement in productivity of its operations (n=27)

| Agree/Strongly agree (%)                | 18 (100%)          | 9 (100%)               | ----a      | 0.4655|

Outsourcing enable hospital Management to focus resources on the core business of looking after patients (n=30)

| Agree/Strongly agree (%)                | 19 (89%)           | 8 (90%)                | 0.8421     | 0.7143|

Outsourcing can be used by a hospital to be able to deliver improved service to the patients (n=28)

| Agree/Strongly agree (%)                | 19 (95%)           | 9 (100%)               | ----a      | 0.6923|

Outsourcing can enable the hospital to improve its internal process through restructuring, re-engineering, standardisation of processes service (n=26)

| Agree/Strongly agree (%)                | 17 (94%)           | 8 (100%)               | ----a      | 0.7200|

Outsourcing provides hospital management with flexibility and convenience for scaling up

<p>| Agree/Strongly agree (%)                | 17 (94%)           | 7 (100%)               | ----a      | 0.7200|</p>
<table>
<thead>
<tr>
<th>Perception about outsourcing risks</th>
<th>Outsourcing</th>
<th>Not Outsourcing</th>
<th>Odds Ratio</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services reducing risk of poor service and limited or over capacity (n=25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outsourcing enables the hospital to gain quick and continuous access to the latest technological developments eg equipment (n=28)</td>
<td>19 (95%)</td>
<td>8 (100%)</td>
<td>----°</td>
<td>0.7143</td>
</tr>
<tr>
<td>Outsourcing can be used by the hospital to be innovative, expand service and rapidly develop new ways of delivering services (n=27)</td>
<td>17 (89%)</td>
<td>8 (100%)</td>
<td>----°</td>
<td>0.4872</td>
</tr>
<tr>
<td>Outsourcing allows the hospital to bring in vendors with newer capabilities and knowledge which can provide competitive advantage over other hospitals (n=27)</td>
<td>19 (95%)</td>
<td>7 (100%)</td>
<td>----°</td>
<td>0.7407</td>
</tr>
<tr>
<td>Perception of characteristics of services to be outsourced</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRITICALITY-For services to be outsourced by the hospital, they should be core/critical to the hospital's mission of delivering health services (n=32)</td>
<td>18 (78%)</td>
<td>8 (89%)</td>
<td>2.2222</td>
<td>0.3342</td>
</tr>
<tr>
<td></td>
<td>Out sourcing</td>
<td>Not Outsourcing</td>
<td>Odds Ratio</td>
<td>P</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>------------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>Agree/Strongly agree (%)</td>
<td>Agree/Strongly agree (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FREQUENCY OF NEED-For services to be outsourced, they should be services that are frequently needed by the hospital for example on a daily basis <em>(n=31)</em></td>
<td>16 (72%)</td>
<td>9 (100%)</td>
<td>----^a</td>
<td>0.1013</td>
</tr>
<tr>
<td>AVAILABILITY-For services to be outsourced by the hospital, they should be services for which there are enough competent suppliers for the hospital to be able to get competitive prices <em>(n=32)</em></td>
<td>20 (87%)</td>
<td>9 (100%)</td>
<td>----^a</td>
<td>0.3571</td>
</tr>
<tr>
<td>MEASUREBILITY-For hospital services to be outsourced, they must be services whose output is easy to measure so that a tight contract can be written and the performance/output of the vendor can be easily monitored <em>(n=31)</em></td>
<td>20 (87%)</td>
<td>8 (100%)</td>
<td>----^a</td>
<td>0.3940</td>
</tr>
</tbody>
</table>

---^a Odds Ratios can’t be calculated due to small numbers
Chapter 4 presented the analysis, interpretation and discussion of quantitative data.

The response rate for this study was satisfactory, standing close to 84%. The collected data were analysed using SAS version 9.3. In order to determine the consistency of the responses from the participants the Cronbach’s reliability coefficient tests were utilised. This study made use of frequencies and percentages to summarise the data. To determine the association between variables contingency tables with Odds Ratios and the corresponding p-values were used. Also, non-parametric tests, the Wilcoxon-Mann-Whitney tests were used as appropriate, calculating the z statistic and the associated p-values (two sided p-values).

The first objective of this study was to describe the current outsourcing practices and processes by general hospitals in Uganda. Most of the hospitals (72%) reported to be outsourcing, with the most frequently outsourced service being cleaning services (78% of hospitals). The most frequently reported reason for outsourcing was to gain quality service from another firm’s expertise (68%). Most hospitals reported being satisfied with their outsourcing services, with at least 60% of hospital manager managers reporting that they were strongly satisfied or satisfied with their outsourced service. The most frequently reported reason for satisfaction was that the anticipated improvement in quality of the outsourced service had been realised (87% of managers).

Before deciding to outsource, majority of hospital managers surveyed (73%) report to have conducted an internal analysis of the relative capability of the hospital to provide the service vs outside suppliers (75%). The most frequently used method for identifying and selecting a vendor for the outsourced service was through open domestic bidding, with 60% of hospital managers reporting to have used this method. The surveyed managers report that during the outsourcing process, the most frequently encountered challenge was the limited number of service providers (57% of managers). Majority of the surveyed hospitals that were outsourcing (71%) reported having in place systems to continuously monitor the outsourcing program. Majority of the hospital managers (87%) reported to be monitoring supplier performance. Rural hospitals were more likely to report challenges with the available number of suppliers during the outsourcing process compared to their urban counterparts (p=0.0152). Hospitals owned by MOH were more
likely to report political interference in the outsourcing process compared to NGO hospitals (p=0.0065).

Slightly more than a quarter (28%) of the hospital managers surveyed indicated that their hospitals were not outsourcing any of the hospital support services. Reasons for not outsourcing included lack of expertise, lack of confidence that outsourcing would benefit the hospital, the managers thinking that outsourcing is risky and thus prefer to use in-house staff and prohibition by hospital policy or law (22% of managers). Slightly more than half (56%) of the hospital managers indicated that their hospitals intend to outsource one of more hospital support services in the near future with the likely services to be outsourced in the future being cleaning and security services (80%).

Objective 2 sought to identify perceived benefits/advantages and drawbacks/disadvantages of outsourcing by hospital managers in general hospitals in Uganda. Majority of the surveyed managers (94%) strongly agreed or agreed with the statement that outsourcing is one approach that can be used by hospital management to improve hospital performance. Generally, the hospital managers strongly agree or agree with the various documented benefits of outsourcing (cost management, greater focus for management, flexibility and access to external expertise/investment or innovation), with at least 79% of the managers agreeing or strongly agreeing with the each of the indicated benefits. The biggest reported barrier to outsourcing was external with more than half of the hospital managers (69%) indicated that to a great or to some extent, absence of a matured vendor market reflected by non-availability of quality outsourcing vendors which makes it difficult for the hospital to outsource. The biggest reported risk to outsourcing by the managers is strategic and is related to the fact that outsourcing could lead to regulatory violations (e.g. violation of procurement act, corruption) and creation of legal obligations which may not be favourable to the hospital, with 87% of managers agreeing or strongly agreeing with this.

The third objective investigated determinants of outsourcing by general hospitals in the Uganda context including factors on which decisions by hospital managers to outsource and what to outsource are based. Results indicate that hospital location has a significant influence on outsourcing. However hospital Managers perceptions about benefits of outsourcing, outsourcing risks, characteristics of services that need to be outsourced and outsourcing barriers have no impact on the hospital’s outsourcing decision.
CHAPTER 5

ANALYSIS, INTERPRETATION AND DISCUSSION OF QUALITATIVE DATA

5.1 INTRODUCTION

In this chapter, the analysis, interpretation and discussion of the findings for the qualitative data is presented. The qualitative data was collected from hospital managers in selected general hospitals that had participated in the quantitative data collection.

The qualitative data collection was meant to obtain in-depth information from the hospital managers and to further explore the responses the hospital managers provided during the quantitative data collection.

The specific qualitative research questions the study sought to answer were:

- What are the various hospital's practices related to outsourcing?
- What are the advantages and motivations for outsourcing by hospitals in Uganda?
- What are the disadvantages and barriers to outsourcing by hospitals in Uganda?
- How do hospitals in Uganda decide whether or not to outsource, and which services to outsource?
- What processes do hospitals in Uganda use to outsource services and to continuously monitor effectiveness of their outsourcing?
- What interventions could be used to increase adoption of outsourcing by hospitals in Uganda where appropriate and feasible?

5.2 RESEARCH METHODOLOGY

The qualitative data collection methodology was applied. The details of qualitative data methodology are discussed in chapter 3. Data collection from the hospital managers
followed the qualitative data collection and occurred about two months after the initial quantitative data collection. The main purpose of qualitative data collection was to explore in more detail the hospital managers’ responses during the quantitative data collection and to obtain the required data to answer the qualitative research questions from the hospital managers’ perspective.

5.2.1 Study population

The study population was the hospital managers from the 32 general hospitals that participated in the quantitative data collection. These managers were directly involved in running their respective hospitals and in the decision making and management processes regarding any outsourcing in the hospital.

The hospital managers included Medical Superintendents and Hospital Administrators. They were from both government/MOH general hospitals and Non-governmental organisation (NGOs) general hospitals.

5.2.2 Sampling and study sample

The participants were selected by purposive sampling from a list of hospital managers who had indicated willingness for a follow on interview during the quantitative data collection. Attempts were made to ensure regional representation in terms of hospital location (North, East, West, South of the country) among the selected hospital managers.

A total of eight hospital managers were followed up for the qualitative data collection. They included seven male and one female hospital manager. Three of the hospital managers were Hospital Administrators while five were Medical Superintendents. Three of the managers were from MOH/government run hospitals while five were from NGO run hospitals.

The duration for which the hospital managers had been working in hospital or in their current positions ranged from 3 years to 12 years.
5.3 DATA COLLECTION

The researcher collected the qualitative data through one-on-one individual interviews with the hospital Managers using an interview guide (Annex E). The individual interview sessions lasted between 30 and 45 minutes to allow prolonged engagement and were personally conducted by the researcher. The interview sessions were recorded using a tape recorder.

5.3.1 Permission to conduct interviews

Written consent was obtained from each participant using a consent form (Annex H) which was signed by the participant before the interview. The consent form indicated the purpose of the study, rights of the participants and the purpose for which the data was to be used.

The participant and researcher also jointly signed a privacy binding form (Annex I). This forms entreats the researcher to keep any confidential information provided by the hospital managers a secret and to be used only for the purposes of the study and to be presented in such a way that the information cannot be traced back to its provider.

5.3.2 Interview guide

The interview guide was semi-structured and had two main sections. One section was for hospitals that reported to be outsourcing one or more of their support services and the other section for those that were not outsourcing.

Each section had open ended questions related to the objectives of the study. During use of the interview guide, where and when necessary, probes were used in order to get additional information.

5.3.3 Conducting interviews

All the interviews were conducted in English using the interview guide. Permission was sought from the participants before the interview commenced. Permission was also requested for the use of the audio tape recorder. The interviews were conducted in the
hospital managers’ offices to collect the data. Open-ended questions were used. Where necessary probing follow on questions were used.

The sample size of eight, though relatively small and unlikely to achieve data saturation was considered sufficient since the aim of the qualitative data collection was to help highlight/enrich the qualitative findings in this QUAL-Qual mixed methods study without necessarily reaching data saturation.

5.3.4 Transcription of interviews

At the end of the qualitative data collection period (one week) the various interviews were transcribed by the researcher. The transcription of the interviews was done verbatim and captured on computer using Microsoft Word 2010. Annex F presents a sample interview transcript.

5.4 DATA MANAGEMENT AND ANALYSIS

Data analysis was an iterative and ongoing process that commenced during data collection continuing during and after the transcription process.

The Microsoft Word versions of the transcript were imported into ATLAS ti version 7, the qualitative analysis software that was used by the researcher to manage and further analyse the data.

Before starting the data analysis, the researcher developed a data analysis schema based on the study objectives and the data collection tool. This is shown in Figure 5.1 below.

The scheme enabled the researcher to develop a provisional list of codes based on a harmonisation with the studies conceptual framework and to enable analysis that directly answers the qualitative research questions.

The researcher carefully read the transcribed data that had been imported into the ATLAS ti software several times, manually coding the data based on the pre-determined
lists of codes while attaching quotations to the various codes. The codes were then assigned to families created by the researcher in ATLAS ti.

Content analysis was done to explore in detail for common themes. Emerging themes and subthemes were then identified. Subsequently, the categories for each subtheme were identified based on the earlier developed codes.
Figure 5.1: Qualitative data analysis schema
Table 5.1: Emerging themes, subthemes and categories

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outsourcing status</td>
<td>Currently not outsourcing (insourcing)</td>
<td>• Opinion about outsourcing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reasons for not outsourcing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Future intention to outsource</td>
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<tr>
<td></td>
<td></td>
<td>• Assistance required</td>
</tr>
<tr>
<td></td>
<td>Currently outsourcing</td>
<td>• Opinion about outsourcing</td>
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<tr>
<td></td>
<td></td>
<td>• Services being outsourced</td>
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<td></td>
<td></td>
<td>• Duration of outsourcing</td>
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<td></td>
<td></td>
<td>• Satisfaction with currently outsourced services</td>
</tr>
<tr>
<td>Outsourcing practices</td>
<td>Outsourcing evaluation and decision-making</td>
<td>• Needs assessment and communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cost analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cost benefit/value for money analysis before outsourcing</td>
</tr>
<tr>
<td>Outsourcing process</td>
<td></td>
<td>• Parties involved in outsourcing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Steps in the outsourcing process</td>
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<tr>
<td></td>
<td></td>
<td>• Challenges encountered</td>
</tr>
<tr>
<td>Outsourcing monitoring</td>
<td></td>
<td>• Parties involved in monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Aspects being monitored</td>
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<tr>
<td></td>
<td></td>
<td>• Monitoring strategies used</td>
</tr>
<tr>
<td>Motivation/reasons for outsourcing</td>
<td>Cost related reasons</td>
<td>• Cost saving and value for money</td>
</tr>
<tr>
<td></td>
<td>Improve hospital/service performance</td>
<td>• Service critical to improving hospital environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve efficiency in task performance</td>
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<tr>
<td></td>
<td></td>
<td>• Improve quality of service</td>
</tr>
<tr>
<td></td>
<td>Access to external expertise/investment or</td>
<td>• Lack of internal capacity</td>
</tr>
<tr>
<td></td>
<td>innovation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Challenges with Human resources/staff</td>
<td>• Difficulty in hiring staff and firing non performing staff</td>
</tr>
<tr>
<td></td>
<td>management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>External factors</td>
<td>• Meet government requirement or Donor expectation</td>
</tr>
<tr>
<td>Benefits of outsourcing</td>
<td>Cost and financial management</td>
<td>• Lower cost of service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre financing by contractor</td>
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<tr>
<td></td>
<td></td>
<td>• Pay for performance</td>
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<td></td>
<td>Better focus for hospital management</td>
<td>• Focus on clinical services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduced staff management time</td>
</tr>
<tr>
<td></td>
<td>Access to external expertise/investment or</td>
<td>• Access to capability not available internally</td>
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<tr>
<td></td>
<td>innovation</td>
<td></td>
</tr>
<tr>
<td>Theme</td>
<td>Subtheme</td>
<td>Categories</td>
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<td>-----------------------------------</td>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>innovation</td>
<td></td>
<td>• Collaboration with vendor for community service</td>
</tr>
<tr>
<td>Risks/disadvantages of outsourcing</td>
<td>Risks related to supplier selection and performance</td>
<td>• External influence in outsourcing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Challenges with contract and relationship Management</td>
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<tr>
<td></td>
<td></td>
<td>• Un met vendor expectations</td>
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<tr>
<td>Outsourcing expectations not realised</td>
<td></td>
<td>• Increased cost of service</td>
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<td></td>
<td></td>
<td>• Poor quality of service</td>
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<tr>
<td>Risks related to presence of outsourced staff</td>
<td></td>
<td>• Impersonation, extortion and masquerading by outsourced staff</td>
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<td></td>
<td></td>
<td>• Lack of control over outsourced staff</td>
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<td></td>
<td></td>
<td>• Theft by outsourced staff</td>
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<tr>
<td>Damage to hospital reputation in community</td>
<td></td>
<td>• Loss of job opportunities for locals</td>
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<tr>
<td></td>
<td></td>
<td>• Outsourced staff and their (poor) behavior associated with hospital</td>
</tr>
<tr>
<td>Advice to others</td>
<td>Advice related to pre-sourcing evaluation</td>
<td>• Tours to other hospitals to learn and share experiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cost and vendor analysis before outsourcing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prioritisation and budgeting</td>
</tr>
<tr>
<td>Advice related to outsourcing process</td>
<td></td>
<td>• Follow due process/established guidelines and involve every one</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• External help/consultants to help with process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider local context and contract locally</td>
</tr>
<tr>
<td>Advice related to outsourcing monitoring</td>
<td></td>
<td>• Supplier vetting and performance monitoring</td>
</tr>
</tbody>
</table>

This section deals with analysis of data obtained through the open-ended one on one interviews with the hospital managers using the interview guide. As mentioned earlier, the interviews were audio taped and transcribed verbatim.

After reading and re-reading the transcripts from the 8 interviews, themes and subthemes were identified and classified into major categories. The coding was done manually by the researcher and was shared with the researcher’s supervisor for review and confirmation.
As indicated in Table 5.1 the analysis of the data collected from the hospital managers revealed six major themes.

The following subsections provide the detailed presentation and discussion of the results according to the themes and objectives of the study. Apart from the subtheme of insourcing under the theme of outsourcing status which relates to data from managers whose hospitals are not currently outsourcing, the rest of the themes and sub-themes relate to data from managers whose hospitals are currently outsourcing.

5.6 THEME 1: OUTSOURCING STATUS

This theme relates to whether the hospitals where the interviewed managers work are currently outsourcing any of the hospital support services (i.e. using an external company or external workers to provide the service) or insourcing (i.e. using the hospital’s own staff to offer the service). This theme also covers the manager’s opinions about outsourcing, the services being outsourced and the level of satisfaction with their outsourced services. For those that reported not to be outsourcing, this theme covers their reasons for not outsourcing and future intentions to outsource.

Two sub-themes emerged from the findings, outsourcing and insourcing. These are discussed below with the corresponding categories under each subtheme.

5.6.1 Subtheme: Currently not outsourcing (in-sourcing)

This subtheme relates to hospital managers who reported that their hospital are not currently outsourcing any of the support services. The categories under this theme include the opinions of the managers regarding outsourcing, their reasons for not outsourcing in addition to their future intention to outsource and any assistance the managers would require for successful outsourcing.

Two hospital managers (one female and one male) out of the eight hospital Managers interviewed (25%) indicated that their hospitals were not currently outsourcing any of the support services required to offer health care to their patients. Both of these managers were from hospitals owned by Non-government organisations (NGOs).
5.6.1.1 Category 1: Opinion about outsourcing

Interestingly, the managers from the hospitals that are currently not outsourcing had favorable opinions regarding outsourcing as a way of improving hospital performance. They indicated that outsourcing can enable hospital managers to focus on the core services of the hospital and it can help improve the quality of the outsourced services, in addition to providing the hospital with access to capabilities that may be currently lacking in the hospital.

As the managers indicated:

“It can improve services in that managers stop concentrating on the small things and begin concentrating on the strategic direction of the hospital. So things like compound cleaning can be outsourced so that managers do need to supervise that directly.”
(Participant 6; page 33)

“Also when you outsource, it’s easier and you are in a better position to request for better services than when employing your own workers…because if u give a task to a company you set out targets which are much easier to follow up because you are only following up with the manager of the company. But with your workers, when you set targets for 100 people and you are supposed to supervise them every day, that’s very difficult.”
(Participant 6; page 33)

“It is good to outsource for services…because there are instances when the hospital has not done well because certain things are lacking and they have to look out for them to provide the service.”
(Participant 7; page 37)

However, the managers also indicated some drawbacks of outsourcing. These were related to the high financial costs of outsourcing, concern for workers of the outsourced company and potential loss of jobs to the local community if the outsourcing company does not employee the locals.
As the managers indicated:

“The costs are high…employing our own people may be cheaper.”
(Participant 6; page 34)

“One disadvantage is that the workers (of the outsourced company) are sometimes over worked. And if the outsourced company originates far from where the hospital is located, they may not employ locals. And that was one of our issues, because there were locals employed who were receiving salaries every month but not delivering…and their reasoning was that the hospital is theirs and they have to be benefit.”
(Participant 6; page 33)

“And the other thing…when you outsource…are those so called companies going to employ the locals, or are they going to come with their own cleaners. Because if they come with their cleaners and yet we have locals here looking for jobs, that is another issue. Because we have to make sure that the community benefits and is part of service provision and they get something.”
(Participant 7; page 37)

The concern for the company workers and locals may be related to the fact that the NGO hospitals being run by the church have a pro-poor or pro-community social stance and compassion for humanity as part of their missions, and hence their concern for the workers and community even if outsourcing would be a more cheaper option.

5.6.1.2 Category 2: Reasons for not outsourcing

The main reasons highlighted by the managers regarding why they were not outsourcing were financial and they related to the perceived high costs of outsourcing and limited availability of funds in the hospital budget to enable outsourcing.

Regarding, the financial and cost reasons, the hospital managers commented as below:

“The main problem is financial-that is why we cannot out source. The hospital does not have funds...we have a budget but we are only able to realise about 85% of that...so in order to ensure this budget does sufficient work, we have to
be efficient. So instead of say employing a company, you employ a few staff and supervise them. You kind of do the donkey work to ensure that they do what the out sourced company would have achieved. But still you don’t achieve the same targets or even the quality is less compared to if you have out sourced.”

(Participant 7; page 37-38)

“We tried to do a financial analysis for security: every month we were paying 1.2 million to workers minus benefits like medical...though we didn't include it; but when we contacted a company for 4 guards, we were to pay 3.4 million which was high. Our guards were not that effective, but that is what we could afford. The other is domestic waste, the difference was about 80%. There were no qualified local companies so we got quotes from Kampala (capital city) which were high. So we thought about it but found it was not feasible cause of the cost.”

(Participant 6; page 34).

Another reason was related to the fact that given the current operations of the hospital, the management does not perceive a need for outsourcing.

As the managers indicated:

“At the moment, we are not out sourcing...because ours is not a very big hospital. And it is manageable where we are. May be if we create more departments. And there are people we are supposed to train to do this and this and we need some specialised people to do this or that, may be that would call for the need to bring in some specialised people.”

(Participant 7; page 38)

“For security, for example, we don't need so many people...that one is manageable. Like if you have only three entrances like we do...you don't need a lot. You just need someone to open the gate and to check those entering. So it is manageable. If you are to outsource it becomes much more expensive to hire those people from a private company.”

(Participant 1; page 8)

Based on the above, it can be concluded that based on the surveyed managers’ perceptions, current barriers to outsourcing in their hospitals include budget and cash
flow constraints, perceived high costs of outsourcing contracts and limited need of outsourced services due to the scope of current hospital operations.

It is interesting to note that, for one of the managers, from their point of view, their perceptions regarding the high costs of outsourcing (compared to outsourcing) are supported by a financial analysis that the hospital had conducted. It is however not clear if this analysis was comprehensive and also included a comparison of the benefits in terms of improved quality of service. An indicative cost benefit analysis for an outsourced service is presented in Chapter 6.

However, the other manager indicated that no such analysis had been conducted but their instinct was that insourcing was cheaper than outsourcing. As the manager indicated:

“We have not gone into that analysis…the beauty is that we buy our own cleaning materials, the water is there, the people are there to do the work and the end of the month you pay them if there is money. If there is no money, you postpone, but they keep doing the work. And under our supervision.”

( Participant 7; page 38)

It is however possible that any formal cost benefit analysis (as presented in the case study in Chapter 6) would not support the manager’s assertion regarding insourcing being cheaper than outsourcing.

The manager who highlighted limited scope or need for the service as a barrier to outsourcing may be perceiving outsourcing majorly as a way of increasing the workforce to scale up services as opposed to a way of improving efficiency of current services regardless of the scale. The Manager commented as below:

“At the moment, we are not thinking of outsourcing…because it is not that very big hospital. And it is manageable where we are. May be if we create more departments. And there are people we are supposed to train to do this and this and we need some specialised people to do this or that, may be that would call for the need to bring in some specialised people.”

( Participant 7; page 38)
5.6.1.3 Category 3: Future intention to outsource

Both managers interviewed indicated that their hospitals would likely outsource one or two hospital services in the future. Indeed one of the managers indicated that one of their neighboring sister institutions (a school) was currently piloting outsourcing of security services and depending on the results, this would be extended to the hospital.

The managers reported the likely services to be outsourced as security and cleaning. The motivations for outsourcing would be to improve the quality and efficiency of current services (security) and also because the services are critical to hospital performance (cleaning).

As the managers indicated:

“I think more of things like theatre—-it is really a delicate service…everything has to be superb. So we would possibly outsource cleaning in the theatre and wards where u really need serious hygiene. So cleaning would be one service to consider outsourcing.”
( Participant 7; page 38)

“I would outsource security because it is currently not so efficient. For example some of the security guards are drunk and sleep on duty but all we can do is suspend them. When you employ people dismissing them is difficult. So we think out sourcing security would improve quality. Currently we keep on losing petty things.”
( Participant 6; page 34)

It is not surprising that the managers indicated that they intend to outsource some of the hospital services in the future given their favorable opinions towards outsourcing. This would however depend on if their earlier highlighted barriers (especially limited funding) are addressed by the hospital managers.

An interesting practice highlighted by one of the managers is the piloting and feasibility study approach before full outsourcing either based on the hospital’s experience or a sister organisation.
The manager indicated:

“So we are now giving it a try…we started like 2 months ago. So the school is outsourcing…they have two guards from a company. So we are seeing how it will work on that side and we will come to the hospital. And in the end, we hope this would reduce at the number of askaris. So we would compare how much the guards cost compared to the askaris”.

(Participant 7; page 40)

The above is a good practice which would enable successful introduction of outsourcing based on a feasibility analysis and benchmarking.

5.6.1.4 Category 4: Assistance required for successful outsourcing

As indicated above, the hospital managers expressed their intention to outsource one of more support services, in the future. They however indicated that for success, their hospitals would need some support. This support includes visits to other hospitals to learn by example, help with developing outsourcing guidelines including outsourcing monitoring strategies.

As the managers indicated:

“The hospital has no (outsourcing) guidelines because we had never outsourced. So if the results of any analysis we do is favorable and we decide to go into the process (of outsourcing) then we would need guidelines.”

(Participant 6; page 35)

“We would also need to develop a monitoring system…design forms and do appraisals to see if they doing what we asked them to do. Also to strengthen supervision…we have to monitor, because much as they are doing the work, we also have to verify.”

(Participant 7; page 39)

“It would be good if we are able to visit a hospital that is outsourcing…to see how they are doing it and how feasible it is…and then give it a try.”

(Participant 7; page 40)

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The above confirm a need for outsourcing guidelines which is one of the expected outputs from this study. It also confirms the need for benchmarking before embarking on outsourcing as part of pre-outsourcing evaluation in addition to the importance of monitoring once outsourcing is started.

5.6.2 Subtheme: Currently outsourcing

This subtheme relates to hospital managers who reported that their hospitals are currently outsourcing one or more support services. The categories under this theme include the opinions of the managers regarding outsourcing, the services currently being outsourced, duration of outsourcing and level of satisfaction with outsourced services.

Six hospital managers (all male) out of the eight hospital managers interviewed (75%) indicated that their hospitals were currently outsourcing at least one of the support services required to offer health care to their patients. These managers were from both government owned (50%) and NGO owned hospitals (50%).

5.6.2.1 Category 1: Opinion about outsourcing

Unsurprisingly, all the hospital managers whose hospitals reported to be outsourcing had favorable opinions about outsourcing as a way of improving hospital performance. Their favorable opinions were related to the advantages of outsourcing including access to cheaper and better quality services and enabling access to new ideas that improve the effectiveness of the outsourced services.

As the managers indicated:

"By and large I think it’s a good process, it makes it cheaper for some services, and makes it efficient and also you get to allocate finances in a more efficient way."

(Participant 2; page 9)
“Overall outsourcing is good because it improves services as long as you are in control of the person who is doing the work. It saves time because you just tell somebody you go and do this work… and your role is just to supervise.”
(Participant 3; page 15)

“I would think it’s a better way to go than insourcing. It helps new ideas to come in (to the hospital), it helps you to get better people to do the work.”
(Participant 4; page 21)

One hospital manager further elaborated on how outsourcing improves performance of the outsourced services noting that:

“Outsourcing can improve hospital performance in that, the manager of the outsourced workers has control over their workers to ensure that they maximise efficiency, because he is motivated by the profit he is supposed to get by the end of the day. So he ensures that the workers fulfil the task and they have to do it in the shortest time frame for then to be able to realise the profit because if he doesn’t he can face a penalty and doesn’t realise his motive.”
(Participant 1; page 1)

Regarding what kind of services can be outsourced, the managers indicated those that don’t require a lot of medical knowledge and those critical to improving the hospital working environment e.g. cleaning services.

The managers commented as below:

“For some services, outsourcing is a very good idea. Services which are not sensitive, which don’t need medical knowledge… e.g. indoor cleaning, outdoor cleaning, security and even catering. I think it’s a good idea for some services. But for some services which need a bit of medical knowledge e.g. incinerator operation, handling body parts, you may not outsource.”
(Participant 2; page 9)
5.6.2.2 **Category 2: Services being outsourced**

The hospital managers reported that their hospitals were outsourcing a range of support services. All the hospital managers indicated that their hospitals were outsourcing cleaning services (both indoor and outdoor services). Other services reported to being outsourced though by not all the hospitals included catering services, security services, IT services, electrical services and plumbing services.

The widespread outsourcing of cleaning services (say compared to catering services) may be related to its relatively easy nature, ease of finding companies providing the service in addition to the ease of monitoring its quality.

Another reason may be related to the perception of hospital managers of cleaning services as being critical to the quality of hospital services offered and to the patient’s perception of the hospital.

As one manager noted:

“We needed people who can clean so that our staff are comfortable to do their work…and that patients who are customers are also comfortable in the environment where they are getting the service.”

(Participant 1; page 4)

5.6.2.3 **Category 3: Duration of outsourcing**

The reported duration of outsourcing varied from 2 years to 13 years. However, for some services e.g. plumbing and electrical services, the outsourcing was for a limited duration when the hospital required access to specialised services to complement those being offered by their in-house staff when the required service was beyond the capability of the in-house staff.

The longest outsourced service was cleaning services. The hospitals that reported to be outsourcing catering indicated this to be a relatively new addition to their outsourcing menu.
The reported duration of outsourcing indicates that hospitals have been outsourcing a while and are expanding the range of services outsourced as they gain experience and as their operational contexts change.

5.6.2.4 Category 4: Satisfaction with outsourced services

All the interviewed managers indicated that they were currently satisfied with their outsourced services. The reported satisfaction was because of improved quality and timeliness of service, cheaper service, access to the services even in situations of constrained cash flows for the hospital, and improved control over service provision since the managers had to deal with only the head of the company unlike in the past when they had to deal with multiple staff.

The managers commented as below:

“Am satisfied…it eases the pressure. Financially, even without money…those people are doing their work whether we are paying them or not since they know we have a contract.”
(Participant 1; page 9)

“Am satisfied…the main reason is quality. The other is timeliness of service. We have been able to control infections. Also, every time our office is clean.”
(Participant 5; page 30)

However, despite the overall satisfaction, responses from some managers indicate that there could be challenges even if these don’t affect the hospital’s level of satisfaction with the outsourced services.

As one manager commented:

“For me I am satisfied, much as there are some challenges…we just have to work around the little challenges and fix them. But am satisfied, because am in control of the outsourced company. Also am doing things cheaply. Even the quality-quality has improved. We have not attained standards but quality has improved.”
(Participant 3; page 18)
Also, the findings indicate that there have been situations in the past when the managers were not satisfied with the outsourced services.

One manager commented as below:

“Currently am satisfied…the one we had before was not doing good work. But the one who came in after is doing well.”

(Participant 4; page 24)

From the above, it’s clear that the interviewed hospital managers are realising the expected benefits of hospitals hence their satisfaction.

It is also clear that hospital managers take satisfaction with outsourced services serious and are even willing to take steps to change the contractor in order to acquire satisfactory services. One manager provided insight into that process as below:

“There were legal issues…he threatened to go to court but we had to call him and talk to him. We told him, you were not performing but we have not terminated you; we have just suspended you and as per our contract with u…we have a right to. But we can assure you that we can deal with you if you abide with our rules and improve performance.”

(Participant 4; page 25)

It is, however, interesting to note that none of the managers mentioned a good relationship with the supplier as one of the reasons for satisfaction.

5.7 THEME 2: OUTSOURCING PRACTICES

This theme relates to the activities undertaken by the hospital and its management before outsourcing (including the decision making process) and during the outsourcing process including monitoring of the outsourced services. The sub-themes in this theme include outsourcing evaluation and decision making, the outsourcing process and outsourcing monitoring, and are discussed below.
5.7.1 Sub-theme: Outsourcing evaluation and decision making

This sub-theme relates to the analysis conducted by the hospital managers to determine if outsourcing was necessary and feasible for the hospital. The categories under this theme include needs assessment and communication, cost analysis, cost benefit/value for money analysis and evaluation of the pros and cons of outsourcing.

5.7.1.1 Category 1: Needs assessment and communication

Data from the interview hospital managers indicate that the hospitals engage in some form of needs assessment before embarking on outsourcing.

One manager commented as below:

“First of all, we have to initiate it at the planning level…we make sure that we do the needs assessment…to find out which services we actually require. We have 23 departments; the heads of department do the needs assessment to determine hospital needs which are forwarded to us as senior management for discussion and then to hospital management board for approval. And once we do this, we also do some survey in terms of finding out the possible cost so that we are able to allocate a reasonable amount of money to such a service once outsourced.”

(Participant 5; page 27)

In some instances, the need for outsourcing emanated from internal audits that uncovered the need to strengthen certain aspects of the hospital’s performance with the audit recommending outsourcing.

One manager commented as below:

“We have a department internally in charge of Infection prevention. We usually do environmental audits with National Environmental Management Agency (NEMA). So it (outsourcing) was a recommendation from the department based on the environment audit.”

(Participant 8; page 41)
Once the need for outsourcing is confirmed, the hospital managers would then have to include it in their funded work plan for it to be implemented or communicate it to the district administration that would be in charge of engaging the outsourced company.

The hospital managers commented as below:

“And once we do that (confirm the need) we also declare this need and once it’s included in the work plan and approved, we go out to seek for the service providers.”

(Participant 5; page 27)

“One of the issues is that we raise our concern with the district. So they tell us before the financial year closes to inform the Chief Administrative Officer (CAO) in writing of the services we would like to outsource the next financial so that the Procurement department prepares for the services to be advertised in the paper so that people bid and are selected.”

(Participant 1; page 4)

5.7.1.2 Category 2: Cost analysis

Providing further insight in the needs assessment process, the hospital managers mentioned a number of analysis conducted by the hospital as part of the outsourcing evaluation and decision making.

One such kind of analysis reported to have been performed is cost analysis aimed at determining the current cost of offering the service.

The hospital managers commented as below:

“We looked at how much we were spending for the other workers we had before. And said if we are to lay off the 25 people…whom we are paying 1.25million and we are getting a contractor whom we would pay 1million. We make a saving. So we had to look for a contractor who wouldn’t go beyond 1.25 million…so we knew if we were to get someone it must be below 1.25 million. And we had to make it clear to the procurement department.”

(Participant 1; page 8)
Besides internal cost analysis, data provided by the interviewed hospital managers indicate that they also did some benchmarking with equivalent institutions to determine how much they were spending on similar services.

One hospital Manager commented as below:

“We compared with other institutions which are in the same business, sister hospitals. And we found out that what they were paying for cleaning services to a contractor was actually lower than what we were spending.”

(Participant 2, page 11)

Finally, the hospital managers also indicated doing some market survey to determine the likely cost of outsourcing if they decided to take that route.

One hospital manager commented as below:

“We also do some survey in terms of finding out the possible cost so that we are able to allocate a reasonable amount of money to such a service once outsourced.”

(Participant 5, page 27)

It’s interesting to note that the managers were conducting some form of costing analysis before outsourcing. However, it is clear that the analysis only focused on financial costs of outsourcing the service in terms of potential contract cost and did not consider other costs in terms of benefits or additional costs resulting from the outsourcing process (e.g. need to train workers of outsourced companies, supervision etc.). It is possible that conducting a broader cost benefit analysis as presented in Chapter 6 would lead to a different outsourcing decision.

5.7.1.3 **Category 3: Cost benefit /Value for money analysis before outsourcing**

One manager hinted that prior to outsourcing, the hospital conducted a cost benefit/value for money analysis of outsourcing, though intuitively.
As the hospital manager commented:

“For you as an administrator you are at a loss, trying to force this person (hospital staff) to do the work. So you find that the hospital is not clean as you expect it. Sometimes they clean; some days they don’t. So it compromises the quality, and so you are not satisfied, the clients are not satisfied. So we decided that okay we are not getting value for money. If there is to be any efficiency let us outsource and see if things can improve. This to me helps because if someone has not done the work, you can’t pay because the contract is not yet binding.”

(Participant 1, page 2-3)

Whereas the above intuitive thinking is commendable, it is not grounded in real data. Complementing such thinking with real data through a formal cost benefit analysis would help the hospital make a more rational decision. An example of such an analysis is presented in Chapter 6.

5.7.2 Sub-theme: Outsourcing process

This subtheme relates to the steps that the hospital went through to outsource in addition, the individuals who were involved in addition to the difficulties encountered by the hospital in the outsourcing process. The categories under this sub-theme include parties involved in the outsourcing process, steps in the outsourcing process and challenges encountered.

5.7.2.1 Category 1: Parties involved in outsourcing

Data from the hospital managers indicate that several parties, both internal and external were involved in the outsourcing process. The internal parties included the hospital administrators (Medical superintendent and hospital managers), other administration staff (e.g. Accountant) and representatives of the user departments for the services to be outsourced.

External parties included the district authorities (for MOH hospitals; these being the oversight authorities for the government hospitals), hospital management boards (for NGO hospitals, these being the oversight authorities) in addition to representatives of
the outsourced companies who were involved in the contract negotiations once a decision to outsource had been made.

The hospital managers commented as below:

“I (Medical Superintendent) was involved, my district Administrator (Chief Administration Officer) and the district procurement team. The Chief Administrator and director of the outsourcing company were involved in the negotiation.”

(Participant 1, page 5)

“Apart from myself (Medical Superintendent), we have in the Hospital Administrator and the account...he deals with monetary issues and how to write the contract. And then we have a head cleaner...who helps to monitor. He is part of the team that supervises the contractor.”

(Participant 3, page 17)

Some hospital managers also indicated involvement of external consultants who guided the outsourcing process. One hospital manager commented as below:

“The people involved were the Hospital Administrator, procurement committee, we also had to get a consultant from outside to guide us, observers, and directors of the companies that applied during bid opening. We did not have guidelines that is why we had to invite consultants.”

(Participant 4, page 24)

The findings indicate that the outsourcing process was managed by a team of individuals (both internal and external to the hospital) and not by a single individual.

From the caliber of people involved (senior managers, users and oversight authorities), it’s clear that outsourcing is considered by hospitals as a strategic decision and not just a mere operational decision that can be left to hospital managers alone or that can be taken without recourse to the hospital oversight authority.

Involvement of external consultants in absence of internal guidelines or capacity is also a reflection of the seriousness that hospital managers attach to the outsourcing
decision. The involvement of observers may be related to the need to ensure transparency and to ensure the integrity of the procurement process for the outsourced company.

5.7.2.2 Category 2: Steps in the outsourcing process

The data provided by the hospital Managers indicates that the outsourcing process begins with a needs assessment conducted by the user department. The needs are then communicated to the hospital management.

As one hospital manager noted:

“First of all, we have to initiate it at the planning level...we make sure that we do the needs assessment...We involve the users, those are the heads of department to find out which services we actually require. And what we do that, we also declare this need to the hospital management for discussion and for it to be approved and included in the work plan.”
(Participant 5, page 27)

The hospital management conducts further analysis to determine if outsourcing is feasible and the likely costs before approving the request and presenting it to the hospital management board.

As one hospital manager noted:

“We have to sit as management...evaluate the type of work, how much it would cost and then the pros and cons and look for a justification of why we to outsource. Of course it has to include the costing, and what policies apply. And then we present it to the hospital management board.”
(Participant 3, page 20)

Once the hospital management board approves, then the procurement process to engage the outsourced vendor begins. The procurement team either internally (for NGO hospitals) or at the district administration (in case of MOH hospitals) is responsible for the procurement process. Data from the managers indicates that the procurement process is a thorough and tedious one, commencing with requests for bids, opening the
bids, evaluating the bids and then selecting a winner. The winning vendor is then awarded the contract by the hospital manager (in case of NGO hospitals) or by the District Chief Administrative Officer (CAO) in case of government/MOH hospitals.

As the hospital managers indicated:

“The procurement department runs the process. They advertise requesting for quotations and bids. At the due date, they call the bidders and open the bids before evaluation commences. They take due diligence…check if the person who has applied has done the work before. They evaluate and see if he is suitable. They also look at the cost. After they have done that…they may be select three bidders who have satisfied the criteria. They then go through more details of evaluating each through past experience and they then zero on one based usually on cost. Then they award the contract. The district does the final approval but usually the district does not change anything. Most of they give a no objection. The contract is with the district, but on our behalf. We participate in all these processes even at the award level. The district is also party to the contract but we sign…the district witnesses. It's such a tedious process but we have to undergo it. The process takes about a period of 2 months. The contracts we do are one year contracts.”
( Participant 1, page 4)

5.7.2.3 **Category 3: Challenges encountered**

A key challenge highlighted by the hospital managers during the outsourcing process was limited availability of local suppliers to provide the required services.

One manager commented:

“It is not so easy to find providers. There are some things in hospital cleaning that need a bit of training. How to handle infectious waste, how to handle body fluids etc. For you to get a company that has worked in a hospital before is very difficult in a rural setting. May be in the city. So we got someone who we thought would learn than we promised ourselves to train them.”
( Participant 2, page 12)
As a consequence of limited availability of qualified service providers, hospital managers indicated that there were no options in case one company is blacklisted and debarred from competing for future contracts. Also some individuals register and bid under several companies limiting effective competition.

The hospital managers commented:

“There is also the issue of limited capacity out there to offer some of the required services…and I don’t know…there is also a tendency of people…because when you go for evaluation and look at the requirements the people have provided. It may read a different name and when it comes to the ground you encounter the same challenges…same management. Same management and yet different company…and yet you may just have black listed their other company”.

(Attendee 5, page 29)

“And sometimes you find that you keep replicating the same people; a group of people registering several companies and yet they are the same people. So one person bids through several companies. You blacklist him this time and next he emerges through another company, and you end up seeing the same faces but with a different company name.”

(Attendee 5, page 28)

A related challenge was where a hospital choses a company to provider an outsourced service based on the company’s indicated capacity during the bidding process but its later discovered that the company does not indeed have the required capacity. This points to instances of forgery in the bidding process.

One manager commented as below:

“We do capacity assessment (before selecting a company)...but I have come across situations whereby you do capacity assessment, even financial or even technical assessment. You find very excellent qualifications, but when it comes to work, these people are not there, meaning that they used people’s credentials to get the outsourcing contract, but when it comes to doing the work, the person is not there. Also financial capacity, you find people go and borrow money, put it on their account to get bank statements and then withdrawal…some people even forge bank statements.”

(Attendee 5, page 29)
In some instances, the managers indicated that for certain services where certification is required to provide the service, situations arose where only one company had the certification.

“We had gotten three potential people, but it was after National Environmental Management Authority (NEMA) came on site and they gave us a company to contact. That is the only person who can do what we wanted…he is the only one who had the license. Good enough we had been with him for a long time…he was doing some other services for us.”

(Participant 8, page 42)

Highlighting the seriousness of the challenge of limited availability of suppliers for outsourced services, one manager hinted that in the absence of qualified local providers, it may even be better for the hospitals to in-source even if outsourcing would have been desirable.

The manager commented:

“Especially for rural areas, it’s not easy to get companies that are serious with what they do. So some hospitals opt to employ their own staff because you don’t get companies that are serious. If you don’t have the right company to do it, rather do it yourself.”

( Participant 2, page 14)

The lack of qualified service providers as indicated above leads to a situation of limited competition which can lead to increased prices because of a monopoly situation. Additionally choosing a service provider based on their exaggerated capacity means that the expected service quality improvement may not be realised.

Another challenge highlighted by the hospital managers was the bureaucratic nature of the outsourcing process which creates delays in onboarding the outsourced vendor. This, the managers noted is a serious challenge in the hospital setting where sometimes need for service is urgent.
The hospital manager commented as below:

“And then generally the system itself…the bureaucracy…from the advert, after you have prequalified, you have to wait for another 15 days for people to raise complaints. And yet in the hospital setting, once want something…you want something. You don’t have to wait. It has to be provided. So most times we experience those challenges caused by bureaucratic delays and affects the way you want to perform.”

(Participant 5, page 29)

The bureaucratic delays, especially related to finalisation of the required paper work have sometimes led to conflict between the hospital and the vendor, as narrated by one hospital manager below:

“We had a service provider come on ground before the contact was finalised. He had won, but not awarded. So he came on ground earlier and we had to stop him much as we wanted the service. So when it came to payment, and depending on the contact, we had to forward it by one week. And when it came to payment we had to prorate and yet he had raised a claim for one month. So we had a little bit of conflict.”

(Participant 5, page 31)

5.7.3 Sub-theme: Outsourcing monitoring

This subtheme relates to activities being conducted by the outsourcing hospitals to ensure that they are achieving their outsourcing objectives and that the outsourced company is performing as expected. The categories under this theme include parties involved in monitoring, aspects being monitored and the monitoring strategies employed.

5.7.3.1 Category 1: Parties involved in monitoring

The data provided by the hospital managers indicate that a range of people were involved in monitoring the outsourced company during service provision. These included individuals from the user departments, internal technical experts in the services being outsourced (e.g. health inspectors) and hospital managers.
The hospital managers commented as below:

“We have a health inspector who checks. He is resident in the hospital. Every day he looks at what they (outsourced company) are doing...inside, outside. So he is really monitoring.”

(Participant 1, page 6)

Some hospital managers reported having dedicated individuals or a team whose role is to monitor the outsourced service.

One manager commented as below:

“We have the staff to do that (monitoring). For example, for cleaning, we have the health inspection team made of health assistant and health inspector. Regularly on daily basis, they monitor and we have made sure it’s part of their daily schedule, so somehow they have to do it...because we appraise them on this.”

(Participant 5, page 31)

Noting the importance of monitoring and actions that can result from the process, one manager is a study on outsourcing by hospitals in Taiwan emphasises that hospitals have to set up a system or director to review and monitor the implementation of outsourcing companies, and if they do not comply with the contract, consequences must be applied (Hsiao et al 2009:[7]).

5.7.3.2 Category 2: Aspects being monitored

Data collected from the hospital managers indicates that one aspect of the outsourcing being monitored by the hospitals is supplier performance in terms of the quality of service being offered.

As one manager commented:

“Before we pay for the services at end of month, they (monitoring team) compile a report, a summary of their evaluation of the vendors’ performance for a month. It’s on the basis of their recommendation that we pay.”

(Participant 5, page 31)
Another aspect the managers mentioned to be outsourcing was cost. However, practices regarding cost monitoring varied with some hospital managers actively monitoring the costs of the service while others took a more passive approach assuming that as long as the vendor did not raise the cost of the contract, there was no need for cost assessment as part of the monitoring process. These two extremes are reflected in the hospital manager’s comments below:

“I actively monitor cost—you know the cost of doing work depends on who is negotiating. Sometimes there may be connivance. So I also look at the cost, how much have we spent.”
(Participant 3, page 17)

“For the cost monitoring and evaluation, we did it at the beginning but haven’t done it again. But we presume it won’t change much because the market price of the implements and other consumables can only get higher. And as long as the contractor does not come to ask for a raise, we may not need to do another survey.”
(Participant 2, page 13)

Another hospital manager indicated that their hospital was also monitoring the vendors adherence to the terms of the outsourcing contract in terms of the expected investments from the vendor, for example the agreed number of staff to be used in delivering the services. This was indicated by the hospital manager as below:

“It starts from the contract…we agree on a number of aspects, e.g. number of people to employ. We also agree that if you don’t have all we asked we reduce the money. And so we monitor based on that (contract).”
( Participant 4, page 25)

One manager highlighted the benefit of cost monitoring, indicating that it had helped them negotiate for a lower contract price with the vendor.
The manager commented as below:

“We have been monitoring the aspect of cost. And the decision we took was not necessarily to get rid of outsourcing as such but it actually helped us to reduce the amount of resources we had been paying out for a particular service. Because we realised that compared to what other hospitals were paying, we were paying slightly higher. For example, our cleaning services, we used to pay 4.8 million per month, but we had to drop it to 3.2 million after comparing.”

(Participant 5, page 31)

From the above, it is clear that the hospital managers were actively monitoring the quality of services being provided and most likely taking corrective action. This may have contributed to the satisfaction earlier reported by the managers emanating from the high quality of services being provided by the vendors.

The contract between the vendor and the hospital would be central in the monitoring as it would include the expected level of performance (service level agreements) or investments to be made by the company in order to perform as expected. These would then be the basis of monitoring assuming they are clearly laid down in the contract. And whereas data from one of the hospital managers indicates that the expected vendor investments may have been included in the contacts, it is not clear if service level agreements were. It is thus not clear how the hospital managers were determining the quality of service provided and making the link to what needs to be paid as indicated by one of the hospital managers.

The outcomes of cost monitoring are clear from the data provided by the hospital managers, specifically the ability to negotiate for lower prices based on continuous cost monitoring as highlighted by one hospital manager. This thus calls for active cost monitoring as opposed to passive cost monitoring as was reported by one of the interviewed hospital manager.

It was also reported that results of monitoring were being used to determine how much to pay the vendor. This was indicated by one hospital manager as below:
“We have a health inspector who supervises them and issues a report before we pay them. So if they are not satisfied...we don't pay.”

(Participant 1, page 5)

Thus supplier performance monitoring enabled the managers to tie payment to vendor performance which is one of the potential benefits of outsourcing compared to insourcing when most times staff are paid regardless of performance.

However, none of the interviewed managers mentioned monitoring the continued need for outsourcing. It is possible that as hospital circumstance change (e.g. changes in scale of hospital services, increase in hospital staff capacity/capabilities) the need or cost effectiveness of outsourcing may reduce necessitating that the hospital reverts to in-sourcing. Thus, this is an important aspect of outsourcing monitoring.

5.7.3.3 Category 3: Monitoring strategies used

The hospital managers reported using a number of strategies to monitor vendor performance. These included daily “walk arounds” by monitoring staff to assess quality of work being done by the vendors.

One hospital manager commented as below:

“We have customer care assistant who moves around the wards daily, they pass through to check if hygiene is good. They bring feedback which is fed to the Quality Assurance (QA) committee every month. Then the hospital administrator and myself pass around...may be twice a week to check.”

(Participant 2, page 13)

One manager noted that during the walk arounds, the monitors take photos to document the quality of service as this forms an integral part of their monitoring report. As the manager commented:

“When these people inspect, they take photos...and when we look at the summary for the whole month, it really verify if the vendor has done quality work.”

(Participant 5, page 31)
Another monitoring strategy mentioned was regular meetings with management of outsourced company to review performance and address any issues as indicated by the hospital manager below:

“We also have regular dialogues and meetings with them (outsourced company). We actually hold monthly meetings with them and when we have our general staff meetings we have invited their management so we are able to identify and address issues.”

(Participant 5, page 30)

Regarding cost monitoring, data from the hospital managers indicates that some hospitals were benchmarking, comparing their current contact costs with what is being paid by peer hospitals, as indicated by the hospital manager below:

“We compared and realised that compared to what other hospitals were paying, we were paying slightly higher.”

(Participant 2, page 11)

It would, however, seem that the hospitals are conducting independent monitoring and not involving managers or supervisors from the outsourced companies as indicated by the hospital manager below:

“These people (outsourced workers) have someone who is always supervising them…their person. Then we have our monitor also. Ours is independent.”

(Participant 1, page 7)

Whereas the decision to keep the two separate may be borne out of the need to prevent the hospital’s independent monitor from being compromised by the outsourced company’s supervisors, there is a missed opportunity in not conducting joint monitoring “walk arounds” between the hospital monitor and vendor’s supervisor. This would enable joint monitoring and shared agreement reducing conflict. However, for this to be effective, there would be need for monitoring checklist jointly agreed between the hospital monitors and vendor supervisory staff. Indeed, as earlier indicated, development of monitoring checklists is one of the areas of assistance highlighted as part of the assistance that hospital managers currently not outsourcing would require.

Based on the above data provided by the hospital managers, the hospital outsourcing process can be summarised by the flow diagram in Figure 5.2 below.
Figure 5.2: Hospital outsourcing and monitoring flow process
5.8 THEME 3: MOTIVATION/REASONS FOR OUTSOURCING

This theme relates to what compelled the managers of the hospitals to outsource one or more support services. The sub-themes include cost and financial reasons, desire to improve hospital/service performance, access to external expertise/investment or innovation, challenges with internal human resources/staff management and external factors.

5.8.1 Subtheme 1: Cost related reasons

This relates to lower costs and improved return on investment for funds paid for outsourced services.

5.8.1.1 Category 1: Cost saving and value for money

Some of the interviewed managers indicated cost saving as a motivation for outsourcing. Based on a survey or analysis conducted, the managers realised that they what they could pay for the service once outsourced was less than what they were currently paying.

As one Manager noted:

“When we did a cost analysis, we realised that for example we were spending 3.5 million for cleaning and yet when we inquired with providers...they were telling us that is high. That we could pay 2.5 million for a month.”

( Participant 4, page 23)

Past studies have indeed confirmed that outsourcing can lead to cost savings. Hodge (2000:101-103) estimated the average cost savings, after including 2% for the cost of the contracting process, to be around 6–12%.

Additionally, besides the direct costs of paying workers, the hospital managers indicated that there were other costs related to offering the services in-house which were viewed as being undesirable and would be saved once the hospital outsourced. Some of these
costs were related to procurement, management and tracking of inventories of materials needed for offering the services in-house.

As one manager noted:

“We decided to outsource cleaning because the job was not being done well by the hospital employees and it was getting expensive. You see if you have to send the bursar to buy cleaning soap, and he has to buy brooms...you have to monitor yourself how these things are being used. You find that it’s too much...every week you have to buy another mop, more brooms, more soap. And at the end of the month, these people can sneak out your materials. So it was more expensive using our staff, the job was not being done...actually out sourcing has done much better and it’s cheaper.”

(Participant 2, page 10)

From the above it's clear that a key motivation for outsourcing by some of the hospital managers was to reduce costs. This was based on both formal and informal analysis conducted by the managers. However, this analysis was mainly financial and may not have fully considered other economic costs related to outsourcing (e.g. training of outsourced workers, supervision etc.). Such an analysis may indeed indicate that outsourcing was more expensive and led to higher costs.

5.8.2 Subtheme 2: Improve hospital/service performance

5.8.2.1 Category 1: Service critical to improving hospital environment/improve efficiency in task performance

Another motivation for outsourcing as indicated by the managers was to improve hospital performance and client satisfaction by outsourcing a critical support service to improve the environment for the hospital workers and clients.

As one manager noted:

“For someone to come and get satisfied he must look at the environment where he is going to get the service. If you really look at some of the aspects of our environment like the toilets…with a high patient load including people who have never used some of these lavatories. Now if you just leave everything to chance
...you may even get an outbreak because the lavatories are not clean. So we felt that that is one of the services to outsource out so that the environment in which we work is conducive.”

(Participant 1, page 4)

5.8.2.2 Category 2: Improve quality of service

Another motivation for outsourcing indicated by the interviewed managers was improvement of the quality of service being offered. Through outsourcing, the hospital aimed at bringing in a company to offer a better service than was currently being offered by the hospital staff.

As one manager commented

“You may have people working but if the environment is not clean and is not conducive, you may not get satisfied. We needed people who could clean well so that our workers are comfortable to do their work and that patients who are customers are also comfortable in the environment where they are getting the service.”

(Participant 1, page 4)

5.8.3 Sub-theme 3: Access to external expertise/investment or innovation

5.8.3.1 Category 1: Lack of internal capacity

The interviewed managers indicated that another motivation for outsourcing was because the hospital lacked internal capacity to perform certain services. This could be because the company does not have the required personnel in-house.

As one hospital manager commented:

“If the establishment does do provide for that...for example if you don’t have someone in the establishment qualified to do that type of work, then definitely we have to outsource. If you look at catering, for example, ideally we are supposed to be having someone responsible for providing such services...but if you look at the current hospital structure, it does not provide for that post. The old structure
used to have domestic assistants. But these days, the kitchen itself or the equipment supposed to be used for catering services are either dilapidated or they have closed. We find it more appropriate to outsource the catering than struggling to create space, to recruit people, it’s tedious and that time is not there.”

(Participant 5, page 27)

In line with the above argument, a study in Taiwan found that outsourcing of medical and common waste management was high in Taiwanese hospitals because the hospitals had limited space, and lacked the area to build refuse burning facilities. Similarly, the study notes that newer hospitals are not built with laundry facilities because the laborers and machines take up too much space. Outsourcing this service thus saves hospitals space and funds (Hsiao et al 2009:[8]).

5.8.4 Subtheme 4: Challenges with Human resources/staff management

5.8.4.1 Category 1: Difficulty of hospital management in hiring and firing staff

hospital support staff

Another motivation for outsourcing highlighted by some of the interviewed hospital managers was to address challenges related to hiring staff. This is especially within the government establishment where minimum qualifications for employment have been established but are higher than those would ideally be required for certain support services. Additionally replacement of lost staff is also cumbersome due to beaurocracy. As such, the hospital would find it difficult to attract and retain staff to offer the service. The outsourced companies are not required to follow the government recruitment standards and so would easily recruit and retain staff.

As one hospital manager indicated:

“According to the regulations for you to be employed in government…you must have a minimum qualification of senior Four. Now most of the cleaners are informal. They are people who have never gone to school. If you advertise that you want to get those people, the process and bureaucracy is long. If someone dies, it takes long to replace them through the formal process, so you have to wait and this places the hospital at a loss. So if you look at the pros and cons it’s
better to outsource. The service providers will have to look for whoever wants a job to come and clean. So for them they can recruit people who are able to do the work even if they may not have been eligible under the government recruitment system.”
(Participant 1, page 3)

The hospital managers also indicated the need to reduce the hospital’s burden for managing support staff as another motivation for outsourcing.
As one hospital manager noted:

“The decision (to outsource) was made because the hospital was failing to manage the group workers…they were becoming a challenge for the hospital to manage. We were tired of having multiple support staff—cooks, cleaners etc. It was also becoming costly because we needed accountants to be in charge of the various pay rolls. So we decided to outsource so that we no longer needed to do this pay roll maintenance.”
(Participant 4, page 23)

Related to the above, is the difficulty of firing non performing staff. Noting the difficult and lengthy process of firing non-performing civil servants, the hospital managers indicate the possibility of not having to go through the process with outsourced staff as part of the motivation for outsourcing.

As one hospital manager indicated:

“It is difficult to fire a civil servant, it's a long process. Like now we have one porter who is not doing a good job. I have written, but I don’t know what was discussed at that point...she absconded for a month and I informed the district administration. She was summoned by the district, but am yet to get feedback. The person is back but is not doing anything and yet the place is dirty. So u can see such a thing…you want to discipline the person, but they say you need to follow due process…you need to first talk to the person, twice, then third time you write a letter. But the truth it's difficult to fire someone. They may come and sign attendance register but they are not at their work place. When you go there …you will not find them there. So it’s a challenge which can be prevented through outsourcing.”
(Participant 3, page 21)
5.8.5 Sub-theme 5: External factors

5.8.5.1 Category 1: To meet regulatory/government requirements or donor expectations

For some of the hospital, the hospital managers indicated that the driver for outsourcing was external either in order to meet a government requirement or to meet donor or other stakeholder's expectations.

The hospital managers commented as below:

“Before we had our own incinerator but it was not well built. Our hospital is in the city and has many communities around it. National Environmental Management Authority (NEMA) intervened and we could not do the incineration on site. We had accumulated a lot of medical waste and though if the rains came, it could be a hazard. So we came up with a proposal to outsource.”

( Participant 8, page 41)

“We have sponsors from overseas who are our partners…and they are actually the ones who encouraged us to outsource. Every time they would come here to do the training they could find that the local domestic workers could not meet their standards. Whenever they would come they were disappointed. They never want any mess anywhere so they encouraged us to outsource.”

( Participant 8, page 44)

5.9 THEME 4: BENEFITS OF OUTSOURCING

This theme relates to the improvements and advantages that the hospital has experienced because of outsourcing. The subthemes include improved cost and financial management, better focus for hospital managers, and access to external expertise/investment and innovation.
5.9.1 Subtheme 1: Improved cost and financial management

5.9.1.1 Category 1: Lower cost of service

A key benefit from outsourcing highlighted by the interviewed hospital managers is that, in their view, it enabled them to get the outsourced service at a lower cost. Part of this was because they no longer had to pay their own staff who were entitled to a number of benefits over and above their monthly salaries.

As one hospital manager noted:

“It is cheaper because the in-house staff are entitled to many benefits—health care, allowances, accommodation and everything. So when we outsourced, it took off pressure from the accommodation….we don’t have to worry about that.”
( Participant 2, page 10)

For some of the hospital managers, they indicated having done an analysis that indicated that indeed the outsourced service was cheaper.

As one manager noted:

“It (outsourcing) is cheaper, we have realised that its much cheaper…we have done an analysis and realised that it is.”
( Participant 2, page 12)

One hospital manager elaborated how by changing the way they outsourced (from use of a company to individually outsourced workers through petty contracts) the hospital was able to achieve a significantly lower cost for the outsourced service.

As the manager noted:

“The other benefit is the cost—I get things at a cheaper cost. With cleaning…for example, when we changed the method of work, from a budget of around 16M two financial years back, we are now spending 8M. So you can see half of the budget is now saved. During that time it was still out sourcing but it was under tender. Those people were not doing very good work. So we said no…lets
disband them and let’s get the people ourselves. So it is still outsourcing but we
do petty contracts.”
(Participant 3, page 15)

Hospital managers from NGO hospitals (which are private and not for profit) that aim at
offering services at low cost, particularly highlight the cost saving benefit of outsourcing
as enabling them to achieve their mission.

As one hospital manager noted:

“As a hospital we aim to services at a very low cost to clients. With outsourcing
we have been able to maintain the standards at low cost. We have been able to
reduce on payment costs to the workers.”
(Participant 8, page 40)

5.9.1.2 Category 2: Pre-financing by contractor

Managers from government hospitals indicated that cash flow is a problem due to
delayed release of funds by government and has the potential to disrupt service
provision. They however indicated that through outsourcing, they were able to maintain
continuity of services since they vendor would pay his workers and later be paid by the
hospital. In a way, the vendor was pre-financing the service.

This was indicated by one hospital manager as below:

“Another advantage is that these people (outsourced workers) do work whether
money has come or not because the service is rendered over a specified period
of time. Government does not release money frequently…like now we are in the
second quarter of the financial year and there is no money. But since you have a
contract, these people continue working as you wait for the money to come and
you pay arrears.”
(Participant 1, page 2)
5.9.1.3 **Category 3: Pay for performance**

Another advantage highlighted by the hospital managers is that outsourcing provided them the ability to link payment for services to performance. This is because unlike in house workers who receive a regular salary and are paid regardless of the quality of their work, for outsourced workers that hospital managers would be able to assess performance to determine whether to pay and how much.

As the hospital managers indicated:

“"You will pay the outsourcing company if they have achieved but for staff, you pay even if they don’t perform. You measure performance to determine the amount, and only pay them (outsourced vendor) when they have done satisfactory work."

( Participant 6, page 34)

5.9.2 **Subtheme 2: Better focus for hospital management**

5.9.2.1 **Category 1: Focus on clinical services**

Another benefit of outsourcing highlighted by the hospital managers is that it has enabled them the hospital management to concentrate on offering clinical services as the vendor concentrates on offering the outsourced services.

As the hospital managers indicated:

“We don’t have that time to oversee and supervise and to actually do this (support) work. So the contractor does the cleaning and for us we concentrate on our work of administration and offering curative services. Before outsourcing, we were actually seen to be struggling to provide this service and the other. First of all we are very short on staff and we also don’t have that time to do that. We also don’t have the technical skills or ability to do some of this work. So when we outsourced we are able to concentrate on the core activities that are expected of us, instead of wasting time providing what could be probably considered secondary to us.”

( Participant 5, page 26)
5.9.2.2 **Category 2: Reduced staff management time**

Elaborating on how, outsourcing provides better focus for hospital managers on the core mandate of the hospital, one hospital manager indicates that this is mainly through reduced management of the outsourced service and workers who are now under the control of the vendor.

As the hospital manager noted:

“Apartment from being cheaper and resource efficient...outsourcing helps to...you know when you have inside staff as a manager you have more supervision responsibilities. But if u outsource...as a manager...you can only demand at the end of the month...improvements in specific areas. So you will get freedom to do other things, you allocate your time better. Also minimum supervision required. Instead of having to be there every day, you can only check twice a week because they are self-driven. And I don't have to worry...where is the soap, where is the Jik, no they take care of that. He has control over his workers...and you just have to ensure that he is doing the work according to the contract.”

(Participant 2, page 12)

“We wanted to reduce our stress to focus on strategic things. So we thought if we gave the contract to a company and paid them, supervision would have been easier.”

(Participant 6, page 35)

5.9.3 **Subtheme 3: Access to external expertise/investment or innovation**

5.9.3.1 **Category 1. Access to capability not available internally**

Another benefit of outsourcing mentioned by the hospital managers is the ability of the hospital to get access to capacity that they may not currently be having. This may be in terms of additional staff, equipment or even technical capacity or training.
As the hospital managers noted:

“The positive aspect is that outsourcing improves our hospital performance in that there are certain things which we don’t have. Which you can only get from out.”
(Participant 3, page 14)

“The outsourced company helps us with cleaners. We have internal staff and those from the outsourced company complement them. They contribute to our infection prevention program. They even help train our domestic cleaners on infection prevention.”
(Participant 8, page 40)

In line with the above mentioned benefit of enabling the hospital to access capability of capacity not available to it internally, in a study in Taiwan, hospital managers mentioned that due to government regulations, public hospitals have limited full time equivalents (FTE) for each hospital, and outsourcing helps hospitals to get more FTE without hiring workers themselves thus increasing the hospital’s capacity (Hsiao et al 2009:[8]).

Related to this, is the benefit of improved capacity of the hospital for delivery of quality outsourced services through introduction of innovations by the vendor which then get infused into the hospital’s way of offering the service.

As one manager noted:

“With Infection prevention, the company we outsourced has come up with some innovation…which we could not manage…building an incinerator. They have also brought in another innovation, use of waste bin liners instead of plastic. He is actually helping us to know how much we are generating.”
(Participant 8, page 40)

In line with the above findings, Young (2003) in a study focusing on a rural public hospital finds that outsourcing resulted in increased staff morale, upgraded capital equipment and improved services.
5.9.3.2 Category 2: Collaboration with vendor for community service

The data provided by the hospital managers indicates that another benefit of outsourcing has been the opportunity to collaborate with vendors for community service as part of corporate social responsibility. This has benefits for both the hospital and vendor in terms of improving their image in the community.

As one hospital manager noted:

“The vendor has introduced an environment awareness program...we now have an environmental day every month...so he provides information and also participates in the community program. And that makes the hospital look good. Sometimes he does interviews, brings cameras we do video footage and he takes it to TV showing how our hospital is clean and how his services are helping and the gadgets he is using and what improvements he has made.”

(Participant 8, page 43)

5.10 THEME 5: RISKS AND DISADVANTAGES OF OUTSOURCING

This theme relates to any drawbacks or setbacks the hospital managers may have experienced either during the process or as a result of the decision to outsource. The subthemes include risks related to supplier selection and performance, outsourcing expectations not realised, risks related to presence of outsourced staff in the hospital and damage to hospital reputation in the community.

5.10.1 Subtheme 1: Risks related to supplier selection and performance

5.10.1.1 Category 1: External influence in outsourcing

The data provided by hospital managers indicates that given the monetary incentives involved for the vendor, the outsourcing process is prone to external interference. The Managers particularly mention political interference in the award of contracts, especially for government hospitals. This may result in a non-suitable vendor being awarded the contract leading to poor quality of service.
As one manager noted:

“One issue is that of influence from other powers...external influence. You don’t know who was awarded because someone may have somebody who is connected but not able to do the work.”

(Participant 1, page 5)

“If there is some political influence in the outsourcing process, the service provider selected may be tempted not to provide a quality service. There are common instances like that.”

(Participant 5, page 28)

5.10.1.2 Category 2: Challenges with contract and relationship management

The interviewed managers highlighted a number of instances where there have been challenges in their relationship with the vendor or with contract management leading to the risk that the anticipated benefits of outsourcing will not be realised. In some cases, the break down in the relationship has resulted in litigation.

The data provided by the hospital managers indicates that internal budget and cash flow constraints have sometimes complicated their relationship with the vendor due to late payment. Delays in release of government funding to the hospitals means that they cannot pay the vendors on time sometimes leading to suspension of services by the vendor.

As the hospital managers noted:

“Payment for the services provided can be a challenge, we may promise some amount but the money is not realised when you need to pay them. Instead of paying them monthly we pay them per quarter. Sometimes the funds come late, and these people say unless we are paid, we are not going to work. So sometimes we may go half a month when these people are not doing the work as expected.”

(Participant 4, page 22)
Also, in instances of budget cuts to the hospital, management may have to re-allocate funds from other priority areas to pay the vendors in order to avoid litigation.

“The financial year may close and budgets are cut. So you are forced to re-allocate some money and pay. Because if you don’t pay, they will come and sue you. That you are not honoring the agreement.”
(Participant 1, page 6)

Another challenge related to contract and vendor relationship management highlighted by the hospital managers is difficulty in terminating the vendor’s contract in case of poor performance.

As one hospital manager commented:

The risk…and this the biggest…you have an agreement with a company and its difficult to terminate a contract in case of inefficiencies…it can be legally difficult. Takes a winding path. Compared to if I have a staff and they are not doing their work, I can summarily terminate them and get another one. For an outsourced company, it’s difficult. You can only demand improvements and it can take you three months, before you actually terminate.”
(Participant 2, page 10)

In further support of the above, one Manager narrated his experience trying to terminate the contract of a non performing vendor as below:

“Once they nearly took us to court. The service provider was not doing the work as we had expected and so we had decided to terminate the contract. He sent us a letter from his attorney threatening to sue us for tampering with their contract. So we had to go back to the drawing board and renegotiate with him.”
(Participant 1, page 6)

Given the difficulty in terminating contracts, some hospital managers highlighted instances where they kept on a vendor despite their poor performance while waiting for their contract to lapse. One hospital Manager also highlighted a situation where because of the duration of the contract offered to the vendor, the hospital is placed at risk of receiving poor service and yet is unable to terminate the contract.
The hospital manager indicated as below:

“On a few occasions we have given contracts to providers and they don’t measure up; they say they will put 30 people on the job as required, but three months later they only have 25 and later 15. As they reduce staff, the quality of service also reduces. And here you have an agreement and if you try to terminate they sue you. So you leave them perform until their contract lapses.”

(Participant 4, page 22)

“Another risk is the duration we offer for the contract. Currently its three years with one year rolling. So if the contractor is not good…you have to wait for a long period. And yet if it was one year, you would terminate and get another one. So that would create some efficiency because the other one would always want to come back…but now with a three years contract, there is a lot of room for complacency.”

(Participant 1, page 6)

Another highlighted risk related to vendor management is a situation where the vendor’s workers are poorly motivated and not performing well but the hospital administration feels powerless to act on the situation. The low motivation may be caused by a situation where the vendor has not paid the workers despite having been paid by the hospital. According to the hospital manager, there are even instances where the selected vendor sells the contract to another vendor leaving the workers stranded and unpaid. As one Hospital Manager commented:

“The other risk is the low motivation of the workers. Sometimes we pay the company, but they don’t pay the workers. We have even had instances where the awarded company sells the contract to another and the workers of the old company end up being stranded.”

(Participant 4, page 25)

5.10.1.3 Category 3: Unmet vendor expectations

Just like any contract, during outsourcing, the vendor and outsourcing hospital have certain expectations. The hospital managers indicate that one of the risks they face in
outsourcing is that the vendors may have high (financial) expectations which they hope to achieve during implementation of the contract.

As the hospital managers noted:

“The difficulty we face is that of expectations. People may think they are going to get a lot of money. So when they bid, they can under quote. Because they want to win the contract. And when they get the award, some realise that the scope of work is so much and that becomes a challenge. After doing the work mid-way, their money is exhausted and for us we have to force them because the contract is binding and they have to do the work. So there is some degree of pulling strings because the person says the money is not adequate.”

(Participant 1, page 5)

Failure for the vendors to meet their financial expectations may lead to several actions by the vendor all of which create a risk of nonperformance or poor performance of the outsourced service. Some of these actions include abscondment by the vendor, reducing the quality of service for the hospital. These inevitably lead to conflict between the vendor and hospital.

As the hospital managers noted:

“At times you find the company absconds because of expectations…they think there is a lot of money in the contract and there will be a lot of balance. Halfway the journey, they realise it is not there. So it becomes a problem for them, and they abscond. Meanwhile the workers keep working but the management is no longer in control. And you can’t pay the workers because you have no contract with them. But sometimes we withdraw the money, pay the workers per what they have done and the balance we put back to the account.”

(Participant 4, page 24)

“Outsourcing can be a problem if the contractor feels he is gaining so little and wants to save so much, he may be tempted to do work which is shoddy and you don’t get value for money.”

(Participant 1, page 1)
5.10.2 Subtheme 2: Outsourcing expectations not realised

Just like the vendors, the hospital managers have expectations once they outsource. These are related to the cost and quality of service.

5.10.2.1 Category 1: Increased cost of service

One risk highlighted by the hospital managers related to outsourcing is that sometimes, the expected reduction in the cost of the service may not be realised, but rather that the financial costs of the service may increase once the hospital outsources.

The increased cost of service may be due to underquoting by the vendor who later turns around to increase the price or because of additional costs that have to be incurred because of outsourcing.

The hospital managers noted as below:

“Later on you realise that they (vendors) quoted a low price that will not scare you…but a few months down the road, they come and say, ok we have an agreement but if you need us to do even that and that and that, you have to increase. So the costs become revised inevitably.”
(Participant 2, page 12)

“The other aspect of it…is the pricing. The outsourced services tend to be expensive because these people pay taxes or they undergo certain other process which tend to increase the amount we spend on services and the price becomes higher compared to if we did it ourselves.”
(Participant 5, page 26)

One hospital manager indicated that the possibility of increased costs by the vendor is a serious risk, which has the potential to cripple the hospital financially. As the Manager noted:

“It (increased cost) can disable the hospital…if the hospital is not financially stable, it will not be able to manage the payments.”
(Participant 4, page 21)
Additionally, disagreements over costs can lead to disruption in services as negotiations continue. It also has the potential to lead to litigation between the vendor and the hospital.

5.10.2.2 Category 2: Poor quality of service

Another risk highlighted by the hospital managers is that the anticipated improvement in the quality of service may not be realised as the vendor ends up providing poor quality of service.

Part of this, the managers indicate may be related to familiarity and complacency one the vendor is contracted and begins offering the service. The vendor may also reduce the quality of service as a way of reducing his costs and thereby increase profit.

As the managers noted:

“Once they (vendors) get used to the system, there is that issue of reluctance to do the work. They feel that things are normal…which a big challenge is. The provider is not keeping to their work…not doing what you actually want them to do…they take it for granted.”

(Participant 7, page 39)

“The other challenge is that sometimes people want to give u a raw deal…they cut corners because they want to increase their profit.”

(Participant 4, page 22)

Some managers note that sometimes the poor quality of service is due to lack of capacity by the vendor. Some of the vendors may exaggerate their capacity during the bidding process but are unable to perform once selected, or they may have underestimated the task at hand.

As one hospital manager indicated:

“For some of the vendors, once the activity has been outsourced to them, it’s very strenuous and actually some of the services providers lack the capacity to
provide the service. Some vendors actually fill in good documents…and all the requirements, but when it comes to the ground they don’t have the capacity. And when it comes to that…you find that because of that activities delay, or if implemented there are issues with quality."

(Participant 5, page 28)

5.10.3 Subtheme 3: Risks related to presence of outsourced staff

This sub theme relates to risks created for the hospital because of the presence of outsourced staff who are “outsiders” to the hospital. The categories under this theme include impersonation, extortion and masquerading by outsourced staff, lack of hospital management control over outsourced staff, and theft by outsourced staff.

5.10.3.1 Category 1: Impersonation, extortion and masquerading by outsourced staff

The hospital managers indicate that once in the hospital, after a while outsourced staff may begin impersonating clinical staff, masquerading as clinical staff and extorting money from patients.

As the hospital managers noted:

“The workers get used to the system and they want to masquerade as clinicians. They want to do clinical work because they think that now this money is not enough…because this work is not suitable…they want to disguise and do other work. There have been cases of impersonation…we have come along a number of cases where you find that a service provider or a staff has picked money from patients because they were impersonating doctors.”

(Participant 1, page 2)

One hospital manager narrated a case of masquerading and extortion that he had encountered in his hospital as below:

“He (outsourced worker) was masquerading…since I know him, he would come to me with a patient, saying this is my relative, can you help him…and of course since I know him I would be willing to help. And yet he would have fished a
Such cases of impersonation, masquerading and extortion tarnish the name of the hospital and could even lead to litigation in case of clinical mistakes made by the masquerading workers.

5.10.3.2 Category 2: Lack of hospital management a control over outsourced staff

The hospital managers indicate that they are a number of challenges and risks related to presence of workers in the hospital who are not under the direct control of the hospital management. The hospital managers indicated that they sometimes feel powerless in directing the work of the outsourced staff or even reprimanding them if they make mistakes.

As the hospital managers indicated:

“Now the challenge is that employing people who are not within...sometimes when they make errors, it becomes difficult to look for them. In fact some people used to hire others to do work for them instead of themselves...which is illegal. Because now if this person breaks equipment...you can't charge them. So those are some of the risks.”

(Participant 1, page 6)

“The outsourced company staff will come do the work and go away. You cannot keep them here for the whole day till 5pm like the employee. For an employee I can summon you any time even at 5Pm to say the work is not yet finished, please do this and that. So losing control over the staff doing the work is one of the disadvantage.”

(Participant 3, page 15)

The managers also indicated that the outsourced staff members are sometimes involved in activities which are beyond their mandate. This takes away from the time...
they are supposed to be doing their assigned tasks and can compromise quality and reduce effectiveness.

As one manager noted:

“Sometimes the outsourced staff members get engaged in activities that are not part of their mandate. For example a staff can ask a cleaner to go to town to buy for them something…that is wrong. The other man’s work is to clean, why do you involve them in other things? And of course, sometimes these people don’t know that…for then they look at these as people who are helping.”

(Participant 3, page 18)

5.10.3.3 Category 3: Theft by outsourced staff

Another risk reported by the hospital managers in relation to presence of outsourced staff in the hospital is theft of hospital supplies and equipment by the outsourced staff.

The hospital managers note as below:

“Because they have taken long in the institution some of them (outsourced workers) start stealing some of our equipment. We have come across cases of indiscipline where you find that they pick our supplies because they have been there and once they are with us they begin to understand and know where we keep what. We have come across people who pick our supplies sometimes even medicines for their personal gain. That one affects us a lot in terms of reducing the actual items we are supposed to use.”

( Participant 1, page 6)

The hospital managers suggest that sometimes the outsourced workers connive with hospital staff to steal hospital property. This may be because the hospital workers know that the outsourced workers are not subject to hospital disciplinary procedures once apprehended and so the hospital workers can use them to ferry out some of the hospital equipment and supplies.
As one hospital manager notes:

“If you are cleaner for example attached to children’s ward, why should I find you in pharmacy which is a restricted area. But once in a while I go there and I find that they are there. So that poses a security risk. They can use them to ferry drugs out. And actually they ever used them to do that. If you are a government worker and we get you, you know what the consequences are; you are fired. So somehow you are restricted to do certain things. That may not be the case with outsourced staff.”
(Participant 3, page 18)

5.10.4 Subtheme 4: Damage to hospital reputation in community

This subtheme relates to a negative attitude by the community/stakeholders to the hospital or a negative picture of the hospital because of outsourcing. The categories under this subtheme include loss of job opportunities for hospital staff and locals, and the poor behavior of outsourced staff being associated with the hospital.

5.10.4.1 Category 1: Loss of job opportunities for hospital staff and for locals

According to the hospital managers, when a hospital outsources, it re-assigns, or if not possible, lays off its staff that have been providing the service.

As one hospital manager noted:

“When we outsourced, we had to lay off staff. That was an issue…of course we had to give then terminal benefits as well…so the good thing is that we re-allocated some to other departments…out door and laundry and we had to lay off some. And it’s never easy, because they were part of us.”
(Participant 3, page 14)

Laying off staff has negative financial and other implications for the laid off workers and downgrades the hospital’s reputation in their eyes and those of their loved ones. Additionally, as the hospital manager indicates, laying off staff can be a hard and emotional issue that not only affects the laid off hospital workers but even those who
remain since as they feel a sense of loss and may begin questioning their future with the hospital. This can affect their performance (survivor’s syndrome).

Another reputational risk highlighted by the hospital managers is the possibility that the outsourced company may not hire some of the local community members. This may project the hospital in a negative light in the community since locals look at the hospital as a source of employment.

As one hospital manager commented:

“When you outsource, are those so called companies going to employ the locals, or are they going to come with their own cleaners? Because when they come with their cleaners and yet we have locals here looking for jobs, that is another issue. Because we have to make sure that the community benefits and is part of it as service provision and they get something.”
(Participant 7, page 37)

**5.10.4.2 Category 2: Poor behaviour demonstrated by outsourced staff members associated with hospital**

Data from the hospital managers indicates that often times, the community does not know the difference between hospital workers and outsourced workers. This creates a risk that negative behavior by the outsourced workers will be associated with the hospital and damage the hospital’s reputation even if the outsourced workers are not employees of the hospital.

As one hospital manager noted:

“When the image of the institution comes into question…and you have to answer sometimes what you are not responsible for. Like when a worker of an outsourced company steals, the community knows that whoever is in hospital is a doctors. So it puts our institutions reputation at stake. People see the outsourced workers as part of you, representing you and yet you cannot reprimand them.”
(Participant 5, page 30)
Additionally, misconduct by the outsourced company or its employees may expose the hospital to legal risks. One hospital manager narrates an example of such a situation as below:

“Once the cleaning contractor disposed papers in the town and they had medical forms from our hospital. The authorities reprimanded us for doing that but we informed them that we had a contractor and every waste that leaves the hospital is his responsibility. But it risked becoming a legal issue for us because issues of patient confidentiality were involved.”

(Participant 8, page 42)

5.11 THEME 6: ADVICE TO OTHERS REGARDING OUTSOURCING

This theme relates to what actions or activities the hospital managers interviewed would advise or recommend to other hospital managers who are planning to outsource; and what they need to be aware of in order to ensure a successful outsourcing experience. The subthemes include advice related to pre-outsourcing evaluation, advice related to the outsourcing process and advice related to outsourcing monitoring.

5.11.1 Subtheme 1: Advice related to pre-outsourcing evaluation

This relates to recommended actions as part of evaluating if outsourcing is feasible and appropriate for one’s hospital before embarking on outsourcing. The categories include tours to other hospitals to learn and share experiences, cost benefit/value for money analysis before outsourcing; and prioritisation and budgeting.

5.11.1.1 Category 1: Tours to other hospitals to learn and share experiences

Almost all managers interviewed recommended that hospital managers planning to or currently not outsourcing visit other hospitals that are currently outsourcing in order to learn from them. Through sharing experiences and learning about the benefits of outsourcing first hand from those who are doing it, they would be moved beyond their fear for outsourcing and motivated to try outsourcing.
The managers commented as below:

“I think they can go for a tour to other hospitals to learn from them how they do it…and they share. They share the budgets…how people have managed to do it. And also to see the improved quality of outsourced services. They have to learn from one another. That would help.”
(Participant 1, page 7)

“There is need to share experiences. Some people fear to go the outsourcing way, because they have not experienced it before. They have their staff members who have been cleaning for the last 10 years and they ask why we should change. And yet there are complaints about hygiene. So there may be need to share experiences on how to identify the correct company and how to get value for money when outsourcing to companies.”
(Participant 2, page 13)

However, the managers cautioned that given the different contexts in which each hospital operates, the lessons learned from such visits would have to be tailored to or considered by the intending hospital in their local context.

As one manager commented:

“But you know every district is unique...because we work in a decentralised context. So you may want to outsource, but what is applicable in one area may not be applicable in another area. So they may get some challenges. So they may get some challenges. But I think from sharing experience and learning from one another, I think they can be able to start something.”
(Participant 1, page 7)

The advice provided by the hospital manager’s is grounded in their experience with outsourcing in their hospitals and their realisation that it’s a complex process that needs careful planning and execution; in addition to their belief that learning by example would help hospitals that are planning to outsource to do it successfully.
As one manager commented:

“Ideally the process is quite a difficult one and it’s also good to share experiences with other institutions that are probably doing well in that area and knowing how they are managing, how have they succeeded.”
(Participant 5, page 33)

5.11.1.2 Category 2: Cost and Vendor analysis before outsourcing

Another piece of advice provided by the hospital managers to those who intend to outsource is the need to conduct some kind of cost analysis before outsourcing. According to the Managers interviewed, managers intending to outsource need to understand their current costs for the service they intend to outsource and the currently available resources in addition to assessing the current quality of the service they are getting from their staff.

As one manager commented:

“They need to do some internal analysis in terms of the quality of care the facility can provide, in terms of how much resources are provided for other services of a similar nature. So not until you do that benchmarking, will you appreciate it. So for them they may be thinking they are doing very well…they might be doing very well, but slightly at a greater opportunity cost. You may pay less here, but eventually you may incur higher costs elsewhere because of quality of care.”
(Participant 5, page 32)

Additionally, the managers intending to outsource need to be aware of additional costs related to outsourcing specifically the tax element. This has to be factored into the cost analysis.

As one manager commented:

“They also have to look at and consider cost. Because once you out source, when you pay you have to put it VAT etc. So something which was 4 million, now becomes 6 million.”
(Participant 3, page 20)
According to the interviewed hospital managers, another area of analysis would be looking at available service providers, their capacity and potential costs of engaging them. The Managers also advise creating competition among the vendors during the outsourcing process by inviting offers from several companies instead of directly approaching one company.

The hospital managers commented as below:

“Look out for the cost of the service, ability of the service provider, where this person is coming from. Because if you get somebody from Kampala (capital city) to come to (rural district), he may not manage. Because the transport from Kampala to (rural district) is being factored in. So that person is going to eat into the budget and may not offer quality service.”

(Participant 1, page 8)

5.11.1.3 Category 3: Prioritisation and budgeting

The interviewed hospital Managers advise any hospital intending to outsource to evaluate their priorities before deciding to outsource. Noting that outsourcing is expensive and that some services are central to the hospital’s mandate of delivering health care and others are not, the interviewed hospital managers highlight the need for prioritisation before outsourcing.

As one hospital manager notes:

“First of all they should appreciate what they have in terms of what financial resources are available. Then, they should be able to get their priorities right...you may end up in a situation where you spend on ancillary services, for example, the core function of a hospital is not to do cleaning. So you may end up spending a lot on support services, instead of spending on offering health care. And you have to safeguard against that. You must identify what is primarily and principally core to the institution. Once you identify the core ones, then that can help you balance the resources that you have. Because you should not spend more on secondary and little on what is primary mandate. You have to look at other priorities within hospital and tailor your budget accordingly. Otherwise you
may be forced to spend on one aspect and then the other aspect is neglected and you don’t serve the purpose.”
(Participant 5, page 32)

Noting that most hospitals are underfunded, one Hospital Manager highlighted the need for increased budgetary allocation by hospitals to ensure that adequate funds are available to pay for outsourced services since some of them are critical to improving hospital performance and quality of service, for example cleaning services.

The manager commented as below:

“For most hospitals…the challenge is financing. Otherwise each one would like the services. But issue is with budgeting. But for certain services e.g. cleaning, they need to increase on their budget because it’s important. And cleanliness increases patronage.”
(Participant 8, page 43)

5.11.2 Subtheme 2: Advice related to outsourcing process

5.11.2.1 Category 1: Follow due process/established guidelines and involve every one

The interviewed hospital managers indicated that they would advise any hospital intending to outsource to follow established regulations or rules. Specifically for the hospital Managers in MOH/Government owned hospitals, the interviewed managers highlighted the need to follow the Public Procurement and Disposal Act regulations in soliciting bids and selecting a vendor, in addition to contract management.

As one hospital manager commented:

“In terms of managing the contract, just follow the PPDA act and the law to the dot. And if there are issues you discuss and solve them within the provisions of the law. And of course, they must follow government (procurement) guidelines. The guidelines for procurement, issues to do with contracts. They must be followed. Once you do things without proper documentation, it attracts audit
queries. So u have to protect yourself. Seek authority if required and follow instructions. Do things within the law."

(Participant 1, page 8)

The managers also advise those intending to outsource to involve all necessary stakeholders in the process, noting that the outsourcing decision cannot be done by one person. They also note that involving several people may be one way of mitigating external influence in the outsourcing process.

As one hospital manager notes:

“There is a lot of politics in the outsourcing process. And if you are not careful you may not manage. You may end up doing what people want and is in the interest of the institution. Someone may say, award me, my contract, me am so and so. People will give calls and say...me I want that work. If you don’t give it to me, you will see. So you have to find a way of managing that, negotiate with people who are involved. People need to understand why you are doing what, the risks involved and the benefits. It’s therefore important to involve every person. This decision cannot be done by one person. Before you bring in some body, you have to involve every one. You also need to involve relevant authorities.”

(Participant 5, page 33)

5.11.2.2 Category 2: External help/consultants to help with process

Noting that the outsourcing process can be complex, subject to manipulation and interference and can lead to litigation if not well handled, some of the interviewed hospital managers said they would advise any hospital intending to outsource to seek external help from consultants to help with the process. The consultants should be people who are knowledgeable in the outsourcing process and applicable regulations.

As the hospital managers noted:

“They would need consultants to help during the process. With outsourcing once you miss one step, you can cause havoc. If you bring in issues of nepotism, favoritism etc. you will get a raw deal. So, they should get a consultant to lay for
you the ground to do the right things; and to objectively analyse and help with the process. Also, they should be able to engage people who are knowledgeable of the current regulation because you can end up in a mess. The regulations have to be followed. You need people who can be able to advise on procedures to avoid flaunting the process, because it can lead to litigation and probably bigger cost."

(Participant 4, page 26)

Involving such external consultants would not only enable the hospital to gain access to expertise for the outsourcing process, it is also likely to instill confidence among those involved in the bidding process as their involvement is likely to make the process more transparent since they are perceived to have no vested interests as they are external to the hospital.

5.11.2.3 Category 3: Consider local conditions and context and contract locally

Another piece of advice provided by the interviewed hospital managers to others intending to outsource is the need to consider local conditions or context of the hospital. The unique circumstances or context in which the hospital operates e.g. availability of local vendors may determine the success or otherwise of the outsourcing.

As one hospital manager commented:

“You know every district is unique...because we work in a decentralised context. So you may want to outsource, but what is applicable in one area may not be applicable in another area. So they may get some challenges. But I think from sharing experience and learning from one another, I think they can be able to start something."

(Participant 1, page 7)

Regarding selection of vendors, the interviewed hospital managers indicated that they would advise any hospital intending to outsource to consider local vendors/vendors in their locality. This would not only lead to lower costs but also provide job opportunities for the community.
As one manager commented:

“For us what we normally do is encourage local service providers with in our locality who are within. They will be cheaper to employ than getting some body form far and also it provides job opportunities for the locals which improves the hospital’s reputation.

(Participant 1, page 8)

5.11.3 Subtheme 3: Advice related to outsourcing monitoring

5.11.3.1 Category 1: Supplier vetting and performance monitoring

The interviewed hospital managers indicated that they would advise any hospital intending to outsource to vet any vendors to ensure that the right vendor is selected.

As one hospital manager indicated:

“They need to vet the providers. This goes with consulting people, digging up track records…most times they won’t tell you. So you have to do background checks…where have they been working, how have they been working. That sort of thing.”

(Participant 2, page 14)

The hospital managers also advise on the need for continuous monitoring of the outsourced vendor’s performance to ensure that they are doing what is expected of them and that their workers are not overworked or demoralised.

As one hospital manager indicated:

“Although sometimes it can be difficult, but you need to monitor. You don’t just outsource something and you don’t monitor performance. You want to see that the work is being done….monitoring would be the daily supervision and also ensure that workers are not overstretched but work is commensurate to what they are being paid.”

(Participant 5, page 35)
5.12 CONCLUSION

This chapter presented the analysis, interpretation, and discussion of the qualitative data. The presentation began with an introduction to the chapter. The findings from the qualitative data collection were presented under the following six themes:

- Outsourcing status
- Outsourcing practices
- Motivation/Reasons for outsourcing
- Benefits of outsourcing
- Risks/Disadvantages of outsourcing
- Advice to other hospitals that intend to outsource

Each theme was discussed under several subthemes which were also subdivided into numerous categories.

The research findings indicate that overall hospital managers have a positive attitude towards outsourcing as a way of improving hospital performance. This includes hospital managers whose hospitals are currently outsourcing and those whose hospitals are not currently outsourcing.

The main barrier to outsourcing highlighted by hospitals not currently outsourcing is limited financing to pay for the outsourced services. The hospital managers, however, indicate a future intention to outsource, mainly cleaning services. They however indicate the need for guidelines to help them through the process.

Hospital Managers whose hospitals are currently outsourcing highlight need for quality service, cost containment and the need to enable management focus on delivering clinical services as the major motivations for outsourcing.

Prior to outsourcing, the hospital managers report that the hospital conducted a needs assessment which was communicated to hospital manager to evaluate the feasibility of outsourcing. Management then sought approval from the hospital board before the procurement process would begin. The procurement process entailed a request for
proposals, evaluation of the proposals and award of the contract. Several parties were involved in the outsourcing process including users of the outsourced services, the hospital managers, and hospital boards; and in case of government owned hospitals, the district management.

Regarding benefits, the hospital Managers report improved quality of service and lower cost as the main benefits of outsourcing. They also report overall satisfaction with outsourced services. Most of the hospitals report outsourcing cleaning services.

The managers also report use of several monitoring strategies to monitor supplier performance including daily walk arounds and regular meetings with the managers of the outsourced companies.

The managers, however, indicate some risks associated with having outsourced workers in their hospitals including masquerading and impersonation of outsourced workers in addition to theft of hospital property by the outsourced workers. They also highlight political interference in the outsourcing process.

The managers advise that any hospital intending to outsource should visit other hospitals currently outsourcing to learn by example on how it can be done. They also advise that the hospital needs to undertake a thorough internal cost analysis and carefully vet vendors for the outsourced services.

The next chapter presents results of a cost benefit analysis of an outsourced cleaning service in one of the studies hospitals. As indicated from the quantitative and qualitative findings, cost saving is one of the motivations for outsourcing. The next chapter evaluates this in one of the study hospitals.
CHAPTER 6

CASE STUDY: COST BENEFIT ANALYSIS OF CLEANING SERVICES IN A SELECTED HOSPITAL IN UGANDA

6.1 INTRODUCTION

This chapter discusses the cost benefit analysis findings. A cost benefit analysis is an evaluation of the monetary costs of a programme or intervention relative to the monetary gains attributed to it (Polit & Beck 2008:714).

6.1.1 Objectives

As earlier described, one of the study objectives was to conduct a cost benefit analysis of an outsourced service in one of the study hospitals. The specific research question for this objective was: How do the costs and benefits of outsourcing a given service in one of the study hospitals compare with the costs and benefits of providing the service in house (in-sourcing)?

The research objective was achieved through a number of steps, including:

- Determining a benchmark cost of insourcing the service in the selected hospital by estimating the costs incurred by the hospital while providing the cleaning services in-house (in-sourcing).
- Determining the cost to the hospital of outsourcing the cleaning service to a private vendor.
- Conducting a qualitative service quality assessments to determine a ‘benefit’ metric for changes in quality perceived by hospital management regarding the outsourced cleaning services.
- Conducting a cost benefit analysis by comparing the raw and quality adjusted costs for in-sourcing and outsourcing of cleaning services in the selected hospital.
6.2 RESEARCH METHODOLOGY

A case study approach was adopted using retrospective data. During the quantitative data collection phase, hospital managers were asked if they were willing to share additional financial information about their outsourced services.

One hospital was used for the case study. The hospital for the case-study was selected because it was currently outsourcing and its managers expressed willingness to share additional information regarding their outsourced services. Also, the required data was available or could be obtained from the hospital managers.

Cleaning services were selected for analysis because this was the only support service being outsourced by the hospital and there was a fair amount of data available on the costs of in-sourcing and outsourcing the cleaning services.

6.2.1 Sample description

Hospital A is a 169-bed rural Non-government Organisation (NGO) hospital located in Western Uganda. The hospital currently has a staff strength of 169 (106 clinical staff and 38 non clinical staff). The hospital sits on about 19 acres of space (76,890.34 square meters).

In the 2013/14 financial year, the hospital had an annual operating budget of approximately UGX 3,509,805,896 ($1,349,925), attended to 25,000 outpatients and admitted 11,000 inpatients that year. The hospital began outsourcing cleaning services (both in-door and outdoor) in 2012 (2 years prior to the study period).

6.2.2 Alternatives and assumptions

This section describes the two options compared as part of the cost benefit analysis.
6.2.2.1 Alternative 1: Outsourcing cleaning services

Cleaning services in hospital A (both indoor and outdoor) were outsourced to a local private vendor through an open bidding procurement method conducted by the hospital administration with approval from the hospital board from 2013.

A one year contract valued at UGX 48,000,000 per year was (4,000,000 per month) awarded to the successful bidder.

Under the outsourcing contract, the vendor provides cleaning staff and all equipment and supplies needed to clean (sweep and mop) the hospital’s floors, windows, walls, doors, toilets, ceilings, equipment and furnishings; fumigate, to remove trash, and to clean and maintain the compound (including cutting the hedge, grass, trimming roads).

The hospital administrator oversees the vendor’s work and monitors the vendor’s performance, but is no longer responsible for directly managing the cleaning staff or providing cleaning supplies. The hospital is, however, still responsible for utilities (water and electricity).

6.2.2.2 Alternative 2: Providing of cleaning services by hospital staff (In-sourcing)

Prior to the outsourcing, the hospital employed 12 cleaning staff who were responsible for the same activities as the outsourced staff. Additionally the hospital provided cleaning supplies and was responsible for utilities. The hospital provided training for the cleaning staff on various aspects including infection prevention.

Regarding why the hospital decided to outsource, in an interview with the Medical Superintendent, he mentions that:

“We did a cost analysis….first we compared with other institutions which are in the same business——sister hospitals. And we found out that what they were paying for cleaning services to a contractor was actually lower that what we were spending. So we decided to outsource.”
6.2.3 Scope of the analysis

The analysis takes the hospital manager's perspective when calculating costs and benefits of outsourcing. Therefore, this study is primarily concerned with analysing the value for money that outsourcing delivers to hospital managers, in terms of its impact on hospital budgets and the quality of services provided.

Assessing the costs and benefits of outsourcing from the societal perspective would be exceedingly complex and is beyond the scope of this study.

The analysis period of this study is one year (2014 to 2015), which should allow the study to capture benefits from outsourcing that may accrue in the short term, such as improvements in the quality of cleaning. This analysis assumes that real costs, such as the cost of personnel, equipment, supplies, and utilities, remain constant throughout the analysis period.

To account for the time difference between the current study period and when the hospital last provided the cleaning services in-house (2 years ago), the study applies a real interest rate to the last costs reported to have been incurred by the hospital when in-sourcing to account for changes in prices (inflation) and the time value of money (nominal interest). A 15% real interest rate was applied, this being the 2 year Treasury bond interest rate quoted by the Bank of Uganda in December 2012.

6.2.4 Costs

6.2.4.1 Collecting costing data

The costing data for this analysis was solicited directly from the hospital managers. During the qualitative data collection interviews, the researcher collected data on the hospital’s cleaning services outsourcing programme including how the cleaning services were organised before and during outsourcing.

Following initial interviews the hospital managers were electronically sent a data collection tool for them to fill and send back to the researcher (Annex D). The tool collected data and information on both indirect and direct costs for the outsourced
cleaning services including data on personnel costs, consumable costs, equipment maintenance costs, and the costs of training and management of the cleaning services. The tool also collected costing data on outsourcing. This data included the value and length of the contracts and the effective dates of the contracts in addition to the services that were included in the outsourcing contracts.

### 6.2.4.2 Costing methodology

Costing for this analysis was conducted using the ‘ingredients/inputs’ or bottom up approach, whereby all indirect and direct costs of each alternative were identified and quantified with a monetary value. Since costing data for the two alternatives considered under this analysis (outsourcing Vs insourcing) were collected for different time periods (i.e. the contract costs for 2014 for the outsourcing and the insourcing costs for 2012 (the last year before the outsourcing programme begun two years ago), the costs are expressed in 2014 constant UGX and 2014 constant United states dollars for comparative purposes. The insourcing costs were converted to 2014 constant UGX by applying the real interest rate of 15% described earlier. This rate also includes inflation. The data reported by the hospital managers in the data collection tool was used to determine the breakdown of the insourcing and the outsourcing alternatives.

The cost breakdowns are presented in Table 6.1
Table 6.1: Cost breakdown of outsourcing and in-sourcing

<table>
<thead>
<tr>
<th>Alternative 1: Outsourcing</th>
<th>Alternative 2: Insourcing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct costs</strong></td>
<td></td>
</tr>
<tr>
<td>Contract Cost</td>
<td>Personnel</td>
</tr>
<tr>
<td>• Total contract Cost</td>
<td>• Salaries</td>
</tr>
<tr>
<td>• Number of years of contract</td>
<td>• Benefits</td>
</tr>
<tr>
<td></td>
<td>• Time worked</td>
</tr>
<tr>
<td>Supplies</td>
<td>Supplies</td>
</tr>
<tr>
<td>• Not Applicable</td>
<td>• Unit price</td>
</tr>
<tr>
<td></td>
<td>• Amount consumed</td>
</tr>
<tr>
<td>Equipment</td>
<td>Equipment</td>
</tr>
<tr>
<td>• Not Applicable</td>
<td>• Maintenance costs</td>
</tr>
<tr>
<td><strong>Indirect costs</strong></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Training</td>
</tr>
<tr>
<td>Not applicable</td>
<td>• Cost of delivering the training</td>
</tr>
<tr>
<td>Hospital Management of Vendor</td>
<td>Hospital Management of cleaning staff</td>
</tr>
<tr>
<td>• Salaries</td>
<td>• Salaries</td>
</tr>
<tr>
<td>• Benefits</td>
<td>• Benefits</td>
</tr>
<tr>
<td>• Time worked</td>
<td>• Time worked</td>
</tr>
<tr>
<td>Operations</td>
<td>Operations</td>
</tr>
<tr>
<td>• Standard unit price of electricity, water, telephones</td>
<td>• Standard unit price of electricity, water, telephones</td>
</tr>
<tr>
<td>• Utility consumption by cleaning staff</td>
<td>• Utility consumption by cleaning staff</td>
</tr>
</tbody>
</table>

Note: Operational costs and costs of supplies were provided by the hospital management as aggregate/total costs for the period. Details of unit prices and quantities were not available.

The table shows that, with outsourcing, the contract covers the direct costs that the hospital incurred when it was insourcing. However, there are additional indirect costs that hospital continues to incur when outsourcing. For example, the hospital still needs to cover utilities and the salary of a hospital manager who oversees and monitors the vendor's work. These indirect costs are in addition to the contract value.

### 6.2.4.3 Alternative 1 (outsourcing) costs

The only direct cost of outsourcing is the cost of the contract.

The hospital management reported the annual cost of the cleaning contract (both indoor and outdoor) to be UGX 48,000,000 (18,461.53USD). The costs of negotiating the contract and managing the procurement process were not included in the analysis, because these costs could not be collected. They are likely offset by intangible benefits of outsourcing that are also not accounted for in this analysis.
Indirect costs of outsourcing for the hospital include management of the vendor, and operations. According to the interview with the Medical Superintendent of Hospital A, the hospital’s administrator is responsible for supervising and monitoring the work of the vendor. The hospital Administrator provided data on the approximate time he spends per week on supervising and monitoring the vendor’s work (0.25 hours per day). A work month was assumed to have 21 working days in a month, each 8 hours long.

Operations costs include electricity and water. The hospital was responsible for these costs before and after outsourcing. Because the hospital continues to provide these utilities to the vendor, this analysis assumes that operations costs under outsourcing are the same as they were under insourcing.

Besides the above direct financial costs of outsourcing, there are nonfinancial costs of outsourcing. These direct nonfinancial costs of outsourcing include reduced knowledge of infection control practices of cleaners, increased turnover of cleaners, and increased effort for the hospital management for negotiating and overseeing private vendors. A potential negative externality (indirect cost) for hospital managers is damaging relationships with hospital staff, which could impact the quality of services that continue to be provided in-house (McPake & Mills 2000: 811-820). These costs are all intangible, and are therefore not considered in this analysis. However, their effect on the results is likely outweighed by the numerous intangible benefits which are also excluded from the analysis.

6.2.4.4 Alternative 2 (insourcing) costs

For insourced cleaning services at Hospital A, the Medical Superintendent provided data on the costs they incurred in the last year prior to commencing the outsourcing (i.e. 2 years before 2014). The direct costs of insourcing include personnel, supplies, and equipment maintenance costs (see Table 6.1).

The personnel costs are calculated based on salary and benefit ranges (reported as 30% of base salary) of the 12 full-time staff employed by the hospital, and the estimated time each staff member dedicated to cleaning. This was assumed to be 100% since the cleaning staff were full time equivalents.
The hospital manager also reported the cost of supplies from the hospital’s records. Since the cleaning operations at the hospital were mainly manual using basic equipment (mops, slashers, mowers etc.), equipment costs were not applied.

The indirect costs of outsourcing of cleaning services included training, management, and operational costs. The costing study calculated training costs using the daily rates of participants and facilitators who participated in the training. The hospital managers also provided data on the annual costs of providing meals and materials during the training.

Management costs were calculated using the salaries and benefits of manager (hospital administrator) directly involved with overseeing the hospital’s cleaning staff, in addition to the percentage of time these managers devoted to supervising cleaning. The hospital superintendent reported the hospital administrator devoted about one hour per day managing the cleaning staff in the hospital when the service was being offered in-house.

Finally, the operational costs for insourcing were the same as those described for outsourcing.

6.2.5 Benefits

From the literature and based on the interviews with the hospital managers in this study, some of the benefits of outsourcing cleaning services in a hospital can be summarised by the table below:
Table 6.2: Benefits of outsourcing cleaning at Hospital A

<table>
<thead>
<tr>
<th>Tangible Benefits</th>
<th>Direct benefits</th>
<th>Indirect benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost savings</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall quality of cleaning</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intangible benefits</th>
<th>Reduced Management effort</th>
<th>Experience working with private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved adherence to guidelines</td>
<td>Potential reduction in hospital-acquired infections</td>
<td></td>
</tr>
<tr>
<td>Improved availability of supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proper mixing of cleaning supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe storage practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased number of cleaning staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved waste collection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.2.5.1 Collecting benefits data

The benefits data used for this study were derived from a structured service quality mini-survey of Hospital management, conducted as part of the costing data collection. Hospital management staff who participated in the interview included the hospital superintendent, the hospital administrator, the chief nursing officer and customer care assistant. As part of providing costing data, the hospital administrator was asked to rate the overall quality of cleaning services before and after outsourcing, using a 10-point Likert scale. He was also requested to solicit ratings from other managers and provide their responses in a table on the data collection tool. Their rating was used to quantify the benefits derived from outsourcing, as explained below.

6.2.5.2 Benefits methodology

The benefits from outsourcing are more difficult to quantify than the costs. As mentioned above, this study takes the perspective of the management of the hospital, and therefore considers only those benefits that directly or indirectly accrue to those managers.

Responses from interviews with the various hospital managers who participated in this study indicate that from the manager’s perspective, direct benefits from outsourcing...
cleaning services include cost savings for the hospital management in some areas such as personnel, supplies, training, and management (because the hospital no longer directly bears these costs), and overall better quality of cleaning services. Other benefits identified include reduced time and effort managing cleaning staff.

As one hospital manager noted:

“I am satisfied because my management burden has reduced. Also am doing things cheaply. Even the quality-quality has improved. We have not attained standards but quality has improved.”

Additional indirect benefits of outsourcing cleaning services include increased opportunities for the management to gain experience working with the private sector, and the potential reduction in the number of hospital-acquired infections due to improved cleanliness.

6.2.5.3 Quantifying benefits

The literature on cost-benefit analyses suggests various approaches for monetising qualitative benefits of an intervention. The two most relevant approaches include measuring a consumer’s willingness to pay for a theoretical service and calculating the cost avoidance resulting from an intervention (Cellini & Kee 2010:493-530; Olsen & Smith 2001:39-52).

Willingness to pay is a method widely used for placing value on health services and environment conservation (Olsen & Smith 2001:39-52; Smith 2003:609-628). In the context of this study, estimating willingness to pay would involve asking a large sample of hospital managers for the maximum Uganda Shillings amount they would be willing to pay for a hypothetical increase in the cleanliness of a hospital. The monetary value obtained from this survey would then be tallied as a benefit of outsourcing cleaning services, assuming that outsourcing resulted in an increase in the quality of the service and thus the cleanliness of the hospital.

Measuring cost avoidance would entail estimating the monetary value of each of the intangible benefits listed in Table 6.2 above.
For example, one could estimate the reduction of hospital acquired infections resulting from the improved cleanliness of the hospital and time savings resulting from reduced management burden in supervising the hospital cleaning staff. The monetary values of infections avoided and time saved could then be modelled and included as benefits of outsourcing.

The willingness to pay and cost avoidance approaches discussed here are resource- and time-intensive, and would require broad assumptions to be made with limited information. Therefore, this study considered only two types of benefits in its analysis: financial cost savings and overall quality of cleaning services.

Quantifying the financial cost savings of outsourcing is straightforward. The cost savings for each cost category are equal to the difference between the cost of that category during insourcing and the cost during outsourcing.

To quantify the differences in quality between outsourcing and insourcing, this analysis weights the costs of each alternative by a ‘quality factor’ and recalculates the financial cost savings as ‘quality-adjusted’ cost savings. The logic behind this method is that the better the quality of a service, the higher its value. By weighting the costs of the alternatives based on observed quality, the price of lower-quality services is inflated to a greater degree than the price of higher-quality services, to reflect the hidden costs of an inferior service.

To calculate the benefit factor of each alternative, the researcher analysed the responses from the service quality mini-survey of Hospital management and converted the responses to units that could be applied to the cost of the alternatives. This was done by converting the survey responses into an ‘underperformance rate’, which represents the unrealised potential of a service.

In the surveys, the hospital managers were asked to rate the overall quality of the outsourced service before and after outsourcing, using a Likert scale. The managers rated quality on a scale from 1 to 10, with 1 being the lowest quality and 10 being the highest. An average of the reported rating for all the managers was calculated for the outsourcing and insourcing options.
Figure 6.1 below shows the hospital management’s average ratings of cleaning services under insourcing and outsourcing.

![Figure 6.1: Management responses to service quality surveys of cleaning services at Hospital A](image)

Using this information, the researcher calculated the underperformance rate for cleaning services at Hospital A before and after outsourcing, using the following equation:

**Underperformance rate = (10 - Likert Scale Rating) * 10**

For example, a service that received a rating of 10 out of 10 on the Likert scale is being delivered perfectly and therefore would have an underperformance rate of 0 percent, because it is being delivered at the highest possible quality level.

(10 – 10) * 0 = 0

If a manager rates a service as 3 out of 10 during insourcing, that service’s underperformance rate is 70 percent.

(10 – 4) * 10 = 70

Therefore, during insourcing, this service was not realising 70% of its quality potential.
In the case of cleaning services at Hospital A, the managers rated the overall quality of the service 8.5 out of 10 on the Likert scale during outsourcing, and 4.8 out of 10 during insourcing.

The table below shows the underperformance rates of outsourcing and insourcing in Hospital A.

**Table 6.3: Calculating underperformance rates of cleaning services at Hospital A**

<table>
<thead>
<tr>
<th>Options</th>
<th>Managers’ overall rating (Likert scaling)</th>
<th>Calculation</th>
<th>Underperformance rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative 1: Outsourcing</td>
<td>8.5</td>
<td>(10-8.5) * 10</td>
<td>15%</td>
</tr>
<tr>
<td>Alternative 2: Insourcing</td>
<td>4.8</td>
<td>(10-4.8) * 10</td>
<td>52%</td>
</tr>
</tbody>
</table>

To weight the costs of the two alternatives (outsourcing Vs insourcing) based on the quality of the cleaning service provided, the researcher converted the underperformance rate into a weighting factor, the ‘quality factor’ (see Table 6.4), using a simple formula:

*Quality factor (QF) = 100 ÷ (100 minus the underperformance rate).*

**Table 6.4: Calculating quality factor of cleaning services at Hospital A**

<table>
<thead>
<tr>
<th>Option</th>
<th>Underperformance rate</th>
<th>Calculation</th>
<th>Quality factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative 1: Outsourcing</td>
<td>15%</td>
<td>100 ÷ (100 – 15)</td>
<td>1.18</td>
</tr>
<tr>
<td>Alternative 2: Insourcing</td>
<td>52%</td>
<td>100 ÷ (100 – 52)</td>
<td>2.11</td>
</tr>
</tbody>
</table>

The costs of each alternative were then multiplied by their respective quality factors to produce quality-adjusted costs (Table 6.5).

*Quality-adjusted costs = Costs * Quality Factor*

Weighting the costs of the alternatives allows managers to assess the value for money of outsourcing as compared to insourcing, taking into account the superior quality of
outsourced services. It is important to note that the quality-adjusted costs do not reflect the real financial costs of the alternatives, but rather serve only the purpose of comparing the value for money of outsourcing and insourcing for this analysis.

**Table 6.5: Weighting the costs of the alternatives by the ‘quality factor’, 2014 UGX unweighted annual cost**

<table>
<thead>
<tr>
<th>Options</th>
<th>Annual cost (UGX)</th>
<th>Quality factor</th>
<th>Calculation</th>
<th>Quality-adjusted costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative 1:</td>
<td>50,973,770</td>
<td>1.18</td>
<td>50,973,770 * 1.18</td>
<td>59,969,140.59</td>
</tr>
<tr>
<td>Outsourcing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative 2:</td>
<td>51,643,344.50</td>
<td>2.11</td>
<td>51,643,344.50 * 2.11</td>
<td>108,722,830.53</td>
</tr>
<tr>
<td>Insourcing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After calculating the quality-adjusted costs of each of the alternatives, the researcher was able to calculate the quality-adjusted cost savings by subtracting the quality-adjusted costs of outsourcing from the quality-adjusted costs of insourcing.

**6.2.6 Limitations**

The quantification of the benefits of outsourcing is highly dependent on the results of the services quality mini-survey of the various hospital Managers which reported a 77% observed increase in quality of cleaning services after outsourcing (from 4.8 out of 10 before the implementation of outsourcing, to 8.5 out of 10 after the implementation of outsourcing). It would have been desirable to survey other hospital staff e.g. nurses to verify the manager’s responses and further inform the analysis. Despite this limitation, it is likely that the management team’s assessment of the differences in quality of cleaning services during insourcing and outsourcing is accurate because the management team surveyed is in a good position to assess all aspects of the outsourcing experience, including negotiating with the vendor, monitoring the cleanliness of all areas of the hospital, and monitoring the incidence of hospital-acquired infections.
6.3 RESULTS

6.3.1 Unadjusted costs annual costs of outsourcing and insourcing

The tables and figures below compare the annual costs of outsourcing and insourcing, and provide the cost breakdown of each alternative.

From the comparison, it is clear that outsourcing cleaning services in Hospital A is slightly less costly than insourcing, both per year and per square meter of hospital area cleaned.

Table 6.6: Comparative annual costs of outsourcing and insourcing

<table>
<thead>
<tr>
<th></th>
<th>Alternative 1: Outsourcing</th>
<th>Alternative 2: Insourcing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost category</strong></td>
<td>2014 UGX</td>
<td>2014 $</td>
</tr>
<tr>
<td><strong>Direct Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract</td>
<td>48,000,000</td>
<td>18,461.53846</td>
</tr>
<tr>
<td>Personnel</td>
<td>42,849,000.00</td>
<td>16,480.38</td>
</tr>
<tr>
<td>Supplies</td>
<td>3,174,000.00</td>
<td>1,220.77</td>
</tr>
<tr>
<td>Equipment</td>
<td>357,075.00</td>
<td>137.34</td>
</tr>
<tr>
<td><strong>Indirect Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>264,500.00</td>
<td>101.73</td>
</tr>
<tr>
<td>Management</td>
<td>675,000</td>
<td>259,615,3846</td>
</tr>
<tr>
<td>Operations</td>
<td>2,298,769.50</td>
<td>884.14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50,973,770</td>
<td>19,605,29596</td>
</tr>
<tr>
<td>Area cleaned (sq. meters)</td>
<td>76890</td>
<td>76890</td>
</tr>
<tr>
<td><strong>Total/square meter</strong></td>
<td>662.94</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Before adjusting for quality, Figure 6.2 shows that, based on the unit cost per square meter of the hospital cleaned, outsourcing is less costly per unit than insourcing, UGX 662.94 and UGX 671.65 per square metre, respectively.
The annual cost breakdown of outsourcing (Figure 6.3) and insourcing (Figure 6.4) show that, with outsourcing, the contract covers the direct costs that the hospital incurred when it was insourcing. However, the hospital continues to incur some additional indirect costs when outsourcing; for example, resources to cover utilities, and cover the salary of a hospital manager who oversees and monitors the vendor’s work. These indirect costs are in addition to the contract value.

Figure 6.3 shows that with outsourcing in Hospital A, the direct costs (contract value) covers 94% of the cleaning costs with indirect costs (management and operation) covering the remaining 6%.
For Hospital A, under insourcing, personnel costs cover 83% of the cleaning costs. The proportion of management costs under insourcing (5%) is higher than under outsourcing (1%). This can be taken as indicating support for the assertion for the interviewed managers that outsourcing reduces management burden of the outsourced service and allows them to concentrate on their core responsibility of providing clinical services.

### 6.3.2 Annual quality-adjusted costs of outsourcing and insourcing

Table 6.7 compares the costs of outsourcing and insourcing after adjusting for the differences in the service quality delivered through the two alternatives. These costs reflect the hidden costs of poor-quality services, which, once revealed by applying the methodology described in the previous section, show that for the studied hospital it costs more to deliver the same quality of cleanliness when insourcing than when outsourcing.
Table 6.7: Quality-adjusted annual costs of outsourcing and insourcing

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Alternative 1: Outsourcing</th>
<th>Alternative 2: Insourcing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014 UGX</td>
<td>2014 $</td>
</tr>
<tr>
<td>Direct Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract</td>
<td>56,470,588.24</td>
<td>21,719.46</td>
</tr>
<tr>
<td>Personnel</td>
<td>90,208,421.05</td>
<td>34,695.55</td>
</tr>
<tr>
<td>Supplies</td>
<td>6,682,105.26</td>
<td>2,570.04</td>
</tr>
<tr>
<td>Equipment</td>
<td>751,736.84</td>
<td>289.13</td>
</tr>
<tr>
<td>Indirect Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>556,842.11</td>
<td>214.17</td>
</tr>
<tr>
<td>Management</td>
<td>794,117.65</td>
<td>305.43</td>
</tr>
<tr>
<td>Operations</td>
<td>2,704,434.71</td>
<td>1,040.17</td>
</tr>
<tr>
<td>Total</td>
<td>59,969,140.59</td>
<td>23,065.05</td>
</tr>
<tr>
<td>Area cleaned</td>
<td>76,890</td>
<td>76890</td>
</tr>
<tr>
<td>Total/square metre</td>
<td>779.93</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Figure 6.5 shows the cleaning cost per square metre both the unadjusted and quality adjusted costs under outsourcing and insourcing. After adjusting for quality, it costs UGX 779.93 ($0.36) to clean each square metre of the hospital under outsourcing, while it costs UGX 1,414.0 ($0.554) to clean each square metre of the hospital under insourcing. The poor rating of in-sourced cleaning services by the hospital managers accounts for this huge difference.

Figure 6.5: Annual costs per square metre of hospital cleaned, UGX
6.3.3 Cost-benefit analysis

Two cost-benefit analyses of outsourcing are presented below. Table 6.8 presents a cost-benefit analysis of outsourcing before adjusting the costs for the quality of the cleaning service of the two alternatives and after adjusting the costs for quality.

The Net Present Value (NPV) of outsourcing over the one year study period is approximately UGX 669,575.00 ($ 257.53) and the NPV per square metre of hospital space is UGX 8.71. This means that the management of Hospital A financially gained UGX 669,575.00 during the study period by choosing to outsource the hospital cleaning services. This gain was through saving due to the lower cost of outsourced services.

After taking into account differences in quality between the two alternatives, (insourcing and outsourcing) the NPV over the one year study period is UGX 48,753,689.94 ($ 18,751.42) and the NPV per square metre of hospital space is UGX 634.07. This means that after considering improved quality of cleaning, the hospital management will gain approximately UGX 48,753,689.94 in total value over the one year period by outsourcing cleaning services. Put differently, with insourcing, if Hospital A wanted to achieve the same level of quality of cleaning services as provided by the vendor, the hospital would have to spend an additional UGX 48,753,689.94 to the costs it would be incurring while outsourcing.

This amount does not reflect real financial savings, but rather reflects an attempt to place value on quality.

Generally, these findings show that outsourcing cleaning services in Hospital A will result in minimal financial savings (UGX 669,575.00). However, the findings also show that outsourcing cleaning services in Hospital A provide greater value for money, in terms of ‘cleanliness per Uganda shilling spent.'
Table 6.8: Cost-benefit analysis of outsourcing with and without quality adjustment 2014 UGX-

<table>
<thead>
<tr>
<th>Tangible benefits</th>
<th>Unadjusted costs</th>
<th>Quality adjusted costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost savings, personnel</td>
<td>42,849,000.00</td>
<td>90,208,421.05</td>
</tr>
<tr>
<td>Cost savings, Supplies</td>
<td>3,174,000.00</td>
<td>6,682,105.26</td>
</tr>
<tr>
<td>Cost saving, Equipment</td>
<td>357,075.00</td>
<td>751,736.84</td>
</tr>
<tr>
<td>Cost saving, training</td>
<td>264,500.00</td>
<td>556,842.11</td>
</tr>
<tr>
<td>Cost saving, Management</td>
<td>2,025,000.00</td>
<td>4,890,092.88</td>
</tr>
<tr>
<td>Cost saving, Operations</td>
<td>2,135,080.03</td>
<td>2,135,080.03</td>
</tr>
<tr>
<td><strong>Total Benefits</strong></td>
<td>48,669,575.00</td>
<td>105,224,278.17</td>
</tr>
<tr>
<td><strong>NPV Benefits</strong></td>
<td>48,669,575.00</td>
<td>105,224,278.17</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract costs</td>
<td>48,000,000</td>
<td>56,470,588.24</td>
</tr>
<tr>
<td>Total costs</td>
<td>48,000,000</td>
<td>56,470,588.24</td>
</tr>
<tr>
<td><strong>NVP costs</strong></td>
<td>48,000,000</td>
<td>56,470,588.24</td>
</tr>
<tr>
<td>Net benefits/costs</td>
<td>669,575.00</td>
<td>48,753,689.94</td>
</tr>
<tr>
<td><strong>NVP net benefits/costs</strong></td>
<td>669,575.00</td>
<td>48,753,689.94</td>
</tr>
<tr>
<td>Total area cleaned</td>
<td>76,890</td>
<td>76,890</td>
</tr>
<tr>
<td><strong>NVP net benefits/costs per square metre</strong></td>
<td>8.71</td>
<td>634.07</td>
</tr>
</tbody>
</table>

6.4 SENSITIVITY ANALYSIS

Sensitivity analysis enables researchers to test the impact of alternative assumptions on the results of an economic analysis. The key assumptions in this analysis are the interest rate and the indirect costs of outsourcing (management and operations).

The researcher conducted a sensitivity analysis to demonstrate the effect of increasing and decreasing the costs of operations and management by 20% each, and of adjusting the interest rate by 20% (from 15% in the base case to 12% and to 18%) on the quality-adjusted Net present Value (NPV) of insourcing.

The results are shown on a tornado diagram below (Figure 6.6). The impact of varying the contract costs by 20% are also plotted for purposes of comparison.
Figure 6.6: Tornado diagram of main assumptions

Figure 6.6 demonstrates that the operational costs, management costs, and the interest rate, have relatively little impact on the quality-adjusted NPV of outsourcing. The NPV is positive for all scenarios where these assumptions are varied by 20%, meaning that outsourcing is still cost-beneficial.

The diagram also shows that even after varying the cost of the contract by 20%, outsourcing still remains cost-beneficial as indicated by the positive quality adjusted NPV of outsourcing. However, varying the cost of the contract has a significant impact on the quality-adjusted NPV of outsourcing. Increasing the quality adjusted cost of the contract by 20 percent (from UGX 56,470,588.24 to UGX 67,764,705.88 ) decreases the quality-adjusted NPV by approximately UGX 11,294,117.65 while decreasing the cost of the contract by 20 percent (from UGX 56,470,588.24 per year to UGX 45,176,470.59 per year) also increases the quality-adjusted NPV by approximately UGX 11,294,117.65.

6.4.1 Impact of interest rate

There is no generally accepted standard mechanism for determining interest rates for cost-benefit analyses. As mentioned before, an interest rate of 15% was used, this being the 2 year Treasury bond interest rate quoted by the Bank of Uganda in
December 2012. This can be considered the real interest rate taking into consideration inflation and the nominal interest rate.

Figure 6.7 below demonstrates the effects of different interest rates on the quality-adjusted NPV of outsourcing. Interest rates from 0% to 20% were applied. The NPV is positive in all scenarios, meaning that outsourcing remains cost-beneficial at all interest rates tested.

![Figure 6.7: Impact of varying interest rate on quality-adjusted NPV](image)

6.4.2 Impact of contract costs

Figure 6.8 below shows the quality-adjusted NPV of outsourcing at different values of the outsourcing contract per square meter cleaned. In Hospital A’s current contract with the vendor, the hospital pays UGX 734.43 (USD$ 0.28) per square metre per year for the vendor to clean the hospital. The vertical line demonstrates that, holding all other assumptions constant, outsourcing is cost-beneficial to the hospital management only when the annual unit cost of the outsourcing contract is less than approximately UGX 1400 (USD $0.54) per square meter per year.
6.4.3 Impact of service quality

This study monetises the benefits derived from increased quality of cleaning services using responses to a mini survey of managers from the two hospitals. Figure 6.9 demonstrates how the responses to the management service quality interview impact the value for money of outsourcing cleaning services.

It is evident from the graph that the value for money of outsourcing is highly dependent on the rating of the quality of cleaning services since outsourcing. An increase of one point on the Likert scale (from 8 to 9) produces an increase of approximately UGX 7,079,690.21 in the value for money of outsourcing (from UGX 45,00,618.85 to UGX 52,085,308.86), while a decrease in one point on the Likert scale (from 8 to 7) produces a decrease of approximately UGX 9,102,458.84 (from UGX 45,005,618.65 to UGX 35,903,159.81). For hospital A, an average quality rating of outsourced services below 5 compared to the average rating of insourced services of 4.8 would result in a negative NPV for outsourcing.
6.5 DISCUSSION

The cost-benefit analysis case study finds that outsourcing cleaning services at Hospital A is slightly less costly than providing those same services in-house. In contrast to this study, a similar study conducted in a hospital in Botswana estimated that outsourcing cleaning services in the hospital compared to the status quo, would result in additional hospital expenditures meaning that outsourcing was more expensive than in-sourcing (Cali, Cogswell, Buzwani, Ohadi & Avila 2015).

This study, in agreement with the Botswana study also shows that outsourcing provides a greater value for money to hospital's managers because it has resulted in a significant observed increase in the quality of cleaning services (77%). Indeed the Botswana study concludes that even if outsourcing was more expensive than in-sourcing, after taking into account improvements in quality, the cost-benefit ratio favors the outsourcing alternative (Cali et al 2015).

The results of the sensitivity analysis conducted in our study are similar to those of the Botswana study. Just like out study, the Botswana study found that outsourcing cleaning services delivered greater value for money than insourcing under all scenarios tested. Also, just like in this study, the cost of the contract and the management’s rating of the quality of the service had the greatest impact on the value for money of outsourcing cleaning services in the studied hospital (Cali et al 2015).
The findings from this case study are specific to cleaning services in Hospital A, and should not be generalised to other services or to other hospitals. However, this cost-benefit analysis reveals several key lessons that would be useful to hospital managers who are exploring the possibility of outsourcing or preparing to negotiate outsourcing contracts with vendors.

6.5.1 Need for detailed information

Assessing the value of outsourcing and making informed decisions requires detailed information on the status quo.

Hospital managers need to collect costing data from insourcing, in order to assess the potential value for money of outsourcing nonclinical services, evaluate bids from private vendors, and engage in effective contract negotiation with vendors. This study demonstrates the importance of collecting accurate data on staff salaries, benefits, and time worked and tracking hospital spending on supplies and utilities in addition to the personnel costs of management involved in supervising the services. Other costs could include training costs related to the service. However, due to poor record keeping by some hospitals, this detailed information may not be available. A costing study conducted in Botswana noted that the management of several hospitals involved in the study were unable to provide some of this information to data collectors.

It is equally important for hospitals to collect data on the unit cost of providing in-house (insourcing) the services they wish to outsource, as this information is crucial for comparing vendors’ bids with the cost of providing a service in-house. For example, hospital managers need to know the hospital’s floor area (usually in square meters) to compare costs of cleaning services. Without this information, hospital managers cannot determine the unit cost of providing services in-house, and therefore will not know whether they are getting a fair offer from vendors, nor whether vendors are making realistic promises that they will be able to uphold.

Our findings from the qualitative data collection indicate that there is little thorough analysis and most of the decisions to outsource or not are based on intuition. As one manager commented:
"We have not gone into that analysis...the beauty is that we buy our own cleaning materials, the water is there, the people are there to do the work and the end of the month you pay them if there is money. If there is no money, you postpone, but they keep doing the work. And under our supervision."

6.5.2 Costs of outsourcing versus in-sourcing

Outsourcing may only be slightly cheaper than outsourcing and could even possibly be more costly than insourcing.

For most hospital managers interviewed, their outsourcing is based on the premise that outsourcing some of the support services to private companies will allow the delivery of higher-quality services at a lower cost. Though the results of this study show that to be true for Hospital A, the difference was minimal. A quick comparison of the costs of outsourcing and insourcing cleaning services at Hospital shows that the annual cost of the outsourcing contract (UGX 48,000,000) is approximately 669,575.00 less than the annual cost of insourcing (UGX 48,669,575.00). Under outsourcing, Hospital A continues to pay all utility costs, and spends time and money managing the vendor. In order to make an accurate cost projection of outsourcing, hospital managers should ensure during negotiations that the contract defines exactly what each party is responsible for providing. Finally, managers should consider the intangible costs of outsourcing. Several identified in this study include theft by outsourced staff, damage to hospital's reputation and other risks. These intangible costs have the potential to result in significant financial loss to the hospital.

6.5.3 Need to consider costs and benefits

Benefits are just as important as costs for decision-making.

Hospital managers should not make decisions based solely on the cost of outsourcing, but rather on the value for money of outsourcing. Even if outsourcing is only slightly cheaper or even more costly than providing a service in-house, it may still be justified if it delivers a significant increase in the level of quality of the service. The cost-benefit analysis of outsourcing cleaning services in Hospital A without taking into account quality, outsourcing appeared to deliver only a slight cost advantage. After adjusting for
the improvement in quality, the analysis shows that outsourcing of cleaning services in Hospital A delivered a higher value for money.

If justifying paying more for a better service, however, hospitals must commit to vigorously monitoring the quality of services provided by private vendors, and hold them accountable for their quality. Managers may consider defining quality standards during the contract negotiation phase to ensure that both parties have the same expectations of what constitutes quality services. Hospital managers should then conduct regular quality assessments together with company managers to ensure that expectations are being met. This is important because as revealed in this study, quality rating of the outsourced services has a significant impact of the value for money from outsourced services.

It is also important for hospitals to consider other benefits of outsourcing in addition to improved quality. Some of the intangible benefits mentioned by the hospital managers interviewed during this study include improved availability of cleaning supplies, improved waste collection, and possible reduction in hospital-acquired infections due to safer practices and increased cleanliness, and introduction of innovations by the outsourced company. These intangible benefits may result in financial savings for the hospital or better health outcomes, both of which may justify the higher up-front financial costs of outsourcing.

Results from the qualitative data collection indicates that most of the analysis conducted by hospital managers is mainly financial and does not take into consideration some of the intangible benefits or even some of the intangible costs and this may be resulting into less than ideal outsourcing decisions. As one Hospital Manager commented:

“When we did a cost analysis, we realised that for example we were spending 3.5 million for cleaning and yet when we inquired with providers…they were telling us that is high. That we could pay 2.5 million for a month.”
6.5.4 Collaboration between hospitals and outsourced vendors

Hospitals and vendors could both gain from closer collaboration. This study demonstrates how both the costs and benefits impact the value for money that hospital managers receive from outsourcing. Closer collaboration between hospitals and vendors through sharing information, joint monitoring of quality, and joint training could lower the costs and increase the benefits of outsourcing for hospital management.

This study highlights the need for hospital managers to collect more data on insourcing, and conduct more-thorough analysis of the potential costs and benefits of outsourcing. However, vendors could also gain from more information and analysis. Vendors often know little about the costs of providing nonclinical services in hospitals, and thus could mistakenly offer to provide these services for a fee that does not cover their full costs. Underbidding is especially likely among young companies without much experience operating in hospitals. As a result of such a situation, vendors may abscond from their contracts or it may cause conflict between the vendor and hospital management as noted by some of the managers interviewed during this study:

“The difficulty we face is that of expectations. People may think they are going to get a lot of money. So when they bid, they can under quote. Because they want to win the contract. And when they get the award, some realise that the scope of work is so much and that becomes a challenge. After doing the work mid-way, their money is exhausted and for us we have to force them because the contract is binding and they have to do the work. So there is some degree of pulling strings because the person says the money is not adequate.”

“At times you find the company absconds because of expectations...they think there is a lot of money in the contract and there will be a lot of balance. Halfway the journey, they realise it is not there. So it becomes a problem for them, and they abscond.”

Hospitals wishing to outsource could build trust with vendors by sharing information on the current costs of providing the service in-house, and giving them a base price upon which to make their bid. When both parties negotiate in the dark, one will likely get a raw deal at the expense of the other. If both parties negotiate with full information, it will be easier to agree on a fair price that is satisfactory to both the hospital and the vendor.
Sharing costing information during contract negotiations could help hospital managers to establish a strong working relationship with vendors, which will facilitate cooperation on other issues for the duration of the contract.

Both parties have an interest in ensuring that the services are delivered at the highest possible quality: in addition to ensuring patient care and safety, hospitals want the greatest value for money, while vendors want to develop a reputation as a high-quality brand and secure future business. Approaching quality assurance in a collaborative rather than confrontational manner could result in better quality outcomes. Joint ‘walkabouts’ where managers from both parties assess the quality of services together are one possible approach (Cogswell et al 2015).

Joint orientation and training sessions, where hospital staff teaches infection control practices to the vendor’s cleaning staff, could also improve the quality of services. Many private companies have little or no prior experience operating in hospitals, and are unfamiliar with the unique requirements and safety protocols of the health sector. Joint training sessions could increase the capacity of private vendors, while improving the quality of the service provided to the hospital.

6.5.5 Evolution of outsourcing costs and benefits over time

The costs and benefits of outsourcing should improve over time. Vendors may be able to provide better-quality services at lower costs as they increase operational efficiency, incorporate innovations in management and service provision methodologies, and increase their economies of scale. The quality of services could also improve as hospitals increase their capacity to monitor vendors and enforce adherence to quality standards.

6.6 CONCLUSION

For most hospitals, the decision to outsource is premised on the assumption that outsourcing will provide better quality services at a cheaper cost. However, this is usually based on intuition and is not backed by a thorough cost benefit analysis. This study evaluated the costs and benefits of outsourcing cleaning services in Hospital A. It found that outsourcing is slightly less costly than in sourcing and also provides better
quality of cleaning services. Once service quality is accounted for, the economic benefits of outsourcing become even greater. The study identifies key lessons for managers who are currently outsourcing or are planning to outsource some of their support services. For successful outsourcing hospital managers should collect more-detailed information on the costs of providing nonclinical services in-house, and more information on the monetary value of increased quality of outsourced services. This information will allow hospital managers to conduct rigorous cost-benefit analyses of outsourcing cleaning and other services in their own context.

The next chapter integrates the quantitative and qualitative findings from the earlier chapters. The focus is on using the qualitative findings to explain the quantitative findings, and to propose an outsourcing framework and guidelines for increasing adoption and effectiveness of outsourcing by hospitals, based on the research findings.
CHAPTER 7

INTEGRATION, DISCUSSION OF QUANTITATIVE AND QUALITATIVE DATA, PROPOSED OUTSOURCING FRAMEWORK AND GUIDELINES

7.1 INTRODUCTION

This study was based on a mixed methods research design. A mixed methods research design is a procedure for collecting, analysing, and “mixing” both quantitative and qualitative research and methods in a single study to understand a research problem (Creswell 2012:3). According to Polit and Beck (2008:309), the advantages of a mixed methods research approach include complementarity, incrementality, and enhanced validity.

Specifically, the study used an explanatory sequential design. In the explanatory sequential design, quantitative and qualitative methods are implemented sequentially starting with the quantitative strand. It is used when a researcher wishes to use qualitative findings to help interpret or contextualise quantitative results.

This study was a QUAN-Qual mixed methods study. The quantitative phase of this study which was the priority phase, addresses the practices, determinants, perceived barriers and perceived benefits of outsourcing by hospitals in Uganda. Information from this first phase was explored further in a second qualitative phase. Qualitative data collection was used to explore important quantitative results with a few participants. The reason for following up with qualitative research in the second phase was to enable better understanding and explanation of the quantitative results. The findings from the second qualitative phase explain in greater depth the results from the initial quantitative phase of the study. This chapter thus integrates the quantitative and qualitative data, using the qualitative data to further interpret and explain the quantitative findings. As a method, it focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies. This will provide a better understanding of the key research findings than either approach alone (Creswell & Plano-Clark 2007:5).
7.1.1 Mixed methods research question

How does the qualitative data on the practices, motivations for and barriers to outsourcing by managers of general hospitals in Uganda help to explain the quantitative results about general hospitals outsourcing motivation, practices, and their determinants?

The key findings from the quantitative phase of the study are presented below and further explained by the qualitative data. The findings are presented per quantitative research objective.

7.2 HOSPITAL OUTSOURCING PRACTICES AND PROCESSES

7.2.1 Extent of outsourcing and services being outsourced

Quantitative data shows that a large proportion of the hospitals in our study were outsourcing (72%) with the most frequently outsourced service being cleaning services (78% of hospitals). From the qualitative interviews, a number of hospital managers consider a clean environment as critical to creating a conducive environment for their staff and clients, and in a situation where in-house staff are not doing a good job, then the hospital will tend to outsource the cleaning services. As one respondent indicated:

"You may have people working but if the environment is not clean and is not conducive, you may not get satisfied. We needed people who could clean well so that our workers are comfortable to do their work and that patients who are customers are also comfortable in the environment where they are getting the service."

Participant 1, page 3

Interestingly, even for managers who were not currently outsourcing, one of the services they intended to outsource in the future was cleaning services noting that:

"We would possibly outsource cleaning in the theatre and wards where you really need serious hygiene."

Participant 7, page 38
On the other hand, one of the least frequently outsourced service was catering services (22%). Data from the qualitative interviews indicates that a number of hospitals no longer provide meals to their patients, instead asking that caregivers provide them with meals prepared from home or purchased out of the hospital. This may explain the low level of outsourcing for catering services.

As one respondent explained:

“We stopped providing food because the budget was not enough...we were actually providing one meal in a week. Then I said if you have someone who is helpless will providing one meal in a week save that person's life? So I said this one we have to stop.”

(Participant 3, page 15)

7.2.2 Motivation for outsourcing

Hospital Managers who reported to be outsourcing indicate the desire to gain quality service from another firm’s expertise as the main motivation for outsourcing (68%). The qualitative data provides further insight into this as indicated by one manager who commented:

“We decided to outsource cleaning because the job was not being done well by the hospital employees”.

(Participant 2, page 10)

Further insight is provided by another manager who commented:

“If the establishment does do provide for that...for example if you don't have someone in the establishment qualified to do that type of work, then definitely we have to outsource.”

(Participant 3, page 15)

Thus it can be concluded that the motivation to outsource in order to gain quality service from another firm’s expertise is driven by poor quality of insourced service and/or lack of internal capacity to provide quality service.
More than half of the hospital managers who were outsourcing (55%) report the need to enable the hospital focus on its core mandate of serving patients as one of their motivation for outsourcing. During the qualitative interviews, one manager elaborated on this aspect as below:

“We don’t have that time to oversee and supervise and to actually do this (support) work. Before outsourcing, we were actually seen to be struggling to provide this service and the other. First of all we are very short on staff and we also don’t have that time to do that. We also don’t have the technical skills or ability to do some of this work. So when we outsourced we are able to concentrate on the core activities that are expected of us, instead of wasting time providing what could be probably considered secondary to us.”

(Participant 5, page 26)

Additionally, the managers commented that by outsourcing the hospital management is able to:

“…reduce (our) stress and focus on strategic things “ in addition to “getting freedom to do other more important things since minimum supervision (of the contractor) is required.”

(Participant 6, page 36)

The least frequently reported reason for outsourcing was the need to reduce employee size, with less than a quarter (22%) of managers citing this as a reason for outsourcing. This may be explained by the difficulty of laying off workers, especially in the public sector even when they do not perform their work, with one manager commenting: “It is difficult to fire a civil servant, it’s a long process.” Additionally, the desire of hospital management to avoid confrontation with workers unions may also not make this an attractive reason for outsourcing.

However, one hospital manager from an NGO hospital explained how the complexity with managing support staff and the need to reduce employee size motivated their outsourcing decision as below:

“The decision (to outsource) was made because the hospital was failing to manage the group workers…they were becoming a challenge for the hospital to
manage. We were tired of having multiple support staff—cooks, cleaners etc. It was also becoming costly because we needed accountants to be in charge of the various pay rolls. So we decided to outsource so that we no longer needed to do this pay roll maintenance."

(Participant 4, page 23)

One manager who had gone through the experience of reducing staff size as a result of outsourcing, notes that:

“...it's never easy (retrenching staff), because they are part of you.”

(Participant 2, page 14)

7.2.3 Satisfaction with current outsourcing

For the services being outsourced, most hospitals reported being satisfied with their outsourcing services, with at least 60% of hospital managers reporting that they were strongly satisfied or satisfied with their outsourced service. The most frequently reported reason for satisfaction with the outsourced services was that the anticipated improvement in quality of the outsourced service had been realised (87% of managers).

Explaining satisfaction with their currently outsourced services, one hospital manager commented:

“Am satisfied...the main reason is quality. The other is timeliness of service. We have been able to control infections. Also, every time our office is clean.”

(Participant 5, page 30)

One satisfied manager, however, commented that:

“...there are some challenges...we just have to work around the little challenges and fix them. We have not attained standards but quality has improved.”

(Participant 3, page 18)

Thus, it is not surprising that some Managers reported dissatisfaction with their outsourced cleaning services though this was a small percentage (11%). The most
frequently reported reason for dissatisfaction was that anticipated cost reduction from outsourcing had not been realised.

The qualitative data indicates that part of the increased cost of service is because the outsourced company has to pay taxes which increases the contract price; with one manager noting:

“…these people (outsourced company) pay taxes or they undergo certain other process which tend to increase the amount we spend on services and the price becomes higher compared to if we did it ourselves.”
Participant 5, page 26

Whereas this type of cost increase can be anticipated, the hospital managers also indicate that sometimes the cost increases occur during contract performance.

One manager commented as below:

“Later on you realise that they (vendors) quoted a low price that will not scare you…but a few months down the road, they come and say, ok we have an agreement but if you need us to do even that and that and that, you have to increase. So the costs become revised inevitably.”
(Participant 2, page 12)

The hospital managers note that increase in the costs of service is serious and,

“it (increased cost) can disable the hospital...if the hospital is not financially stable, it will not be able to manage the payments.”
Participant 4, page 21

7.2.4 Outsourcing process and challenges encountered

The quantitative data indicates that less than half of the hospital managers reported conducting an analysis of the market for the service to be outsourced or determining the strategic outsourcing options or the relationship strategy to be adopted and how to manage, monitor or evaluate the relationship with the supplier. However, the managers also report that during the outsourcing process, the most frequently encountered
challenge was the limited number of service providers (57% of managers). Rural hospitals were more likely to report challenges with the available number of suppliers during the outsourcing process compared to their urban counterparts (p=0.0152).

It is likely that if the managers had done a market survey before outsourcing, they would be able to identify potential providers or the survey would indicate to them that outsourcing was not feasible in their context due to limited suppliers. Limited availability of suppliers creates a monopoly and is likely to increase the price of services.

The qualitative data provides some insight into this challenge of limited service providers. For some of the instances, the provider needs certification to offer the service and there are only a few providers with the required certification. One Manager indicated that when outsourcing for waste management services, there was “only one person who can do what we wanted….he is the only one who had the license.

Elaborating further one the challenge of limited providers, one manager commented:

“It is not so easy to find providers. There are some things in hospital cleaning that need a bit of training. How to handle infectious waste, how to handle body fluids etc. For you to get a company that has worked in a hospital before is very difficult especially in the rural areas. May be in the city.”
(Participant 2, page 12)

The qualitative data also indicates that sometimes, the few available providers take advantage of this situation by

“registering several companies and so sometimes you find that you keep replicating the same people.”
(Participant 5, page 28)

Slightly less than half (48%) of the surveyed hospital managers report having encountered challenges with contractual issues during the outsourcing process. Urban hospitals were more likely to report challenges with contractual issues during the outsourcing process compared to their rural peers (p=0.0056). The qualitative data identifies some of the contractual issues as difficulty in terminating the contract, long...
duration of the outsourcing contract which leads to supplier lock in and misunderstanding of the hospital contracting process by the vendor.

As one manager commented:

“We had a service provider come on ground before the contact was finalised. He had won, but not awarded. So he came on ground earlier and we had to stop him much as we wanted the service. So when it came to payment, and depending on the contact, we had to forward it by one week. And when it came to payment we had to prorate and yet he had raised a claim for one month. So we had a little bit of conflict.”

(Participant 5, page 31)

An equal proportion of managers (38%) report limited in-house capacity to outsource and political interference as challenges encountered during the outsourcing process. As one Manager noted, outsourcing is “quite a difficult process and once you miss one step, you can cause havoc.” To address the issue of limited in-house capacity, one hospital manager indicates that they had to bring in a consultant to guide the outsourcing process.

As the manager noted:

“We had to get a consultant from outside to guide us, we did not have guidelines that is why we had to invite consultants. You need people who can be able to advise on procedures to avoid flaunting the process, because it can lead to litigation and probably bigger cost.”

(Participant 4, page 24)

Regarding the issues of external or political influence in the outsourcing process which was highlighted by 38% of the managers, one Hospital Manager from an MOH hospital provided some insight into the challenge of external or political influence as below:

“There is a lot of politics in the outsourcing process. And if you are not careful you may not manage. You may end up doing what people want and is in the interest of the institution. Someone may say, award me, my contract, me am so and so.
People will give calls and say…me I want that work. If you don’t give it to me, you will see.”
(Participant 5, page 33)

The manager further elaborates the consequences of political interference in the outsourcing process noting that:

“…if there is some political influence in the outsourcing process, the service provider selected may be tempted not to provide a quality service. There are common instances like that.”
(Participant 1, page 1)

Whereas the hospital manager from the MOH hospital suggest that there are common instances of political interference, a manager from an NGO hospital indicates that they:

“…do not have that corruption thing and also beaurocracy is not a big problem”.
(Participant 6, page 36)

Interestingly, managers from MOH hospitals were likely to report political interference as one of the challenges encountered during the outsourcing process than managers from NGO hospitals (p= 0.0065).

7.2.5 Monitoring of outsourcing

Majority of the surveyed hospitals that were outsourcing (71%) reported having in place systems to continuously monitor the outsourcing program. Majority of the hospital managers (87%) reported to be monitoring supplier performance, while 80% of the managers reported to be monitoring cost effectiveness of the outsourcing program.

The hospital managers reported using a number of strategies to monitor vendor performance. These included daily “walk arounds” by monitoring staff to assess quality of work being done by the vendors. Explaining how this is accomplished, one hospital manager commented as below:

“We have a customer care assistant who moves around the wards daily, they pass through to check if hygiene is good. They bring feedback which is fed to the
Quality Assurance (QA) committee every month. Then the hospital administrator and myself pass around…may be twice a week to check."

(Participant 2, page 13)

One manager noted that during the walk arounds, the monitors take photos to document the quality of service as this forms an integral part of their monitoring report that is the basis for payment of the vendor. This regular monitoring may be contributing to the high level of satisfaction since it provides opportunities for early identification and resolution of issues and also contributes to improved supplier performance.

A large proportion of managers (80%) reported to be monitoring the cost of their outsourcing program. One Manager describes how this monitoring has benefited the hospital as below:

“We have been monitoring the aspect of cost. And the decision we took was not necessarily to get rid of outsourcing as such but it actually helped us to reduce the amount of resources we had been paying out for a particular service. Because we realised that compared to what other hospitals were paying, we were paying slightly higher. For example, our cleaning services, we used to pay 4.8 million per month, but we had to drop it to 3.2 million after comparing.”

(Participant 5, page 31)

The most frequently utilised monitoring strategy was regular meetings with the supplier to review performance (93% of managers). These meetings are both with hospital management and general staff. The qualitative data indicates that these meetings are critical to identifying and addressing any issues. As the manager notes:

“We hold monthly meetings with them (outsourced company) and when we have our general staff meetings we have invited their management so we are able to identify and address issues.”

( Participant 5, page 30)
7.3 HOSPITAL MANAGERS’ OPINIONS ABOUT OUTSOURCING, PERCEIVED BENEFITS/ADVANTAGES AND DISADVANTAGES OF OUTSOURCING

7.3.1 Opinions and knowledge about outsourcing

Majority of the surveyed managers (94%) strongly agreed or agreed with the statement that outsourcing is one approach that can be used by hospital management to improve hospital performance.

Elaborating on how outsourcing can improve hospital performance, the hospital managers commented as below:

“It can improve services in that managers stop concentrating on the small things and begin concentrating on the strategic direction of the hospital. So things like compound cleaning can be outsourced so that managers do need to supervise that directly.”

(Participant 6, page 33)

“Also when you outsource, it’s easier and you are in a better position to request for better services than when employing your own workers…because if you give a task to a company you set out targets which are much easier to follow up because you are only following up with the manager of the company. But with your workers, when you set targets for 100 people and you are supposed to supervise them every day, that’s very difficult.”

(Participant 6, page 33)

One hospital manager further elaborated on how outsourcing improves performance of the outsourced services noting that:

“Outsourcing can improve hospital performance in that, the manager of the outsourced workers has control over their workers to ensure that they maximise efficiency, because he is motivated by the profit he is supposed to get by the end of the day. So he ensures that the workers fulfil the task and they have to do it in the shortest time frame for then to be able to realise the profit because if he doesn’t he can face a penalty and doesn’t realise his motive.”

(Participant 1, page 1)
7.3.2 Perceptions about service importance, characteristics and outsourcing

The quantitative findings indicate that the hospital managers consider cleaning services to be critical to the hospitals efforts of offering quality health care with 94% of managers indicating that they consider cleaning services to be very important or important to health care delivery in the hospital. This may be related to the perception of hospital managers of cleaning services as being critical to the quality of hospital services offered and to the patient’s perception of the hospital.

As one manager noted:

“We needed people who can clean so that our staff are comfortable to do their work…and that patients who are customers are also comfortable in the environment where they are getting the service.”

(Participant 1, page 4)

The surveyed hospital managers consider catering services the least important to quality health care delivery in the hospital with only 45% of managers indicating that catering is very important or important for hospital health care delivery. Also, 10% of hospital managers report catering services to be of little importance or unimportant for hospital health care delivery, this being the highest percentage for all the services considered on this combination of measures. And as earlier indicated, catering services were one of the least frequently outsourced services with only 22% of hospitals reporting to be outsourcing catering services.

The qualitative data indicates that most hospitals no longer offer catering services and expect caretakers to make arrangements for their patients’ meals and not rely on the hospital. One of the hospital manager’s comment below provides insight into that as below:

“We stopped providing food because the budget was not enough. We were actually providing one meal in a week. Then I said if u have someone who is helpless and cannot feed themselves...providing one meal in a week is not enough. We have to stop. So now we don’t provide for any person.”

(Participant 3, page 15)
7.3.3 Perceptions about benefits of outsourcing

Most managers cite cost management as a key benefit of outsourcing in their hospitals. Outsourcing contributes to cost management in a number of ways including improving productivity (i.e. producing more output with same inputs). Over 90% of the hospital managers strongly agree or agree that outsourcing can be used by a hospital to achieve improvement in productivity of its operations through cost management.

One manager explained that one way outsourcing would contribute to cost management is by eliminating the need to pay the hospital staff benefits once the service is outsourced and the hospital no longer has to employ staff. As the manager commented:

“It (outsourcing) is cheaper because the in-house staff are entitled to many benefits-health care, allowances, accommodation and everything. So when we outsourced, it took off pressure from the accommodation…we don’t have to worry about that.”
(Participant 2, page 10)

The hospital managers identify greater management focus as a key benefit of outsourcing. Regarding greater focus for management, the benefit that most managers agree with it that outsourcing can be used by a hospital to be able to deliver improved service to the patients with 90% of surveyed managers strongly agreeing or agreeing with this statement. Explaining outsourcing improves management focus on delivering the hospital’s core services, the hospital managers commented as below:

“We don’t have that time to oversee and supervise and to actually do this (support) work. So the contractor does the cleaning and for us we concentrate on our work of administration and offering curative services. Before outsourcing, we were actually seen to be struggling to provide this service and the other. First of all we are very short on staff and we also don’t have that time to do that. We also don’t have the technical skills or ability to do some of this work. So when we outsourced we are able to concentrate on the core activities that are expected of us, instead of wasting time providing what could be probably considered secondary to us.”
(Participant 5, page 26)
“We wanted to reduce our stress to focus on strategic things. So we thought if we gave the contract to a company and paid them, supervision would have been easier.”
Participant 6, page 36

However, it’s interesting to note that contrary to the view above where outsourcing reduces the need for management to control workers delivering the service and hence focus on other areas, some managers indicate that the fact that the hospital managers were no longer in direct control over the outsourced workers was a disadvantage with outsourcing.

As one manager commented:

“The outsourced company staff will come do the work and go away. You cannot keep them here for the whole day till 5pm like the employee. For an employee I can summon you any time even at 5Pm to say the work is not yet finished, please do this and that. So losing control over the staff doing the work is one of the disadvantage.”
(Participant 3, page 15)

Regarding access to external expertise/investment or innovation the benefit that most managers agree with it that outsourcing enables the hospital to gain quick and continuous access to the latest technological developments e.g. equipment with 90% of surveyed managers strongly agreeing or agreeing with this statement. The qualitative data indicates that through outsourcing the hospital managers are able to gain access to additional staff, equipment, and training for hospital staff and new ways of delivering the service. The hospital managers elaborated on the above as below:

“The outsourced company helps us with cleaners. We have internal staff and those from the outsourced company complement them. They contribute to our infection prevention program. They even help train our domestic cleaners on infection prevention.”
(Participant 8, page 40)

“With Infection prevention, the company we outsourced has come up with some innovation…which we could not manage…building an incinerator. They have also
brought in another innovation, use of waste bin liners instead of plastic. He is actually helping us to know how much we are generating.”

(Participant 8, page 40)

The hospital managers even cite instances where they have been able to leverage the vendor’s programs and collaborate with the vendor for community service. One hospital manager exemplified this as below:

“The vendor has introduced an environment awareness program…we now have an environmental day every month…so he provides information and also participates in the community program. And that makes the hospital look good. Sometimes he does interviews, brings cameras we do video footage and he takes it to TV showing how our hospital is clean and how his services are helping and the gadgets he is using and what improvements he has made.”

(Participant 8, page 43)

However, some hospital managers disagreed with a commonly cited benefit of outsourcing which is that it can help control cost; with 11% of hospital managers disagreeing with the statement that outsourcing can be used by a hospital to achieve cost saving and to control costs. The qualitative data indicates that this could be based on some managers’ experiences who have indeed observed an increase in costs after outsourcing. This may be due to the fact that vendors have to pay tax and so build that in their price or situations where vendors have come back to negotiate higher prices than what they had earlier quoted.

As the hospital managers commented:

“Later on you realise that they (vendors) quoted a low price that will not scare you…but a few months down the road, they come and say, ok we have an agreement but if you need us to do even that and that and that, you have to increase. So the costs become revised inevitably.”

(Participant 2, page 12)

“The other aspect of it…is the pricing. The outsourced services tend to be expensive because these people pay taxes or they undergo certain other process
which tend to increase the amount we spend on services and the price becomes higher compared to if we did it ourselves.”
(Participant 5, page 26)

7.3.4 Perception about barriers to outsourcing

More than half of the hospital managers (69%) indicated that to a great or to some extent, absence of a matured vendor market reflected by non-availability of quality outsourcing vendors which makes it difficult for the hospital to outsource. Interestingly and in support of this, as earlier indicated, the surveyed managers report that during the outsourcing process, the most frequently encountered challenge was the limited number of service providers (57% of managers).

The following quotes from the hospital managers elaborate the above findings:

“It is not so easy to find providers. There are some things in hospital cleaning that need a bit of training. How to handle infectious waste, how to handle body fluids etc. For you to get a company that has worked in a hospital before is very difficult in a rural setting. May be in the city.”
(Participant 2, page 12)

The hospital managers further explain the consequences of such a situation, especially creation of a monopoly where the few vendors who have the capacity create several companies to ensure that they get selected. Consequently the hospital is limited to only a few options even if some of them may have been blacklisted by the hospital. As the hospital manager commented:

“There is also the issue of limited capacity out there to offer some of the required services. And sometimes you find that you keep replicating the same people; a group of people registering several companies and yet they are the same people. So one person bids through several companies. You blacklist him this time and next he emerges through another company, and you end up seeing the same faces but with a different company name.”
(Participant 5, page 28)
The hospital managers also cite internal/organisational barriers to outsourcing. These relate to lack of the required infrastructure (e.g. low level of computerisation, financial data management, process standardisation) and the management skills to effectively outsource; 60% of surveyed managers indicated that this applied to them to a great or to some extent. The qualitative data indicates that part of this is explained by lack of internal guidelines on outsourcing. Additionally, given the complexity of outsourcing, some managers indicate that they needed to bring in consultants during the process due to lack of internal capacity. As the managers note:

“The hospital has no (outsourcing) guidelines…and if we decide to go into the process (of outsourcing) then we would need guidelines.”
(Participant 5, page 35)

“We needed consultants to help during the process. With outsourcing once you miss one step, you can cause havoc. So we had to get a consultant to lay for us the ground to do the right things; and to objectively analyse and help with the process.”
(Participant 4, page 24)

7.3.5 Perceived risks of outsourcing

From the surveyed managers perspective, the highest risk to outsourcing is strategic and is related to the fact that outsourcing could lead to regulatory violations (e.g. violation of procurement act, corruption) and creation of legal obligations which may not be favorable to the hospital, with 87% of managers agreeing or strongly agreeing with this. Interestingly about 38% of managers report political interference as one of the challenges encountered during the outsourcing process.

Elaborating on the above, one Manager comments as below:

“One issue is that of influence from other powers…external influence. You don’t know who was awarded because someone may have somebody who is connected but not able to do the work.”
( Participant 1, page 5)
If there is some political influence in the outsourcing process, the service provider selected may be tempted not to provide a quality service. There are common instances like that."

(Participant 1, page 2)

However, it would seem that political interference is more of a problem with outsourcing by MOH hospitals and less for NGO owned hospitals. The quantitative data indicates that hospitals owned by MOH were more likely to report political interference in the outsourcing process compared to NGO hospitals (p= 0.0065).

One manager from an NGO hospital seemed to confirm this with his comment below:

"In our mind we knew we were to give a competent company because we do not have that corruption thing and also beaurocracy was not going to be big."

(Participant 6, page 36)

7.4 DETERMINANTS/FACTORS ASSOCIATED WITH OUTSOURCING BY GENERAL HOSPITALS IN UGANDA

7.4.1 Hospital characteristics and outsourcing

The results indicate that there is a significant difference in the proportion of hospitals outsourcing and those not outsourcing between rural and urban hospitals (p=0.0033). Thus it can be concluded that hospital location has a significant influence on outsourcing.

The above is confirmed by the quote from one of the hospital managers as below:

“Especially for rural areas, it’s not easy to get companies that are serious with what they do. So some hospitals opt to employ their own staff because you don’t get companies that are serious. If you don’t have the right company to do it, rather do it yourself.”

(Participant 2, page 14)
7.4.2 Management perceptions and outsourcing

The quantitative results indicate that there are no significant differences (p>0.05) in the hospital managers perceptions about the benefits of outsourcing, outsourcing risks, characteristics of services that need to be outsourced and outsourcing barriers per outsourcing status (outsourcing or not outsourcing). This leads to the conclusion that the hospital Managers perceptions have no impact on the hospital's outsourcing decision.

As earlier indicated most managers have a favorable attitude towards outsourcing and this is confirmed by both the qualitative and quantitative data.

Manager from non-outsourcing hospital commented positively about outsourcing as below:

"It can improve services in that managers stop concentrating on the small things and begin concentrating on the strategic direction of the hospital. So things like compound cleaning can be outsourced so that managers do need to supervise that directly."

( Participant 6, page 33)

"Also when you outsource, it's easier and you are in a better position to request for better services than when employing your own workers...because if you give a task to a company you set out targets which are much easier to follow up because you are only following up with the manager of the company. But with your workers, when you set targets for 100 people and you are supposed to supervise them every day, that's very difficult."

( Participant 6, page 33)

"It is good to outsource for services...because there are instances when the hospital has not done well because certain things are lacking and they have to look out for them to provide the service."

( Participant 7, page 37)

The above are not different from the positive comments provided by managers whose hospitals were currently as outsourcing.
7.5 ADDITIONAL INSIGHTS GAINED BY COMBINING THE QUALITATIVE AND QUANTITATIVE DATA

One of the advantages of mixed methods study design is that by using both qualitative and quantitative approaches, one approach can help to make up for the weakness of the others approach. In this study for example, the quantitative findings yielded a lot of facts and information regarding outsourcing by hospitals. Most of these were related to the hospital managers’ perceptions and attitudes. However it is difficult to understand these attitudes or opinions without further engaging or probing the managers which is difficult to do in a quantitative approach. The qualitative approach however provided a chance for the managers’ to elaborate or explain their opinions and attitudes. This contributed to a deeper understanding of outsourcing by general hospital in Uganda.

Additionally, the qualitative data provided some additional insights that were not revealed by the quantitative data. For example, the risks related to having external staff of outsourced companies in a hospital setting were particularly insightful. The hospital Managers indicated during qualitative data collection that some of the outsourced staff impersonated and masqueraded as clinicians and extorted money from patients. This is a dangerous situation since it can lead to legal consequences for the hospital and also damage the hospital’s reputation. Also it puts into question the quality of service provided by the hospital since non-qualified people may be involved in diagnosing patients. Unfortunately such instances where non-qualified support staff are involved in diagnosing patients have recently been reported in the local media in Uganda (see http://www.newvision.co.ug/news/676756-minister-decries-absenteeism-as-askaris-diagnose-patients.html).

Another insight provided was the community’s perception of outsourced workers as part of hospital staff. As such their behavior in the community is attributed to the hospital and may damage the reputation of the hospital. This insight can help hospital managers to avoid this by for example having a formal meeting with the community leaders at the inception stage to introduce the outsourced company and its workers emphasising that they are not workers of the hospital but only contractors. Additionally, outsourced workers may have to be identified distinctively either by their uniform or identity tags to create a clear distinction between the hospital staff and outsourced staff.
Also, the qualitative data pointed out a key concern about outsourcing held by NGO hospitals who besides trying to heal the sick also have a social mission of generally improving the welfare of their communities. The hospital managers from these hospitals who were not outsourcing expressed the concern that outsourcing would deny employment to the local community which they see as a key stakeholder of the hospital and one that needs to benefit from the presence of the hospital in the community.

The hospital managers commented as below:

“And if the outsourced company originates far from where the hospital is located, they may not employ locals. And that was one of our issues, because there were locals employed who were receiving salaries every month but not delivering…and their reasoning was that the hospital is theirs and they have to be benefit.”
(Participant 6, page 34)

“And the other thing…when you outsource…are those so called companies going to employ the locals, or are they going to come with their own cleaners. Because if they come with their cleaners and yet we have locals here looking for jobs, that is another issue. Because we have to make sure that the community benefits and is part of service provision and they get something.”
(Participant 7, page 37)

Additional insights provided by the qualitative data point to limited financing as the main barrier to outsourcing. This may not have been apparent from the quantitative data since most of the barriers identified could still be solved but not necessarily lead to outsourcing. This is because there was no differences in perceptions and attitudes regarding barriers to outsourcing among hospital managers from outsourcing and non-outsourcing hospitals.

Confirming financing as the overarching barrier to outsourcing, one hospital manager from a hospital that was currently outsourced commented as below:

“For most hospitals…the challenge is financing. Otherwise each one would like the services. But issue is with budgeting. But for certain services e.g. cleaning,
they need to increase on their budget because it’s important. And cleanliness increases patronage.”
(Participant 8, page 43)

This was re-echoed by a hospital manager from a hospital that is currently not outsourcing. The Manager commented as below:

“The main problem is financial—that is why we cannot out source. The hospital does not have funds…we have a budget but we are only able to realise about 85% of that…so in order to ensure this budget does sufficient work, we have to be efficient. So instead of say employing a company, you employ a few staff and supervise them. You kind of do the donkey work to ensure that they do what the out sourced company would have achieved. But still you don’t achieve the same targets or even the quality is less compared to if you have out sourced.”
(Participant 6, page 34)

7.6 PROPOSED FRAMEWORK AND GUIDELINES FOR OUTSOURCING BY HOSPITALS IN UGANDA

One of the objectives of this study was to develop an outsourcing framework and guidelines for use by hospital managers during the outsourcing process.

Findings from the study indicates that various policy frameworks exist that support outsourcing by hospitals in Uganda. However, there are still gaps in availability of guidance for hospital managers on how to ensure effective outsourcing. The recommendations provided in Chapter 8 provide comprehensive and sufficient guidance for hospital managers who may want to outsource and how to increase effectiveness of their outsourcing.

However, there is need for each hospital to have outsourcing guidelines for their hospital. These should specifically focus on the risk management aspects of outsourcing and should be included within a framework that hospitals can follow during outsourcing. The proposed framework and guidelines are presented in the following sections.
7.7 OUTSOURCING FRAMEWORK

Figure 7.1 provides an overall framework that can be followed by hospitals during their outsourcing. The proposed framework is based on the study findings and literature review is elaborated below.

As the framework shows, findings from the study indicate that at the macro level various policy documents exist that can be leveraged by the hospitals to justify their outsourcing. These include Public Procurement and Disposal act and the MOH public private partnership policy. At the hospital level, however, hospitals may have to ensure that outsourcing is included in their strategic plans to justify outsourcing to their various governing board. Also, resource availability and the hospital’s experience need to be considered as part of evaluating feasibility of outsourcing. At the hospital management level, the hospital manager’s knowledge and opinions regarding outsourcing will have an influence on the outsourcing decision.

According to the proposed framework, once an analysis of the policy, hospital and management level factors described above prove conducive for outsourcing, there will be need for stakeholders to agree on the outsourcing objectives to be pursued. These may include cost reduction and quality improvement among others.

The hospital will then to carry out various analyses including an activity/service importance analysis, internal capability analysis and which will guide selection of an outsourcing strategy.

Based on the above analysis, if outsourcing is found to be appropriate and feasible the hospital can them begin the implementation process which will include development of specification, evaluation criteria, sourcing, evaluation and selection. During implementation the hospital will need to pay special attention to risk and relationship management of the outsourced vendor.

For a successful outsourcing program, the hospital will need to continuously monitor the expected outcomes from outsourcing and to manage the performance of the selected vendor.

The next section presents guidelines to help operationalise the proposed framework described above.
Figure 7.1: Proposed outsourcing framework

### Stage 1
Activity/service importance analysis

### Stage 2
Activity/Service capability analysis

<table>
<thead>
<tr>
<th>Relative capability position</th>
<th>Less capable</th>
<th>More capable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Invest to perform internally or outsource</td>
<td>Q2 Perform internally and develop or outsource</td>
<td>Q3 Outsource</td>
</tr>
</tbody>
</table>

### Stage 3
Select outsourcing strategy

- Importance of process to competitive advantage/hospital mission or performance

### Stage 4
Implement

- Lower cost of service
- Improved quality of service
- Reduction in staff

### Stage 5
Manage risks and relationships

- Risk monitoring and Mitigation
- Conflict resolution
- Joint monitoring team
- Contract administration

**Environmental and policy level:** PPDA Act, MOH PPP Policy

**Hospital level:** Strategic plan, Resource availability, outsourcing experience

**Management level:** Opinions and perceptions about

**Outsourcing objectives:** Cost reduction, quality improvement, capacity enhancement

**Expected outcomes and performance management**

**Outputs**

- Lower cost of service
- Improved quality of service
- Reduction in staff

**Performance Management and Monitoring**

- Service level development
- Key performance indicator development
- Process and work flow mapping
- Cost analysis
- Benchmarking

If outsourcing is appropriate & feasible, implement process: Specification, evaluation criteria, sourcing, evaluation and management level: opinions and perceptions about.
7.8 BACKGROUND AND RATIONALE FOR OUTSOURCING GUIDELINES

Results from this study indicate that outsourcing of support services by general hospitals is relatively widespread. Currently, hospitals report outsourcing cleaning services, security services, IT and catering services. Even among those not outsourcing, the managers report that they intend to outsource one or two support services in the future.

Results of the study recognise that outsourcing can create benefits to the general hospital in terms of improved quality of services at a lower cost in addition to innovation and access to improved technology and practices from the outsourced companies. Additionally, outsourcing enables the hospital to focus on its core mandate of clinical service delivery.

The study also recognises that a number of hospitals conduct some kind of evaluation before outsourcing including a financial analysis and importance of the activity to hospital performance. However, there is limited market analysis to determine availability of vendors prior to commencing the outsourcing process. Also, the hospitals conduct some monitoring of outsourced services including monitoring of vendor performance through a variety of mechanisms like workarounds and joint meetings. Finally, the study also recognises certain risks and disadvantages to the general hospitals as a result of outsourcing. These include: increase in costs, poor vendor performance, and damage to the hospital's reputation.

These guidelines basing on the findings of this study and building on the recommendations earlier provided are intended to guide hospitals in their outsourcing and to increase effectiveness of their outsourcing. However, the guidelines will need testing in practice and should be the focus of further discussions with hospital managers so as to be implemented in practice.
7.9 OBJECTIVES OF THE OUTSOURCING GUIDELINES

The overall objective of these guidelines is to promote outsourcing where feasible and appropriate as a means of improving hospital performance and to ensure that the outsourcing process is effectively carried out and results into benefits for both the hospital and the outsourced vendor.

The specific objectives of the guidelines are to:

- Provide a framework which guides hospitals in all outsourcing arrangements.
- Promote effective and thorough pre-sourcing evaluation as a basis for ensuring sound decision making by the hospital and as a way of ensuring value for money from outsourced services.
- Promote sound risk management practices that ensure maximum benefits for all parties involved in the outsourcing relations.
- Set out in broad terms what the hospital and outsourced vendors should expect from each other in terms of prudent and best business practices.
- Promote effective monitoring and contract relationship management between the hospital and outsourced service providers.

7.10 ASSESSMENT OF OUTSOURCING ARRANGEMENTS

Every hospital should assess if an outsourcing arrangement that is in existence or being contemplated involves a service that is critical or core to the hospital's mandate of offering health care to its clients.

Ideally as a starting point, the hospital should outsource services that are not core to its mandate and for whom a sufficient number of providers exist to ensure good prices. As a guide, general such non-core or non-critical activities would include support services like cleaning, laundry and security.
Factors to be considered when making this assessment will include:

- The financial and reputation impact (in terms of the hospital’s quality of care) of a failure of the outsourcing service provider to perform over a given period of time.
- The cost of the outsourcing arrangement as a share of total costs or budget of the hospital.
- The degree of difficulty, including the time taken, to find an outsourcing service provider on the market.

### 7.11 OUTSOURCING POLICY

The hospital should have a general policy on its approach to all aspects of outsourcing. To be effective, the policy must be communicated in a timely manner to all necessary stakeholders and should be implemented through all relevant levels of the hospital and be revised periodically in light of changing circumstances and applicable laws.

Bearing in mind that no outsourcing is risk free, the outsourcing policy should therefore at a minimum:

- Cover the mechanism for appropriate monitoring and assessment of the outsourcing service provider by the hospital.
- Specify an internal unit or individual responsible for supervising and managing each outsourcing.
- Specify conflict resolution and mitigation strategies in case of dispute between the hospital and outsourced vendor.
- The main phases in the outsourcing including:
  - The decision to or not to outsource or change an existing outsourcing (the decision-making phase) emphasising use of internal hospital data to make the decision, set benchmark process and negotiate contracts.
  - Initial and periodic due diligence on the outsourcing service provider.
  - A well-defined vendor acquisition process with evaluation components such as terms of reference document, specification of requirements and evaluation of proposals.
Drafting a written outsourcing contract and service level agreement (the contract-drafting phase).

The implementation, monitoring and maintenance of an outsourcing arrangement (the contract phase).

Dealing with the expected or unexpected termination of a contract and other service interruptions (the post-contract phase).

- Cover the hospital’s plan and implementation arrangements to maintain the continuity of the services in the event that the provision of services by an outsourced service provider fails or deteriorates to an unacceptable degree, or the outsourcing institution experiences other changes or problems.

- Include some form of contingency planning and the establishment of a clearly defined exit strategy in case of failure of the outsourcing.

- Require the hospital to manage the risks associated with its outsourcing arrangements. Such risks include loss of operational control, service provider failure, and breach in privacy and security of the hospital due to presence of outsourced workers, and failure to meet regulatory requirements.

**7.12 OUTSOURCING CONTRACTS**

All outsourcing arrangements should be subject to a written contract and conducted within the existing national legal framework e.g. the Public Procurement and Disposal Act (for MOH hospitals) or applicable institutional procurement guidelines (for NGO hospitals).

The contract should be reviewed by the hospital's legal counsel to ensure that it is legally enforceable and that it reasonably protects the hospital from risk.

The outsourcing hospital should ensure that the written outsourcing contracts contain, among others, provisions pertaining to:

- the operational area or activity that needs an outsourced service
- service levels and performance requirements
- service quality audit and monitoring procedures
- service continuity plans in the event of service disruption
• where appropriate, insurance to be maintained by the outsourced service providers
• process for onboarding the outsourced vendor and the transition period if applicable
• notification requirements and approval rights for any material changes to services, systems, controls, key project personnel including change to the service provider’s significant sub-contractors if any
• default arrangements and termination rights for a variety of conditions including change in control, convenience, substantial increase in cost and insolvency
• price or fee structure, duration and the mode of payment
• dispute resolution arrangements which attempt to resolve problems in an expeditious manner as well as provision for continuation of services during the dispute resolution period
• liability and indemnity for misconduct by the vendor or their assigned staff
• confidentiality and security of information of both the hospital and its clients
• prohibition of assignment of the contract to a third party without the hospital’s prior consent
• where appropriate training of outsourcing institution staff
• review of the outsourcing service provider standards, policies, and procedures relating to the outsourced service to ensure that they meet the hospital’s minimum standards
• the hospital’s right to access at any time records and any information related to the provided service, any report or any results of audits and performance reviews on the service provider and any sub-contractor that the service provider may use
7.13 INTERNAL DUTIES AND RESPONSIBILITIES REGARDING OUTSOURCING

Each hospital is responsible for the operations of the outsourced activities. Given the strategic nature of outsourcing, and associated risks, the ultimate responsibility for proper management of the risks associated with outsourcing, lies with the hospital’s board and senior management.

The hospital board should:

- review and approve outsourcing policy and the risk-management policies for outsourcing as recommended by management
- review periodically, but at least annually, management reports demonstrating compliance with the approved risk-management policies for outsourcing
- approve any outsourcing arrangement that exceeds the level of authority delegated to management
- review periodically the content and frequency of management's outsourcing reports
- ensure that person(s) responsible for administering the risk management policies for outsourcing possess the quality and competency required
- ensure that there are regular audits and reviews to assess whether or not the risk-management policies and procedures for outsourcing are being followed and to confirm that sufficient risk management processes for outsourcing are in place
- ensure that there are regular reviews of the hospitals operations to assess the continued need and feasibility of outsourcing

In relation to outsourcing, management of each outsourcing hospital should:

- develop a risk-management programme for outsourcing that reflects the hospital’s outsourcing policies and recommending it for approval by the board
- establish procedures adequate to the operation and monitoring of the risk-management programme, which provide for an assessment of all outsourcing arrangements including an evaluation of the service provider’s performance
- implement the risk-management and monitoring programme for outsourcing
• carry out periodic internal self-assessment to test the effectiveness of the outsourcing programme
• manage and control outsourcing risk within the risk-management programme
• develop and implement appropriate reporting systems to permit the effective management and control of existing and potential outsourcing risk exposure
• develop lines of communication to ensure timely dissemination of outsourcing policies and procedures and other relevant outsourcing information to all individuals involved in the process
• report to the hospital board, or to a committee of the board, on the operation and effectiveness of the programme

7.14 CONCLUSION

In this chapter, the quantitative and qualitative data and findings from the two phases of the study have been integrated. The integration approach applied is iterative emphasising the connection between the findings from the two phases. The qualitative data has been used to explain, elaborate or expand on or complement the quantitative findings as appropriate.

The integration enabled the researcher to develop a more complete picture of outsourcing by general hospitals in Uganda by presenting two complementary sets of results, identify divergence (e.g. between the opinions or practices of NGO hospitals and MOH hospitals) and complementary perspectives across the quantitative and qualitative methods. Also use of the two approaches (qualitative and quantitative) helped cover up for the shortcomings of each approach. Some insights provided by the qualitative approach which were not apparent from the quantitative data are indicated further highlighting the advantages of the mixed methods study design.

Finally, the chapter also contains a proposed outsourcing framework and guidelines for increasing adoption and effectiveness of outsourcing by hospitals. The framework and guidelines are based on the findings from both the qualitative and quantitative phases of the study including best practices observed, gaps identified in current outsourcing by hospitals and suggestions or advice provided by key informants interviewed during the qualitative data collection.
The next chapter presents the conclusions, limitations and recommendations of the study. Specifically it suggests activities and interventions that can be implemented to increase adoption and also ensure successful outsourcing by hospitals based on the evidence from the findings of the study.
CHAPTER 8

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

8.1 INTRODUCTION

This chapter presents a summary of the key findings, implications of the findings, limitations, and conclusions of the study. Also presented are recommendations for encouraging and improving effectiveness of outsourcing by general hospitals in Uganda. Specifically, proposed guidelines for improving effectiveness of outsourcing by general hospitals in Uganda arising from the findings of this study are outlined.

8.2 AIM AND OBJECTIVES OF THE STUDY

This study addresses the practices, motivations, perceived benefits/advantages and barriers/disadvantages to outsourcing by hospitals in Uganda. The aim is to increase adoption and or effectiveness of outsourcing by hospitals where appropriate and feasible as a strategic management tool for improving hospital performance in Uganda.

The objectives of this research were to:

- Describe the current outsourcing practices and processes by general hospitals in Uganda.
- Identify perceived benefits or advantages and drawbacks or disadvantages of outsourcing by general hospital managers in Uganda.
- Identify determinants and factors associated with outsourcing by general hospitals in Uganda.
- Conduct a cost benefit analysis of an outsourced service in one of the study hospitals.
- Identify interventions to increase adoption and effectiveness of outsourcing by hospitals in Uganda where appropriate and feasible.
- Develop an outsourcing framework and guidelines for use by hospital managers during the outsourcing process.
8.3 RESEARCH DESIGN AND METHODOLOGY

The study was a mixed methods study using both quantitative and qualitative approaches. Specifically, the study used an explanatory sequential design in which quantitative and qualitative methods were implemented sequentially starting with the quantitative phase (QUAN → Qual) which was the priority phase.

During the quantitative phase, survey data was collected using a self-administered questionnaire from hospital managers from 32 randomly selected general hospitals. During the follow on qualitative phase, data was collected from 8 purposively selected hospital managers who had participated in the quantitative phase and had expressed willingness to participate in the follow on phase. In-depth individual interviews using an interview guide were used to collect the qualitative data.

Statistical analysis was conducted for the quantitative data using SAS version 13. Atlas ti version 7 was used to organise and manage the qualitative data. Content analysis was done to explore in detail for common themes from the qualitative data. Emerging themes and subthemes were then identified. Subsequently, the categories for each subtheme were identified basing on the earlier developed codes. The quantitative and qualitative data were integrated using an iterative approach that emphasised the connection between the findings from the two phases. Specifically, the qualitative data was used to explain, elaborate or expand on or complement the quantitative findings as appropriate.

8.4 STUDY CONCLUSIONS

The findings from the quantitative and qualitative phases are summarised below according to the study objectives.

8.4.1 Current outsourcing practices and processes by general hospitals in Uganda

The quantitative and qualitative findings indicate that Outsourcing by general hospitals is relatively widespread with 72% of the hospitals surveyed in the quantitative phase
reporting to be outsourcing at least one or more of their support services. Cleaning services are the most frequently outsourced services (78 %) because as indicated in the qualitative data collection, managers consider a clean environment for staff and clients as being critical for improving hospital performance. Even among those who are currently not outsourcing, slightly more than half (56%) of the hospital managers indicated that their hospitals intend to outsource one of more hospital support services in the near future with the likely services to be outsourced in the future being cleaning and security services (80%).

Most managers are driven to outsource mainly in order to improve quality of their services by tapping into the expertise and capacity of the outsourced companies (68% of hospitals). The most frequently reported reason for outsourcing was to gain quality service from another firm’s expertise (68%). Most hospitals reported being satisfied with their outsourcing services, with at least 60% of hospital manager managers reporting that they were strongly satisfied or satisfied with their outsourced service. The most frequently reported reason for satisfaction was that the anticipated improvement in quality of the outsourced service had been realised (87% of managers).

Most of the hospital managers try to approach the outsourcing decision rationally. Before deciding to outsource, majority of hospital managers surveyed (73%) report to have conducted an internal analysis of the relative capability of the hospital to provide the service vs outside suppliers (75%). However there is little external market analysis conducted. Not surprisingly, the surveyed managers report that during the outsourcing process, the most frequently encountered challenge was the limited number of service providers (57% of managers) especially in the rural areas.

Additionally, most managers try to follow due process during the contracting process as laid down by the Public Procurement and Disposal Act. The most frequently used method for identifying and selecting a vendor for the outsourced service is through open domestic bidding, with 60% of hospital managers reporting to have used this method.

Most hospital managers have built in some monitoring mechanisms in their outsourcing. However there is room for improving the quality of this monitoring by increasing the aspects being monitored beyond vendor performance. Majority of the surveyed hospitals that were outsourcing (71%) reported having in place systems to continuously
monitor the outsourcing program. Majority of the hospital managers (87%) reported to be monitoring supplier performance.

Outsourcing is viewed by most hospital managers as a strategic approach to improving hospital performance. A large proportion of hospitals with a strategic plan indicate that their strategic plan includes outsourcing (72%). Additionally, during the outsourcing process, a number of high level stakeholders including hospital management and the board are involved in the process thus highlighting the strategic importance placed on outsourcing by the hospitals.

8.4.2 Perceived benefits/advantages and drawbacks/disadvantages of outsourcing by general hospital managers in Uganda

Most of the hospital managers perceive outsourcing to be a double edged sword with both advantages and disadvantages. Majority of the surveyed managers (94%) strongly agreed or agreed with the statement that outsourcing is one approach that can be used by hospital management to improve hospital performance. Generally, the hospital managers strongly agree or agree with the various documented benefits of outsourcing (cost management, greater focus for management, flexibility and access to external expertise/investment or innovation), with at least 79% of the managers agreeing or strongly agreeing with the each of the indicated benefits.

The biggest reported barrier to outsourcing is external with more than half of the hospital managers (69%) indicated that to a great or to some extent, absence of a matured vendor market reflected by non-availability of quality outsourcing vendors makes it difficult for the hospital to outsource. The biggest reported risk to outsourcing by the managers is strategic and is related to the fact that outsourcing could lead to regulatory violations (e.g. violation of procurement act, corruption) and creation of legal obligations which may not be favorable to the hospital, with 87% of managers agreeing or strongly agreeing with this. The managers indicate that political interference in the outsourcing process is widespread particularly among MOH hospitals.
8.4.3 Determinants and factors influencing outsourcing decisions by general hospital managers in Uganda

Regarding hospital characteristics and their impact on outsourcing, results indicate that hospital location has a significant influence on outsourcing. This may be related to availability of vendors, with rural areas being specifically challenged. Rural hospitals were more likely to report challenges with the available number of suppliers during the outsourcing process compared to their urban counterparts ($p=0.0152$).

However, hospital managers perceptions about benefits of outsourcing, outsourcing risks, characteristics of services that need to be outsourced and outsourcing barriers have no impact on the hospital's outsourcing decision. This can be attributed to the fact that most managers already have a favorable attitude towards outsourcing.

8.4.4 Cost benefit analysis of an outsourced service in one of the study hospitals

For most hospitals, the decision to outsource is premised on the assumption that outsourcing will provide better quality services at a cheaper cost. However, this is usually based on intuition. To test that premise, a cost benefit analysis was conducted for cleaning services in one of the hospitals. Though the results of this study show that to be true for Hospital A, the difference was minimal. A quick comparison of the costs of outsourcing and insourcing cleaning services at Hospital shows that the annual cost of the outsourcing contract (UGX 48,000,000) is approximately 669,575.00 less than the annual cost of insourcing (UGX 48,669,575.00). Once service quality is accounted for, the economic benefits of outsourcing become even greater. For successful outsourcing hospital managers should collect more-detailed information on the costs of providing nonclinical services in-house, and more information on the monetary value of increased quality of outsourced services. This information will allow hospital managers to conduct rigorous cost-benefit analyses of outsourcing cleaning and other services in their own context.
8.4.5 Summary of conclusions

Generally, the top five conclusions that can be drawn from this study are as below:

A number of hospital managers have a favorable attitude towards outsourcing and recognise its importance in increasing hospital performance. Thus, a number of hospital managers are currently outsourcing one or two support services and are generally satisfied with the outsourcing. Their main motivation for outsourcing is to improve quality and reduce cost of the outsourced services. About half of managers currently not outsource report that they intend to outsource one or more services in the future.

Besides the advantages and benefits of outsourcing, the hospital managers also recognise a number of risks and disadvantages of outsourcing. Some of the risks relate to political interference in the outsourcing process, unmet vendor expectations and inability by the hospital to achieve the intended goals of outsourcing, for example through increased cost of the outsourced service. The managers also recognise a number of risks associated with having outsiders (outsourced workers) in the hospital environment whom the public perceives to be part of the hospital. These risks specifically include impersonation and extortion by outsourced workers in addition to theft of hospital property.

From the hospital managers’ perspective, the main barrier to outsourcing by general hospitals in Uganda is lack of funding due to limited budget or cash flows constraints. Faced with these constraints, hospital managers perceive outsourcing to be expensive or not justifiable given their scope of operations. However, the cost benefit analysis conducted for one hospital indicates that this may not be true as the results indicated that for the studied hospital outsourcing was slightly cheaper than insourcing, and even become cheaper once the costs for outsourcing and insourcing were adjusted for quality of service.

Most of the general hospitals have considered outsourcing at some point. And before deciding to outsource or not, some analysis has been carried out including a cost benefit analysis. However, most of the analysis conducted has been rudimentary and not considered all the costs of providing the service in-house and also not taken into consideration quality aspects. It is thus likely that outsourcing has been ruled out even if
it would have been the ideal option. Also, for those who eventually outsource, lack of detailed cost information for their in-house provision of the service means that they don’t have a benchmark cost that they can use during negotiations with potential vendors. Also limited external analysis is conducted for example market analysis to determine availability of service providers and to refine the hospital’s outsourcing and vendor management and relationship strategy. Limited availability of qualified service providers is the most frequently encountered challenge by hospitals during the outsourcing process.

There exists a government legal and regulatory framework in form of the Public Procurement and Disposal authority to guide the contracting process during outsourcing. Also the MOH policy on private public partnership provides a broad framework that the hospitals can use to outsource. However, there is lack of guidance to the hospitals on how to conduct the pre-sourcing analysis and how to monitor and oversee the outsourcing in order to ensure effectiveness.

8.5 LIMITATIONS OF THE STUDY

This mixed methods study was quite comprehensive and covered various aspects of outsourcing by hospital in Uganda. However, the study had some limitations that may affect generalisation of the study results. An overall limitation is that the study focused on government/MOH and NGO/private not for profit hospitals and did not include the private for profit hospitals. These are likely to be outsourcing and would have shared perhaps a different perspective. Also the study only focused on outsourcing of support services. This limits the generalisation of findings to hospitals support services and to only MOH and NGO hospitals.

The other study limitations are listed below per phase or aspect of the study.

8.5.1 Limitations of the quantitative study phase

A key limitation of the quantitative phase of the study was the small sample size used. As earlier indicated for a population size of 92 hospitals, the ideal sample size was calculated to be 47. However, given the enormous cost of collecting data from 47 hospitals all over the country, a sample size of 32 was eventually decided upon. This is
the minimum required sample size for any meaningful statistical analysis. However due to response rates and completeness for some analyses the sample size was less than 32.

Data from the hospital managers was obtained using highly structured questionnaire based on 5-point Likert scale which was self-administered, so, it was not possible to probe the responses given by the participants. However follow up was conducted with some of the managers during the qualitative phase of the study which provided an opportunity for more in-depth exploration and probing. However, the sample size for the follow on study was also limited as only 8 managers were followed up.

8.5.2 Limitations of the cost benefit analysis

The cost benefit analysis attempted to quantify and cost the benefits of outsourcing and insourcing and to compare the two. The quantification of the benefits of outsourcing is highly dependent on the results of the services quality mini-survey of the various hospital Managers which reported a 77% observed increase in quality of cleaning services after outsourcing (from 4.8 out of 10 before the implementation of outsourcing, to 8.5 out of 10 after the implementation of outsourcing). These are very subjective and have no real scientific basis. It would have been desirable to survey other hospital staff e.g. nurses to verify the manager’s responses and further inform the analysis.

Despite this limitation, it is likely that the management team's assessment of the differences in quality of cleaning services during insourcing and outsourcing is accurate because the management team surveyed is in a good position to assess all aspects of the outsourcing experience, including negotiating with the vendor, monitoring the cleanliness of all areas of the hospital, and monitoring the incidence of hospital-acquired infections.

8.5.3 Limitations of the qualitative phase

The qualitative data was collected from hospital managers who expressed readiness to be interviewed in the second phase of the study. Some of the managers indicted during the first (quantitative) phase of the study they were not willing to participate in the second (qualitative) phase. It cannot be assumed that the responses of the managers
who agreed to participate in the second phase are essentially the same as those
managers who declined the follow on interview.

For a more comprehensive picture it would have been desirable to interview some of
the hospital vendors, patients and policy makers as general informants to triangulate
some of the information provided by the interviewed hospital managers. However, this
was beyond the scope of the study.

Despite all the above limitations, the study findings are reliable, valid and trustworthy.
The use of quantitative and qualitative data collection and analysis methods increased
the validity, reliability and trustworthiness of the study results.

8.6 RECOMMENDATIONS FROM THE STUDY

One of the objectives of this study was to identify interventions to increase adoption of
outsourcing by hospitals in Uganda where appropriate and feasible as part of strategic
management, based on an evaluation of the advantages and disadvantages of
outsourcing. This section provides such recommendations based on the research
findings. Besides recommendations to improve adoption of outsourcing, the section also
provides recommendations to improve effectiveness of current or future outsourcing
endeavors.

The recommendations cover several areas including: recommendations to increase
adoption of outsourcing, recommendations on vendor relationship management,
recommendations on outsourcing monitoring and reporting, Capacity building for
hospital Managers, Financing and Budgetary Considerations, Contract Management,
Lack of Private Providers, and Vendor Inexperience and Strengthening Hospital-Vendor
Relationships

Based on the findings of this study, it is recommended that:

- Opportunities should be created for information sharing and sharing of
  experiences between managers from outsourcing and insourcing hospitals. This
  will enable the insourcing managers to learn by example and to adapt any
  lessons learned to their local context.
- Government should ensure adequate financing for hospitals in Uganda. Additionally, hospital management should ensure that adequate budget provision is made for support services.

- Hospital Management should negotiate and establish service level agreements (SLAs) with the vendor as part of the outsourcing process. Additionally, the hospital’s ability to manage outsourcing contracts containing service level agreements should be strengthened.

- The relationship between that of the vendor and company should be of a true partnership between the hospitals and the vendor.

- Outsourcing monitoring and reporting should also be built in the contract. Routine monitoring should be collaborative between the hospital management and vendor.

- The hospital management should establish and maintain a collaborative relationship with the vendor. The outsourcing relationship should not be one of a supplier mentality, but rather a partner mentality. The vendors contract manager is most successful when (s)he is seen as an equal and participating member of the hospital’s management team.

- Deliberate attempts should be made by hospital management to establish a cordial relationship with management of the outsourced company. This will help ease some of the tensions and potential conflicts in addition to creating good will among both parties.

- Capacity building should be provided for hospital managers in assessing the need and feasibility of outsourcing in their hospitals in addition to negotiating and managing outsourcing contracts.

- Hospitals should proactively assist in capacity development of fledgling service providers.

A number of recommendations also arise from the cost benefit analysis. These recommendations are as below:

- During the cost benefit analysis as part of pre-outsourcing evaluation, hospital managers also need to consider the costs above and beyond the contract cost that they will continue to incur after switching to outsourcing.
- Hospitals should reassess the costs and benefits of outsourcing periodically, as they are likely to improve as vendors and hospital managers gain experience with the outsourcing process.
- Hospitals may improve their ability to negotiate lower prices, and could get better deals as they develop long-term, trusting relationships with vendors.

Table 8.1 presents the various recommendations, the research findings supporting those recommendations and indicative interventions or activities for the proposed recommendations.
Table 8.1: Recommendations, supporting findings and proposed interventions

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities should be created for information sharing and sharing of</td>
<td>Majority of the surveyed managers (90%) strongly agreed or agreed that they knew at least one hospital that is currently</td>
<td>• Encourage study tours by non-outsourcing hospitals to hospitals that are currently outsourcing.</td>
</tr>
<tr>
<td>experiences between managers from outsourcing and insourcing hospitals. This</td>
<td>outsourcing one or more of the support services it requires.</td>
<td>• Establish mechanisms for hospital managers to share experiences regarding outsourcing e.g. a hospital managers</td>
</tr>
<tr>
<td>will enable the insourcing managers to learn by example and to adapt any</td>
<td>During outsourcing, the most frequently encountered challenge was the limited number of service providers (57% of managers).</td>
<td>bulletin or peer review meetings.</td>
</tr>
<tr>
<td>lessons learned to their local context.</td>
<td>“It would be good if we are able to visit a hospital that is outsourcing...to see how they are doing it and how feasible it is...and then give it a try.” (Insourcing hospital manager)</td>
<td>• Develop outsourcing guidelines for use by hospital managers who wish to outsource (should include pre-sourcing evaluation and monitoring including check lists).</td>
</tr>
<tr>
<td></td>
<td>“The hospital has no (outsourcing) guidelines .....so if we decide to go into the process (of outsourcing) then we would need guidelines.” (Insourcing manager)</td>
<td>• Create a data base of suppliers of various hospital support services with information on capacity and past performance.</td>
</tr>
<tr>
<td></td>
<td>“We did not have guidelines that is why we had to invite consultants.”</td>
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</tbody>
</table>
## Financing and budgetary considerations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government should ensure adequate financing for hospitals in Uganda. Additionally, hospital management should ensure that adequate budget provision is made for support services.</td>
<td>“For most hospitals....the challenge is financing. Otherwise each one would like the services. But issue is with budgeting. But for certain services e.g. cleaning, they need to increase on their budget because it's important. “</td>
<td>• Ensure adequate funding for hospitals to ensure availability of the required funds for the hospital to outsource if appropriate and feasible.</td>
</tr>
<tr>
<td></td>
<td>“Sometimes the funds come late, and these people say unless we are paid, we are not going to work. So sometimes we may go half a month when these people are not doing the work as expected.”</td>
<td>• Ensure timely release of funds to hospitals to enable them meet their funding obligations arising from the contract with the vendor.</td>
</tr>
<tr>
<td>Only 40% of managers report employing benchmarking of their out sourced service quality and cost with the best or other hospitals in the country.</td>
<td>Tracking of costs of outsourcing services not conducted by 33% of managers.</td>
<td>• Hospital managers also need to consider the costs above and beyond the contract cost that they will continue to incur after switching to outsourcing.</td>
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<tr>
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<td>• Closer collaboration between hospitals and vendors through sharing information, joint monitoring of quality, and joint training could lower the costs and increase the benefits of outsourcing for hospital management.</td>
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<tr>
<td></td>
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<td>• Hospitals should reassess the costs and benefits of outsourcing periodically, as they are likely to improve as vendors and hospital managers gain experience with the outsourcing process.</td>
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<tr>
<td></td>
<td></td>
<td>• Hospitals should improve their ability to negotiate lower prices, and could get better deals as they develop long-term, trusting relationships with vendors.</td>
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</table>
### Service level agreements (SLA) as basis of the outsourcing contract

<table>
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<tr>
<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
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</thead>
<tbody>
<tr>
<td>A general service contract requires a good faith effort on the part of both entities. Thus, hospital Management should negotiate and establish service level agreements (SLAs) with the vendor as part of the outsourcing process.</td>
<td>&quot;We told him, you were not performing but we have not terminated you; we have just suspended you and as per our contract with you...we have a right to. But we can assure you that we can deal with you if you abide with our rules and improve performance.&quot;</td>
<td>• An SLA should be an integral component of the contract providing the details needed for all parties to understand specific requirements and standards and monitor compliance with those standards.</td>
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<td></td>
<td>&quot;Before we pay for the services at end of month, they (monitoring team) comply a report, a summary of their evaluation of the vendors’ performance for a month. It’s on the basis of their recommendation that we pay.&quot;</td>
<td>• The SLA should allow the hospital considerable leverage and flexibility to address and correct vendor performance issues, short of complete contract. Under the SLA approach, hospitals may create and refine a point-based performance system to encourage/enforce the level of performance desired.</td>
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<tr>
<td></td>
<td>&quot;These people (outsourced workers) have someone who is always supervising them...their person. Then we have our monitor also. Ours is independent.&quot;</td>
<td>• The SLA should be as detailed as possible and should include sufficient service information that the vendor clearly understands the hospital’s expectations (i.e., what constitutes “good performance”).</td>
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<td></td>
<td>&quot;We also have regular dialogues and meetings with them (outsourced company). We actually hold monthly meetings with them and when we have our general staff meetings we have invited their management so we are able to identify and address issues.&quot;</td>
<td>• There should be sufficient monitoring of the SLA by the vendor and hospital. A breach in the management cycle of the SLA effectively compromises the entire system. Without sufficient monitoring and good reporting, performance issues cannot be identified and addressed.</td>
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<tr>
<td></td>
<td>Majority of the hospital managers (87%) reported to be monitoring supplier performance. The most frequently utilised monitoring strategy was regular meetings with the supplier to review performance (93%)</td>
<td>• Hospital management should allocate sufficient time to manage the contract.</td>
</tr>
</tbody>
</table>
"You measure performance to determine the amount, and only pay them (outsourced vendor) when they have done satisfactory work."

"The difficulty we face is that of expectations. People may think they are going to get a lot of money. So when they bid, they can under quote. Because they want to win the contract. And when they get the award, some realize that the scope of work is so much and that becomes a challenge."

Contract monitoring should be rigorous and routine.
- Regular meetings should be scheduled with outsourced vendors to regularly review and evaluate performance.
- Hospital management need to make scheduled and nonscheduled inspections.
### Contract Management

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<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
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<tbody>
<tr>
<td>The relationship between that of the vendor and company should be of a true partnership between the hospitals and the vendor.</td>
<td>“So losing control over the staff doing the work is one of the disadvantage.” “Another risk is the duration we offer for the contract. Currently its three years with one year rolling. So if the contractor is not good…you have to wait for a long period.” “These people (outsourced workers) have someone who is always supervising them…their person. Then we have our monitor also. Ours is independent.” “We had a service provider come on ground before the contact was finalised. So when it came to payment, and depending on the contact, we had to forward it by one week. And when it came to payment we had to prorate and yet he had raised a claim for one month. So we had a little bit of conflict.”</td>
<td>• Key performance indicators should be developed and included in the contract. • Hospital managers should be re-oriented to their new role of managing the contract, not the contractor’s staff. • The service provider should monitor the day-to-day performance of its line workers, and the hospital monitors the key performance indicators to measure overall compliance and assure quality. • There should be sufficient planning and monitoring of the mobilisation phase on both the part of the hospital and vendor. This phase is critical to ensuring a smooth and safe transition • The contract should be regularly re-bid to ensure that the hospital continues to pay a fair price for the service and is not missing the opportunity to introduce new technology or methodologies.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Research findings supporting recommendation</td>
<td>Indicative interventions or activities</td>
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<tr>
<td>Outsourcing monitoring and reporting should also be built in the contract. Routine monitoring should be collaborative between the hospital management and vendor.</td>
<td>29% of outsourcing hospitals did not have in place systems to continuously monitor the outsourcing program. “Although sometimes it can be difficult, but you need to monitor. You don’t just outsource something and you don’t monitor performance. You want to see that the work is being done.” “On a few occasions we have given contracts to providers and they don’t measure up; they say they will put 30 people on the job as required, but three months later they only have 25 and later 15.”</td>
<td>• Institute a mechanism for systematic monitoring by the hospital of contractor staffing levels, attrition rates, and shift coverage. • Institute a mechanism for vendors to regularly report to hospital management stock room inventory levels for required supplies, stock-out emergencies, or stock substitutions that needed hospital approval. • The hospital administrator/management and contractor need to conduct a joint annual performance reviews of the outsourced service and should include service beneficiaries/users.</td>
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</table>
## Strengthening relationship management on both the side of the hospital and the vendor

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<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
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<tr>
<td>The hospital management should establish and maintain a collaborative relationship with the vendor. The outsourcing relationship should not be one of a supplier mentality, but rather a partner mentality. The vendors contract manager is most successful when (s)he is seen as an equal and participating member of the hospital’s management team.</td>
<td>“We have customer care assistant who moves around the wards daily, they pass through to check if hygiene is good. They bring feedback which is fed to the Quality Assurance (QA) committee every month. Then the hospital administrator and myself pass around...may be twice a week to check.”</td>
<td>• Establish systematic, scheduled communication with vendor site managers to jointly review management reports on staffing, inventory, incidents, quality monitoring, and budget performance.</td>
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<td>“We also have regular dialogues and meetings with them (outsourced company). We actually hold monthly meetings with them and when we have our general staff meetings we have invited their management so we are able to identify and address issues.”</td>
<td>• Educate Hospital contract managers on their role as monitors of contract performance, not supervisors of vendor staff.</td>
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<td></td>
<td>“These people (outsourced workers) have someone who is always supervising them...their person. Then we have our monitor also. Ours is independent.”</td>
<td>• Ensure that each party plays their role, specifically that hospital fulfils its responsibility outside the purview of the service provider (eg provision of utilities-water, electricity) as this may have negative impact on the vendor ability to perform their work.</td>
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<td>• Special attention should be paid by both parties to relationship management through identification and designation of experienced client managers on both sides. The relationship between the hospital and the vendor/service provider is complex, and will always involve a degree of tension based on inherent differences in goals. This complexity requires a level of management sophistication on the part of both the hospital and the vendor.</td>
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Establishing a cordial relationship between the vendor and the hospital management

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<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
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<tbody>
<tr>
<td>Deliberate attempts should be made by hospital management to establish a cordial relationship with management of the outsourced company. This will help ease some of the tensions and potential conflicts in addition to creating good will among both parties.</td>
<td>“They contribute to our infection prevention program. They even help train our domestic cleaners on infection prevention.” “Sometimes the image of the institution comes into question...and you have to answer sometimes what you are not responsible for. Like when a worker of an outsourced company steals, the community knows that whoever is in hospital is a doctors. So it puts our institutions reputation at stake. People see the outsourced workers as part of you, representing you and yet you cannot reprimand them.” “The other risk is the low motivation of the workers. Sometimes we pay the company, but they don’t pay the workers. We have even had instances where the awarded company sells the contract to another and the workers of the old company end up being stranded.” “There are some things in hospital cleaning that need a bit of training. How to handle infectious waste, how to handle body fluids etc. For you to get a company that has worked in a hospital before is very difficult in a rural setting. May be in the city. So we got</td>
<td>• Channels and modes of communication should be clarified so both sides understand them. • Vendors’ site managers should be provided opportunities to serve on relevant hospital committees e.g. infectious disease control. • Develop monitoring tools together so both sides understand their purpose and application; conduct audits in a highly professional manner to focus on performance improvement; review reports together to identify problems and determine how to resolve (collaborative approach). • Conduct an orientation for the vendor at the very start of the contract; this should help the vendor better understand the mission and organisation of the hospital and the uniqueness of the hospital environment; the orientation should also serve as a way for the vendor to introduce itself to all hospital staff and community so everyone knows who’s who. • Hospital management should provide training to the vendor in infection control and other risk areas to avoid critical</td>
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</tbody>
</table>
someone who we thought would learn than we promised ourselves to train them.”

“Government does not release money frequently....like now we are in the second quarter of the financial year and there is no money.”

- Mistakes and to help the vendor understand the rationale for hospital protocols and how the vendor’s procedures must respect these.
- Hospital should continue to provide periodic in-service training, particularly for vendors who have little or no prior experience working with hospitals.
- Hospital should consider providing medical exams free to the vendor (as a good faith concession) and look for other ways to reach out with support, e.g., office space that could be provided at a minimal cost to the hospital. This will encourage the vendor to reciprocate in future situations when the hospital may need concessions from the vendor.
- Hospital Management should treat contractors with respect and not get into their operational issues unless there are signs of serious problems.
- The hospital should get agreement with the contractor on a clear and realistic payment timeline (based on the hospital’s actual circumstances) and stick to it.
<table>
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<th>Recommendations</th>
<th>Research findings supporting recommendation</th>
<th>Indicative interventions or activities</th>
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<tr>
<td>Capacity building should be provided for Hospital Managers in assessing the need and feasibility of outsourcing in their hospitals in addition to negotiating and managing outsourcing contracts</td>
<td>“They would need consultants to help during the process. With outsourcing once you miss one step, you can cause havoc.” “They should be able to engage people who are knowledgeable of the current regulation because you can end up in a mess. The regulations have to be followed. You need people who can be able to advise on procedures to avoid flaunting the process, because it can lead to litigation and probably bigger cost.” A key challenge encountered during the cost benefit analysis was limited availability of costing data.</td>
<td>• Train managers in developing and incorporating service level agreements into vendor’s contracts. • Train Managers in collaborative approaches, negotiation and conflict resolution to empower them in overseeing nonclinical outsourced services to manage conflict and negotiate appropriate solutions to problems that arise between hospitals and contractors in the relatively new outsourcing environment. • Hospital Managers should be trained in how to regularly monitor and record costs related to hospital services and to conduct cost benefit analysis for in-house and outsourced services as part of outsourcing decision-making.</td>
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<tr>
<td>Recommendations</td>
<td>Research findings supporting recommendation</td>
<td>Indicative interventions or activities</td>
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| Hospitals should proactively assist in capacity development of fledgling service providers. | During the outsourcing process, the most frequently encountered challenge was the limited number of service providers (57%).

“There are some things in hospital cleaning that need a bit of training. How to handle infectious waste, how to handle body fluids etc. For you to get a company that has worked in a hospital before is very difficult in a rural setting. May be in the city. So we got someone who we thought would learn than we promised ourselves to train them.” | • The assistance may include training and orientation to the special requirements of hospitals (in exchange for a price break in the contract for the first year), a stepped approach to contracting some services, and detailed service information provided in the service level agreement. |
8.7 CONTRIBUTION OF THE STUDY

Theoretically this study falls within current concerns of increasing effectiveness of current health services through use of more cost effective approaches that take into consideration dwindling health budgets. Specifically, it falls within the realm of new public management which advocates for use of private sector approaches to improve management and performance of public sector institutions including hospitals.

The findings of this study have provided useful insights into outsourcing by general hospitals in Uganda, particularly motivations, practices, barriers, benefits and drawbacks of outsourcing by the general hospitals. To the best of the researcher’s knowledge, this is the first of such a comprehensive study on this aspect in Uganda. The study used a robust methodology using qualitative and quantitative approaches including a cost benefit analysis that looks at the costs and consequences/benefits of outsourcing through an economic lens. It is, therefore, envisaged that this study has contributed to the emerging body of knowledge on hospital management in Uganda particularly outsourcing; and also contributed to the existing global knowledge on the subject.

As a result of the findings of this study the researcher has proposed recommendations for increasing adoption of outsourcing by hospitals where feasible and appropriate and for improving the effectiveness of outsourcing by general hospitals. Additionally supporting guidelines have been developed. If these recommendations are implemented and the supporting guidelines are operationalised, it is hoped that it will greatly increase the adoption and effectiveness of outsourcing as a way of improving hospital performance in Uganda and perhaps in other limited resource countries in Africa and elsewhere in the world.

8.7.1 Implications of the study

The findings of this study have implications for health managers, policy makers and other stakeholders (e.g. funders/donors) interested in improving management and performance of health services generally and hospitals services in particular.
The various stakeholders need to discuss issues and recommendations arising from this study and to develop concrete action steps for implementing some of the recommendations in order to improve outsourcing by hospitals and larger hospital and health services management in Uganda as part of implementation of the Public Private partnership for health policy.

8.8 CONCLUDING REMARKS

The aim of this study was to investigate the practices, motivations, benefits and barriers to outsourcing by hospitals in Uganda. The purpose was to provide a framework, guidelines and recommendations that can be used to increase adoption and effectiveness of outsourcing by hospitals where appropriate and feasible as a strategic management tool for improving hospital performance.

It is the researcher’s view that this aim has been duly achieved. The study finds that a number of hospitals are currently outsourcing support but there is room to improve effectiveness of their outsourcing program. For example the study finds little use of economic evaluation in guiding the outsourcing decision making. As such, the study demonstrates how hospitals can carry out such an analysis.

The researcher is of the opinion that the framework, guidelines and recommendations presented in this thesis based on the study findings, if implemented will go a long way in improving hospital performance. Given the current economic context of dwindling resources and increasing demand for health services, it’s imperative that hospital managers seriously consider outsourcing as part of their strategic management tool kit. Indeed a number of policy makers are already saying: Everyone is outsourcing, shouldn’t hospitals do to? It’s the researchers’ hope that results of this study can contribute to answering that question.

As Lee Kuan Yew said: “If you deprive yourself of outsourcing and your competitors do not, you’re putting yourself out of business”.

http://www.inspirationalstories.com/quotes/if-you-deprive-yourself-of-outsourcing-and-of-lee-kuan-yew-quote/. And re-echoing Stephen Covey, it’s the researcher’s belief that outsourcing is inevitable and it’s not necessarily treating people like things.
REFERENCES


<table>
<thead>
<tr>
<th>Name of the Hospital</th>
<th>___________________________</th>
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<tbody>
<tr>
<td>Location</td>
<td></td>
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<tr>
<td>Town:</td>
<td>___________________________</td>
</tr>
<tr>
<td>District</td>
<td>___________________________</td>
</tr>
<tr>
<td>Hospital Ownership:</td>
<td>1=Government/Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>2=Uganda Protestant Medical Bureau</td>
</tr>
<tr>
<td></td>
<td>3=Uganda Catholic Medical Bureau</td>
</tr>
<tr>
<td></td>
<td>4=Uganda Islamic Medical Bureau</td>
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</table>

| Number of beds in Hospital | ....................... |
| Number of bed days for 2013 | ....................... |
| Total Staff in Hospital | ....................... |

<table>
<thead>
<tr>
<th>Clinical Staff</th>
<th>Non Clinical Staff</th>
<th>Annual budget for 2013</th>
<th></th>
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<table>
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<tr>
<th>Date:</th>
<th>___________________________</th>
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<tbody>
<tr>
<td>Interviewer/s:</td>
<td>___________________________</td>
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</table>

Names and Title of People Interviewed
Note: Only record main interviewee

1=Medical Superintendent
2=Hospital Administrator
3=Other (Specify)

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
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</table>
Good day. My name is ________________. I am representing Mr. Mujasi Paschal, a doctoral student at the University of South Africa (UNISA). He is conducting a study on outsourcing by general hospitals in Uganda. The study has two phases. In this first phase, he is carrying out a survey on outsourcing practices by various hospitals, hospital manager’s opinions about the benefits and risks of outsourcing and the services outsourced. Some financial data on outsourced services will also be collected. We are visiting selected hospitals throughout the country and this hospital was selected to be in the survey.

The results of this national survey will add to the existing body of knowledge and understanding of the subject of outsourcing, particularly in the health sector in developing countries and specifically on the context of hospitals in Uganda; and will be useful to health planners, policy makers and health services managers.

I would like to ask you a series of questions about your hospital’s current outsourcing practices and your personal opinion about various aspects of outsourcing.

Mr. Mujasi Paschal might want to request for a follow on interview with you in the near future to further explore your responses to this survey; and I would like to know your willingness to be contacted for that purpose in the future. Do you have any questions?

<table>
<thead>
<tr>
<th>Can we continue?</th>
<th>Yes………………………..1</th>
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<tr>
<td></td>
<td>No………………………….0</td>
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<tr>
<td>Would you be willing to be contacted in the future to further explore your responses to this survey</td>
<td>Yes………………………..1</td>
</tr>
<tr>
<td></td>
<td>No………………………….0</td>
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<tr>
<td>If YES, please indicate contact details</td>
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SECTION 1: OPINIONS/KNOWLEDGE ABOUT OUTSOURCING AND SERVICE IMPORTANCE

To start off the interview, I am going to ask you about your hospital’s strategic planning; your opinion about some aspects of outsourcing and the importance of certain services that your hospital needs to deliver health care to your patients.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Code Classification</th>
<th>Instructions/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>Does your hospital have a strategic or business plan?</td>
<td>Yes………………………..1</td>
<td>If answer is No,</td>
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<td></td>
<td></td>
<td>No………………………….0</td>
<td>➔ GO TO 103</td>
</tr>
<tr>
<td>102</td>
<td>Does the strategic plan include outsourcing as one of the strategies for improving hospital performance?</td>
<td>Yes………………………..1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No………………………….0</td>
<td></td>
</tr>
<tr>
<td>103</td>
<td>Please indicate your level of agreement with the statements below regarding outsourcing by hospitals</td>
<td>Strongly Agree 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree 2</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>Not sure 3</td>
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<td></td>
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<td>Disagree 4</td>
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<tr>
<td></td>
<td></td>
<td>Strongly Disagree 5</td>
<td></td>
</tr>
<tr>
<td>104</td>
<td>Outsourcing is one approach that hospital management can use to improve performance of their hospitals</td>
<td></td>
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<tr>
<td>105</td>
<td>I know at least one hospital that is currently outsourcing one or more of the services it requires to deliver health care to its patients</td>
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</tbody>
</table>
The Public Procurement and Disposal Acts (2003) and the MOH Public Private Partnership (PPP) policy 2009, can be used as a basis by hospitals to outsource.

**107. Compared to clinical services, how important would you say the following services are to your mandate of delivering health care**

<table>
<thead>
<tr>
<th>Service</th>
<th>Very Important 1</th>
<th>Important 2</th>
<th>Moderately Important 3</th>
<th>Of Little Importance 4</th>
<th>Unimportant 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td></td>
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<tr>
<td>IT Services</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Question</td>
<td>Code Classification</td>
<td>Instructions/Comments</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>
| 201 | Is your hospital currently outsourcing any of the services you need to run the hospital and provide health care to your clients? | Yes………………………..1  
No………………………0 | If answer is No, ➔ GO TO 401 |
| 202 | Which of the following services is your hospital currently outsourcing? | Laundry……………………..A  
Security……………………..B  
Cleaning ………………………..C  
IT Services ……………..D  
Catering……………………..E  
Other (Specify)……………..F | Circle all that apply |
| 203 | What is the approximate annual value (in Uganda shillings) of the outsourcing contract for these services | <1,000,000 ……………………. 1  
1,000,001-10,000,000 ………… 2  
10,000,001-50,000,000 ………… 3  
50,000,001-100,000,000 ………… 4  
>100,000,000 ……………………. 5 | |
| 204 | Are you willing to share some documents and financial information about your outsourced services? | Yes………………………..1  
No………………………0 | If Yes, ask for and obtain copies at end of survey |
| 205 | For the services currently being outsourced, for how many months has the hospital been outsourcing those services? | Laundry……………………..Months  
Security……………………..Months  
Cleaning ………………………..Months  
IT Services ……………..Months  
Catering……………………..Months  
Other (Specify)……………..Months | |
| 206 | What have been the benefits/advantages to the hospital of outsourcing the services it currently outsources? | Improved client service………A  
Reduced Costs of service…………………..B  
Smaller work force which is easy to manage…………………..C  
Others (Specify)……………..D | Circle all that apply |
| 207. | What have been some of the drawbacks/disadvantages of outsourcing to the hospital (CIRCLE WHATEVER IS MENTIONED) | Quality of service has worsened. ........................................... A  
Cost of service has gone up. .................................................... B  
Staff dis-satisfaction due to laying off of staff to accommodate contractor. ........................................... C  
Loss of control and flexibility over outsourced service. ............................ D  
Decline in hospital’s capacity to provide the outsourced service. ............ E  
Loss of privacy/confidentiality regarding hospital operations .......... F  
Others (Specify) ........................................................................ G |
| 208. | What would you say is the hospital’s management overall level of satisfaction with your currently outsourced services? | Very Satisfied 1  
Satisfied 2  
Neither Satisfied, Nor Dis-satisfied 3  
Dis-satisfied 4  
Very dis-satisfied 5 |
| 209 | Laundry |  |
| 210 | Security |  |
| 211 | Cleaning |  |
| 212 | IT Services |  |
| 213 | Catering |  |
| 214 | For the services for which you are satisfied, what are the reasons for your satisfaction? | Anticipated reduction in costs has been realized. ............................. A  
Good relationship with supplier ........................................ B  
Anticipated improvement quality of service has been realized. .......................... C  
Other (Specify) ........................................................................ D |
For the services for which you are dissatisfied, what are the reasons for dissatisfaction?

Anticipated cost reduction has not been realized.
Contract management with the supplier has been problematic.
Reduction in quality of service.
Complaints by staff about laying off staff.
Complaints from clients.
Other (Specify).

Circle all that apply.

After asking this question ➔ GO TO 601
**SECTION 3: OUTSOURCING PROCESSES**

Now am going to ask you some questions about the process your hospital went through to decide about outsourcing your currently outsourced services and how you are managing and monitoring the outsourcing process.

<table>
<thead>
<tr>
<th>No</th>
<th>Question</th>
<th>Code Classification</th>
<th>Instruction s/Comment s</th>
</tr>
</thead>
<tbody>
<tr>
<td>301</td>
<td>What internal processes/analysis did the hospital go through to decide whether or not to begin outsourcing some of its required services</td>
<td>None, decision was made intuitively………………………….A Analysis of the importance level of the activity to the hospital’s mandate…………………………B Analysis of the relative capability of the hospital to provide the service Vs outside suppliers………………………….C Market analysis for the services to be outsourced……………………….D Determination of the appropriate strategic sourcing options…………E Determination of the relationship strategy with supplier………………F Determination of how the relationship with supplier will be established, managed, monitored and evaluated………………..G</td>
<td>Circle all that apply</td>
</tr>
<tr>
<td>302</td>
<td>Why did the hospital decide to begin outsourcing the services that it currently outsources?</td>
<td>To save costs ..........................A To enable the hospital focus on servicing patients.......................B Gain quality service from another firms’ expertise.........................C To increase flexibility by using a contracted work force..................D Wanted to reduce employee size.....E Other (Specify).................................F</td>
<td>Circle all that apply</td>
</tr>
<tr>
<td>303</td>
<td>By what procurement method was the service provider for the outsourced service selected?</td>
<td>Open domestic bidding......................1 Restricted domestic bidding......................................2 Through a Request for Proposals.............3 Direct procurement.........................4</td>
<td></td>
</tr>
<tr>
<td>304</td>
<td>What challenges did you face during the outsourcing process?</td>
<td>Limited in house capacity to outsource..........................A Limited number of service providers............................B Contractual issues.................................C Law/owning authority could not allow it and had to negotiate...............................D Political interference in the outsourcing process...............................E Other (Specify).................................F</td>
<td>Circle all that apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
</tbody>
</table>
| 305 | Have you put in place strategies for continuously monitoring the feasibility and cost effectiveness of your outsourcing program? | Yes…………………………1  
No…………………………0 | If answer is No,  => GO TO 501 |
| 306 | What aspects of your outsourcing program are you continuously monitoring | Supplier performance…………….A  
Cost effectiveness…………………B  
Continued feasibility of outsourcing………………………….C  
Continued need for outsourcing……D | Circle all that apply |
| 307 | What strategies have you put in place for continuously monitoring the performance feasibility and cost effectiveness of your outsourcing? | Regular meetings with supplier to review performance………………….A  
Regularly tracking the costs of the sourced services………………….B  
Regular satisfaction surveys with outsourced services among staff and clients……………………………….C  
Market surveys to determine changes in supplier availability and capabilities……………………………D  
Benchmarking our outsourced service quality with quality of the service in the best hospitals in the country…….. E  
Continuous internal analysis regarding importance of the outsourced service to hospital performance... ..................F  
Continuous internal capability analysis to deliver the outsourced service……G | After answering this question,  => GO TO 501 |
SECTION 4: REASONS FOR NOT OUTSOURCING AND FUTURE INTENTIONS REGARDING OUTSOURCING

Am going to ask you some questions about your hospital’s reasons for not outsourcing and your hospital’s future intentions regarding outsourcing.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Code classification</th>
<th>Instruction /Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>401</td>
<td>Why are you currently NOT outsourcing any of your hospital services like cleaning, laundry, security, IT services?</td>
<td>Hospital policy/Law doesn’t allow it………………………………………..1 Don’t have the expertise…………….2 Don’t think it would be of benefit to the hospital ……………………….………3 No qualified service providers……….4 Think its quite risky and prefer to provide services in-house…………….5 Other(Specify)………………………....6</td>
<td>Circle all that apply</td>
</tr>
<tr>
<td>402</td>
<td>Do you currently have plans/intend to outsource any of your services like cleaning, laundry; IT services in the next one year?</td>
<td>Yes………………………..1 No………………………….0</td>
<td>If answer is No, ➔ GO TO 501</td>
</tr>
<tr>
<td>403</td>
<td>If YES, what is the likelihood that your hospital will outsource the following services?</td>
<td></td>
<td>Tick what applies for each service After asking this questions ➔ GO TO 501</td>
</tr>
<tr>
<td></td>
<td>404 Laundry</td>
<td>Definitely 1 Very probably 2 Probably 3 Probably Not 4 Very Probably Not 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>405 Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>406 Cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>407 IT Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>408 Catering</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SECTION 5: PERCEIVED BENEFITS/ADVANTAGES OF OUTSOURCING

I am going to read out to you some of the potential benefits/Advantages of outsourcing and ask you to indicate your level of agreement with the statements about the potential outsourcing benefits.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>501.</td>
<td>Outsourcing can be used by a hospital to achieve cost saving and to control costs</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>502.</td>
<td>Outsourcing can be used by a hospital to achieve improvement in productivity of its operations</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>503.</td>
<td>Outsourcing can be used by a hospital to be able to deliver improved service to the patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>504.</td>
<td>Outsourcing can take away unwanted load off the hospital management and enable them to focus all energies/resources on the core business capabilities/competencies of looking after patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>505.</td>
<td>Outsourcing can be used by the hospital to enable the conversion of fixed cost commitments (e.g. support staff salaries to) variable costs linked with predefined deliverables/results/output by the contractor of an outsourced service</td>
<td></td>
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</tr>
<tr>
<td>506.</td>
<td>Outsourcing can be used by the hospital to gain quick and continuous access to the latest technological developments relevant for the business e.g. modern cleaning equipment</td>
<td></td>
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</tr>
<tr>
<td>507.</td>
<td>Outsourcing can be used by the hospital for internal process improvement by way of restructuring, re-engineering, standardization of processes for the outsourced service</td>
<td></td>
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</tr>
<tr>
<td>508.</td>
<td>Outsourcing can be used by the hospital to be innovative, expand service and rapidly develop new ways of delivering services e.g. catering services that are currently being delivered in-house</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>509.</td>
<td>Outsourcing by the hospital will make things flexible and convenient for the management by enabling them to scale up the outsourced service and also reduce the risk of poor service or having limited or over capacity internally for the outsourced service</td>
<td></td>
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</tbody>
</table>
Out sourcing can allow the hospital to bring in vendors with newer capabilities and knowledge for delivery of the outsourced service giving the hospital competitive advantage over other hospitals.
### SECTION 6: PERCEIVED RISKS/DISADVANTAGES OF OUTSOURCING

Now I am going to read out to you some of the potential risks/disadvantages of outsourcing and ask you to indicate your level of agreement with the statements about the potential outsourcing risks.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>601.</td>
<td>Outsourcing by the hospital can lead to loss of confidentiality and some times breach of privacy since the contractor gets to know the internal operations of the hospital</td>
<td></td>
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</tr>
<tr>
<td>602.</td>
<td>Outsourcing by the hospital can lead to loss of process control for delivery of the outsourced service</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>603.</td>
<td>During the outsourcing process by the hospital, there can be regulatory violations (e.g. violation of procurement act, corruption) and creation of legal obligations which may not be favourable to the hospital</td>
<td></td>
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<tr>
<td>604.</td>
<td>Outsourcing by the hospital creates complexity in vendor relationship management</td>
<td></td>
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</tr>
<tr>
<td>605.</td>
<td>Outsourcing by the hospital can lead to over reliance on vendors which may be risky to the hospital in case the vendor performs poorly</td>
<td></td>
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<tr>
<td>606.</td>
<td>Outsourcing by the hospital leads to increased management complexities since it requires special skills to successfully outsource and manage the vendor</td>
<td></td>
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<tr>
<td>607.</td>
<td>Sometimes outsourcing by the hospital may not lead to the expected deliverables/benefits</td>
<td></td>
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</tbody>
</table>
### SECTION 7: PERCEIVED ROAD BLOCKS / BARRIERS TO OUT SOURCING

Below are some statements regarding potential bottle necks that organisations may face regarding the decision to out source. Please indicate to what extent you perceive these apply to your situation/hospital

<table>
<thead>
<tr>
<th></th>
<th>To a great Extent</th>
<th>To Some Extent</th>
<th>Not a all Extent</th>
<th>To a little Extent</th>
<th>To a very little Extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>701.</td>
<td>My hospital lacks the required infrastructure (e.g. low level of computerization, financial data management, process standardization,) and the management skills to effectively out source of the services it requires in its mandate of delivering health care to patients</td>
<td></td>
<td></td>
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<tr>
<td>702.</td>
<td>Regulatory and policy restrictions (eg Procurement regulations, MOH policy, hospital board policy etc) under which the hospital operates make it difficult to out source any of the services currently being produced in-house</td>
<td></td>
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<tr>
<td>703.</td>
<td>Resistance from current employees and employee unions due to fear of staff changes (eg lay offs) which may result from the hospital adopting outsourcing make it difficult for the hospital to out source</td>
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<tr>
<td>704.</td>
<td>The size and scale of our hospital operations/organization make it difficult for the hospital to out source</td>
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<tr>
<td>705.</td>
<td>Absence of matured vendor market reflected by non-availability of quality outsourcing vendors makes it difficult for the hospital to outsource,</td>
<td></td>
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</tbody>
</table>
Finally, am going to read out some statements regarding characteristics of services that the hospital could ideally outsource. Please indicate your level agreement with the statements regarding characteristics of services that should ideally be outsourced by the hospital.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>801. For services to be outsourced by the hospital, they should be core/critical to the hospital’s mission of delivering health services</td>
<td></td>
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<tr>
<td>802. For services to be outsourced, they should be services that are frequently needed by the hospital for example on a daily basis</td>
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</tr>
<tr>
<td>803. For services to be outsourced by the hospital, they should be services for which there are enough competent suppliers for the hospital to be able to get competitive prices</td>
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<td></td>
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</tr>
<tr>
<td>804. For hospital services to be outsourced, they must be services whose output is easy to measure so that a tight contract can be written and the performance/output of the vendor can be easily monitored</td>
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</tbody>
</table>
ANNEX B: REPORT ON QUESTIONNAIRE PRE-TEST
REPORT ON QUESTIONNAIRE PRE-TEST FOR THE STUDY ON OUT SOURCING
BY HOSPITALS IN UGANDA; May 24, 2015

Background

Following the scientific and ethical approval of the doctoral study on “Outsourcing by Hospital’s in Uganda”, as required by good research practice, it was necessary to conduct a pre-test/pilot of the developed questionnaire before full scale data collection.

This report provides a summary of the purpose and objectives of the pilot/pre-test, the approach used and the findings. It also provides recommendations for modifications in the study approach to ensure high response rates and quality data collection.

The report is prepared for approval by the research supervisor (Prof. ZZ Nkosi) and to grant approval for full scale data collection.

Purpose and Objectives

The purpose of the pilot/pre-test was to check that the design of the questionnaire works in practice, and to identify and amend problematic questions and refine the questionnaire.

Specifically, the objective was to identify any problems related to the content, wording, layout, length, instructions, and coding of the questions in questionnaire and any practical issues in administering the questionnaire.

The pilot/pre-test was also aimed at identifying issues that may affect response rate and any practical issues such as likely costs of data collection, specifically the costs of administering the questionnaire.

Methods

Questionnaire review and preparation

The draft questionnaire was reviewed by the research supervisor and another colleague who provided comments. These were addressed before the pilot. Based on a suggestion from a colleague who was concerned about the time it would take to collect data from the dispersed study sites, an electronic version of the questionnaire was also designed in Qualtrics an online survey software and insight platform.

Sample selection

Two samples were used; one to pre-test the paper version and the other to pre-test the electronic version of the questionnaire.

For piloting the electronic version of the questionnaire five colleagues of the researcher were conveniently selected.
For piloting the paper version of the questionnaire, four hospitals that are not part of the final study sample were conveniently selected based on ease of access. The sample comprised of the following hospitals: Nyenga hospital, Bugiri hospital, Nagalama Hospital and Jinja hospital.

**Data collection**

The selected colleagues were sent via e-mail, a link to the electronic version of the questionnaire for them to attempt filling it and provide feedback on the working of the questionnaire and identify any issues that may reduce response rate or quality of the data collected.

The researcher travelled to the selected hospitals to administer the paper version of the questionnaire to the target respondents (hospital manager’s) in the selected hospitals and to receive their feedback regarding their experiences in answering the questions.

**Findings**

**Process of data collection**

Initially, the researcher prepared an introduction letter for use to gain access to the respondents. However the initial respondent insisted on an official letter which was still being awaited from MOH. This delayed the pre-test. The official introduction letter was finally received on April 14, 2015 paving way for the pre-test which was conducted between April 15 2015 and May 15, 2015.

The initial plan was for the researcher to administer the questionnaire to the respondents by reading out the questions and ticking the respondents answer. However this did not seem practical as most of the target respondents (hospital managers) were busy and did not have the time to be interviewed. They instead suggested that the questionnaire is left for them to fill later and for the researcher to come back another day to collect the filled questionnaire.

The electronic version of the questionnaire was well received by all the colleagues selected to participate in the pre-test of the questionnaire and the link was working well. The skip logic build into the questionnaire was also working well. Through the Qualtrics software used to design and manage the data collection process, the researcher was able to track progress of the respondents regarding if they had opened the questionnaire and progress in filling the questionnaire.

**Duration of filling the questionnaire**

All the selected colleagues were able to fill the questionnaire within a week of receiving the notification e-mail. On average, it took about 25 minutes to fill the questionnaire. It is however possible that the colleagues were able to fill the questionnaire in such a short time since they did not have to be concerned about the quality of the data they were
providing. Some colleagues stopped filling the questionnaire on one day and were able
to continue the following data which they liked since it provides the respondent some
flexibility in completing the questionnaire.

For the paper filled questionnaire, respondents from two hospitals asked that the filled
questionnaire is collected the following day. Respondents from the other two hospital
asked that the researcher falls up with them on phone a week later. Some still needed a
remainder even after a week. However, the respondents mentioned that it took them
between 30-45 minutes once they concentrated to fill the questionnaire. They however
mentioned that they needed to consult the hospital management records for some of
the required data (e.g. past budget, duration of contracts etc.) The fact that same day
data collection may not be possible is of concern as it may lead to a long duration of
data collection and increase costs.

Clarity of questions and instructions.

A review of the filled questionnaires collected indicates that the questions were well
understood by the respondents. There were very few incidences of crossed out
responses. This was confirmed by the verbal feedback received from the respondents.
However one respondent suggested that it may be useful to provide a working definition
of outsourcing as applied in the study to the respondents to provide them a frame of
reference and to enable them answer the questions

The instruction for selecting options and the skip instructions were correctly followed by
the respondents.

All relevant questions were answered and there was no missing data. This could be
attributed to the fact that respondents were provided ample time to fill the questionnaire
at their convenience.

Adequacy of provided responses

The respondents mentioned that they were able to find their response within the
provided options. They also welcomed the idea of an “Others” option for them to
indicate their response if this was not in the options provided.

Specifically, regarding the outsourced services, some respondents mentioned some
clinical services (e.g. Surgical Services) among the “Other” category. However, the
study focuses on non-clinical services and hence there is no need to add these among
the possible responses. However, some respondents mentioned certain support
services (e.g. legal services) which could be the focus of this study. Within limits, these
will be added to the options provided, in addition to maintaining spaces for respondents
to write in services which may not be part of the options provided
Compensation for time taken for filling questionnaire

During the study design and proposal development, it was anticipated that the respondents would not need to be compensated for time taken to answer the questions. The local Institutional review board was of the view that since the questionnaire was long, it would be necessary to compensate the respondents with the equivalent of 5,000 UGX (about 20 Rand). However, during the pilot, the respondents complained that this was too little and suggested doubling this to 10,000 UGX (about 40 Rand).

Conclusions and Recommendations

Findings from the pilot test indicate that the questionnaire is suitable for data collection. The questions and instructions are well understood by the respondents and the questionnaire contains all suitable answer options. There are adequate provisions for respondents whose responses may not be part of the provided options (i.e. space for an “other” category and blank write in spaces).

However, there will be a need to provide a written definition of outsourcing to ensure that all respondents have the same understanding and answer the questions with the same frame of reference.

Given that the target respondents are busy and so same day data collection may not be possible, the data collection process is likely to take long and be expensive. To reduce on duration and costs of data collection, all respondents will be sent an electronic version of the questionnaire and follow up will be done by phone to determine if the respondent would like to be visited and be provided with a hard copy of the questionnaire. Respondents will then be provided with the questionnaire to fill out when they find the time as opposed to the data collector reading out the questions and ticking the respondents’ answers.

Also, an alternative list of hospitals to be interviewed will be prepared in case one hospital takes long to respond and needs to be substituted. This list will be prepared before the data collection.

In line with recommendations from the local Institutional review board and feedback from the respondents that participated in the pilot, funds will be set aside to compensate respondents who participate in the study. An amount of UGX 10,000 (about 40 Rand) will be provided. For those who fill the questionnaire electronically, this will also contribute towards their internet costs. Chapter 3 of the dissertation will be updated accordingly to indicate that respondents were compensated for participating in the study.
Next steps

Once approval is provided for full data collection, two data collectors will be trained to assist with data collection based on the earlier developed manual. The training will additionally cover the experiences from the pre-test as presented in this report.

As soon as the training is finalized, an electronic version of the questionnaire will be sent to respondents in the study sample for whom e-mail addresses are readily available. A travel itinerary will be prepared to ensure that data collection is completed within 30 days. A List of 5 alternative hospitals based on random selection will be prepared in case there is need to substitute for one hospital due to delay in responding to the survey (i.e. non response)

The researcher will begin working on data entry screens in SPSS. This will ensure that data is entered as soon as data collection is completed. Dummy data analysis tables will also be prepared and shared with the study supervisor.
ANNEX C: LETTER FROM STATISTICIAN

The research committee,  
School of health studies,  
UNISA.

Re: **DATA ANALYSIS FOR STUDENT; DLitt Et Phil 35620293**

I wish to certify that I have analysed the quantitative data for DLitt Et Phil Student, Mujasi Paschal Nicholas (Student Number 35620293). To the best of my knowledge, I declare that this research is his original work and the results are the outcome of the research ‘**PRACTICES, MOTIVATION, PERCEIVED BENEFITS AND BARRIERS TO OUTSOURCING BY HOSPITALS IN UGANDA**’

Yours,
Signed:

Rose Bosa  
STATISTICIAN
ANNEX D: DATA COLLECTION TOOL FOR COST BENEFIT ANALYSIS
Cost benefit analysis of Cleaning Services

General information

- Is there a difference in the cleaning services/tasks/activities that were being provided/conducted by the in-house cleaning staff compared with those being provided/conducted by the contractor?
  If YES, what is the difference?
- What is the approximate area (in square meters) of the hospital area to be cleaned?
- Is there a difference in the total area that was being cleaned by the in-house cleaning staff compared with the total area being cleaned by the contractor?
  If YES, what is the difference?

In-house cleaning services

- How many cleaners did the hospital have on its pay roll before out sourcing the cleaning services?
- What was the monthly salary for each cleaner?
- What tasks/activities were the cleaners responsible for?
- Who in the hospital management structure was supervising the cleaners?
- What is the monthly salary of the officer who was supervising the cleaners?
- On average, how many hours per day would this officer spend on supervising the cleaners?

Contracted cleaning services

- What aspects/tasks does the cleaning contract with the out sourced provider include?
- What responsibilities, if any does the cleaning contract place on the hospital?
- Who in the hospital management structure is responsible for supervising the cleaning contractor?
- What is the monthly salary of the officer responsible for supervising the cleaning contractor?
- On average, how many hours per day does this officer spend on supervising the cleaner?
### Detailed Data collection tool

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<th>Financial Year:</th>
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**Note:** Data can be entered per quarter if detailed monthly data is not available.
ANNEX E: QUALITATIVE DATA COLLECTION TOOL
OUTSOURCING BY HOSPITALS IN UGANDA

INTERVIEW GUIDE

A. Hospitals currently outsourcing

1. What do you think of outsourcing as a way of improving hospital performance?

2. What do you see as some of the advantages and disadvantages of outsourcing?

3. What process did the hospital go through to decide whether outsourcing was feasible and appropriate to the hospital?

4. Why did the hospital eventually decide to outsource?

5. What services is the hospital currently outsourcing (i.e. contracted to outside companies)?

6. Why did the hospital specifically decide to outsource the services it is currently outsourcing?

7. What stages and process did the hospital go through to outsource those services?

8. Who was involved in the process?

9. What were some of the difficulties in the outsourcing process?

10. What have been the benefits to the hospital of outsourcing those services?

11. What have been the risks and drawbacks to the hospital as a result of your outsourcing decision?

12. Would you say you are satisfied or dissatisfied with the hospital’s outsourced services? Why?

13. What strategies has the hospital put in place to continuously monitor the feasibility and cost effectiveness of its current outsourcing practices?

14. What do you think could be done to encourage other hospitals to begin outsourcing some of the services they currently provide in-house if feasible and appropriate?
15. What considerations should they be aware of as they decide to outsource?

**B. Hospitals currently NOT outsourcing**

1. What do you think of outsourcing as a way of improving hospital performance?

2. What do you see as some of the advantages and disadvantages of outsourcing?

3. Why is the hospital currently NOT outsourcing any of the services it requires to provide health care to its clients?

4. If your hospital ever thought of outsourcing, what process would it have to go through to decide whether outsourcing is feasible and appropriate for the hospital?

5. If your hospital decided to outsource, what services do you think you would outsource? Why?

6. What process would the hospital have to go through to outsource those services? Who would be involved in the process?

7. What strategies would the hospital use to continuously monitor the feasibility and cost effectiveness of its outsourced services?

8. What difficulties do you think the hospital would face in the outsourcing process?

9. What do you think could be done to encourage your hospital to begin outsourcing some of the services you currently provide in-house if feasible and appropriate?

10. What help would your hospital need for a successful outsourcing process?
ANNEX F: SAMPLE QUALITATIVE INTERVIEW TRANSCRIPT

Interview with Medical Superintendent Iganga Hospital

Interview start time: 2: 50pm
Interview end time: 3: 35pm

Been working for three years. Out sourcing for more than 36 months

Before that, we used …u know as a govt practice we are supposed to tender any service above one million so the cleaning services consume over 3m/month . so as per govt requirements as per PPDA we are supposed to tender it out

What do you think of outsourcing as a way of improving hospital performance?

It can improve hospital performance in an aspect that, one some one has control over their workers to ensure that they maximise efficiency…because somebody is motivated by the profit he is supposed to get by the end of the day. So he ensures that the workers fulfil the task and they have to do it in the shortest time frame for then to be able to realise the profit because if he doesn’t he can face a penalty and doesn’t realise his motive

However on the other side…outsourcing can be a problem if the contractor feels he is gaining so little and wants to save so much, he may be tempted to do work which is shoddy and u don’t get value for money

The other aspect could be that if there is some political influence…some one who is a service provider, he may be tempted not to provide a quality service

Another advantage is that these people do work whether money has come or not because the service is rendered over a specified period of time…yet govt realises money not frequently….like now we are in the seconf quarter of the FY..but no money. But at these people continue working as you wait for the money to come and you pay arrears

Me: Outsourcing can help the hospital to be efficient because the service provider wants a profit

He has control over his workers…and for you you just have to ensure that he is doing the work according to the contract.

What do you see as some of the advantages and disadvantages of out sourcing?

What process did the hospital go through to decide whether outsourcing was feasible and appropriate to the hospital?
They normally do an evaluation…but because…..what prompts that is the bureaucracy in government

People who are initially ..........people have a tendency of looking at govt as a source of employment ..but our culture here in Uganda is that once someone is employed he doesn’t care about the job. He feels the job he has is not up to what he expects.

So if u are a cleaner and ur supposed to clean…they begin thinking that in a hospital setting…probably they may also want to be called a Dr. So instead of doing cleaning work, they want to do clinical work

So for u as an admin..you are at a loss…trying to force this person to do the work. So you find that the hospital is not clean as you expect it. Some times they clean..some days they don’t. So it compromises the quality…and so ur not satisfied, the clients are not satisfied. That is why it cause some inertia among the people.

So I think that is why government decided that okay we are not getting value for money. If there is to be any efficiency let us outsource and see if things can improve. Which to me helps because if some one has not yet started work, you cant pay because the contract is not yet binding.

They want to do clinical work because they think that now this money is not enough…because this work is not suitable…they want to disguise and do other work.

In fact some people used to hire others to do work for them instead of themselves…which is illegal. Because now if this person breaks an implement …you cant charge them. So those were some of the loopholes in the system

Yes, we had cleaners before…but the other aspect was….according to the regulation for you to be employed in government..you must have a minimum qualification of senior Four….Now most of the cleaners are informal. They are people who have never gone to school. Now..if u advertise that you want to get those people…the process and beauracracy is long..u know. IF some one dies…to replace it takes long…so if you are to wait, the institution is at a loss. So if u look at the pros and cons..its better to out source…the service providers will have to look for whoever wants a job to come and clean. So for them they can recruit people who are able to do the work even if they may not have been eligible under the government recruitment system.

So for contractor does the cleaning and for us we concentrate on our work of administration and offering curative services.

The workers we had were informal…they would just come…do the work and at the end of the month..pay them like 50K and they go.
Because our institutional had so many…we had over 20. So that is over 1M…so the Auditor general can query you that why are you spending so much. They probably know there is value for money. But it is above one million…so we needed a waiver. So then we were then supposed to out source and some one does the work on your behalf

**Why did the hospital eventually decide to outsource?**

**What services is the hospital currently out sourcing (i.e. contracted to outside companies)?**

**Why did the hospital specifically decide to out source the services it is currently outsourcing?**

Because cleaning service is a very big challenge…to get people who are qualified as per the government regulations…who are formally employed…they are not easy to get. Yet some one to come and get satisfied he must look at the environment where he is going to get the service. You may have people working here but if the environment is not clean and is not conducive, you may not get satisfied.

So, we needed people who can clean so that our workers are also comfortable to do their work…two, patients who are customers are also comfortable in the environment where they are getting the service

Three…if u really look at some of the aspects of our environment like the toilets…with a high patient load….people have never used some of these lavatories. Now if you just leave everything to whatever…you may even get an outbreak because the services are not clean. So we felt that that is one of the services to tender out so that the environment in which we work is conducive

**What stages and process did the hospital go through to out source those services?**

One of the issues is that we raise our concern with the district. So they tell us before the financial year closes to inform the CAO in writing of the services we would like to outsource the next FY so that the PPDA department prepares those thinfs to be advertised in the paper so that people bid and they are selected. They take due deligence…check if the person who has applied has done the work before. They evaluate and see if he is suitable. They also look at the cost. After they have done that…they may be select three bidders who have satisfied the criteria. They then go through more details of evaluating each through past experience and they then zero on
one based either on cost….the company which is being awarded this work…what is their past performance. Are they royal? Are they fraudsters? Do they have any past criminal record…so by the time they award they have done due diligence. Then they award the contract. These days they have began giving them three years …rolling contractor. So that instead of repeating the cycle every year which takes long.

Eg there was a time when we didn’t have cleaning services….now they have made it that okay you can give three years and evaluate every year.

The procurement department run an advert and select. And once they select they then award a contract. They give me a copy which I file. And from that copy, every year we make assessment.

We have a health inspector who supervises them and issues a report before we pay them. So if they are not satisfied…we don’t pay. We look at the terms of the contract and then make a report.

Contractor is issued by the district…not hospital? …But hospital is part of the district.

**Who was involved in the process?**

I was involved, my district Administrator and the district people. At the district, there is the CAO and then the PPDA team. We call it Procurement department. They are the people who are concerned with public procurement.

**What were some of the difficulties in the outsourcing process?**

The difficulty we face is that…one some times expectations …people may think they are going to get a lot of money. So when they bid, they can under quote. Because they want to win the contract. And when they award it some realise that the scope of work is so much and that become a challenge….after doing the work mid way, the money is exhausted and for us we have to force them because the contract is binding and they have to do the work. So there is some degree of pulling strings because the person says the money is not adequate.

Another aspect is of…influence from other powers…external influence. You don’t know who was awarded because some one may have some body who is connected but not able to do the work.

Then of course…payment. Some times the funds come late, and these people say unless we are paid..we are not going to work. But then we say…hey the contract is clear.

So sometimes we may go half a month or whatever when these people are not doing the work as expected.
Three, the financial year may close and budgets are cut. So you are forced to re-allocate some money and pay. Because if you don’t pay, they will come and sue you. That you are not honouring the agreement.

Regarding availability of service providers…well, I don’t think that could be a difficulty. Because our institution is not so big…people have done this work before…so it was not an issue

**What have been the benefits to the hospital of outsourcing those services?**

**What have been the risks and drawbacks to the hospital as a result of your outsourcing decision?**

Yea, the other risk ..once they nearly took us to court. The service provider was not doing the work as we had expected and so had decided to terminate the contract. He sent us a letter from his attorney threatening to sue us for tampering with their contract.

So we had to go back to the drawing board. Re-negotiated

Another risk is the duration we offer for the contract….Three years with one year rolling. So if the contractor is not good…you have to wait for a long period. And yet if it was one year, you would terminate and get another one. So that would create some efficiency because the other one would always want to come back…but now for three years, there is a lot of room for complacency

Then the other aspect is that once they get used to the system,…there is that issue of reluctance to do the work. They feel that things are normal…which is a big challenge. Also there workers get used to the system and they want to masquerade as clinicians. So they start with normal running of the hospital

The other aspect is because they have taken long in the institution…some of them start stealing some of our equipment. That is the other risk

**Would you say you are satisfied or dissatisfied with the hospital’s outsourced services? Why?**

Am satisfied…it eases the pressure. Financially, even without money…those people are doing their work whether we are paying them or not.

I think the quality of service is fair compared than we had before given the money we pay them…about 3.6M per quarter. Very little money. Me I believe that shd even be for one month…but because we are under funded we have to work within that. So me I think its fair

**What strategies has the hospital put in place to continuously monitor the feasibility and cost effectiveness of its current outsourcing practices?**
Before we pay, health inspector checks...he is resident. Every day he looks at what they are doing...inside, out side. So he is really monitoring.

Of course the other aspect is that we look at the monetary aspect...whether there are any changes...but that one we have no control because that one is already fixed...it's already implied

But these people have some one who is always supervising them...their person. Then also ours is independent...so everything is ok.

We only look at the cost element when we are budgeting...and looking at previous budget and other priorities. And so if some one can do the work within that...then it's ok. But from our assessment, the money is not enough. Because if you look at the fuel they are using eg they have a lawn mower...plus other equipment they are using, then there is ware and tear...so if all these are factored in, you may find that they are not breaking even

Me: So when doing budget, you have a budget for cleaning. So when you tender out, you compare and see who is within budget and that the one you are likely to chose

The services include: Lawn and compound cleaning, they clean the wards, the toilets, collect and dispose garbage, clean all the trenches, trim the hedges.

**What do you think could be done to encourage others hospitals to begin out sourcing some of the services they currently provide in-house if feasible and appropriate?**

I think they can go for a tour to other hospitals to learn from them how the best...and they share. They share the budgets...how people have managed to do it. They have to learn from one another. That would help.

But you know every district is unique...because this is decentralisation. So you may not have...some one may want but what is applicable in one area may not be applicable in another area. So they may get some challenges. But I think from sharing experience and learning from one another, I think they can be able to start something

**What considerations should they be aware of as they decide to out source?**
Look out for the cost of the service, ability of the service provider, where this person is coming from. Because if you get some body from Kampala to come to Palisa, he may not manage. Because the transport from Kla to Palisa is being factored in. So that person is going to eat into the budget and may not offer quality service.

So for us what we normally do is encourage local service providers with in our locality who are within. One, they will be cheaper to employ…than getting some body form far.

Also you have to look at other priorities wuthin hospital and are able to tailor your budget accordingly. Otherwise u may be forced to spend on one aspect and trhen the iother aspect is neglected and yet you don’t serve the purpose.

In terms of managing the contract, just follow the PPDA act and the law to the dot. And if their issues you discuss and solve them within the provisions of the law.

So how come not out sourcing some of the other services like Security:

Security, some of those people employed and we don’t need so many people…that one is manageable. Like if you have only three entrances..u don’t need a lot. Just need some one to open, check. So its manageable.

If you are to out source…it becomes much more expensive to hire those people from a private company.

**Cost determination initial out sourcing to ensure you are being efficient**

We looked at how much we were spending for the other workers we had before. And said if we are to lay off the 25 people…taking 1.25 and we are getting a contractor who would go for 1m. We make a saving. So we had to look for a contractor who wouldn’t go beyond 1.25M …so we knew if to get someone it must be below 1.25. And we had to make it clear to the procurement department. And as they were making their evaluation they had to contact us and say we have selected these three …but normally go with lowest bidder. But if they select a bidder with a price higher than our budget, then that means we are going to be in liability to be sued for failure to pay. So we have put in that as another caution on our side. But they share these budgets because they are entered into the system at the district…so they know how much we have for what.
Acess to capability not available internally

Bid evaluation

Budget and cash flow constraints

Challenges with contract termination

Communicate to district management intention to outsource

Connivance between hospital and outsourced staff

Consider local conditions

Consider total cost of outsourcing including taxes

Contact local

Contract award

Contract type

Control over outsourced workers

Cost benefit /Value for money analysis before outsourcing

Cost of service

Cost saving

Determining likely cost of outsourcing

Difficulty in firing staff due to government bureaucracy

Difficulty in recruiting staff due to government bureaucracy

Duration of outsourcing

Eases pressure on management

Effective contract and relationship management
Evaluate pros and cons of outsourcing in local context
External influence in outsourcing
Extortion of patients by outsourced staff
Familiarity and reluctance to perform
Financial evaluation and monitoring
Focus on clinical services
Follow due Process
Government directive/policy
Hospital staff use contracted staff for other business
Improved efficiency in task performance
Improved quality of service
Improves hospital performance
Incorporation into hospital workplan
Increased budgetary allocation to hospitals
Increased cost of service
Internal cost analysis
Involve every one
Lack of internal capacity
Limited availability of local suppliers
Limited need/scope for service
Loss of control over workers
Masquerading and Impersonation by contractors staff
Minimise internal connivance
Monitoring cost
Need for Monitoring Outsourced service
Need to follow established guidelines
Needs Assessment
Needs assessment prior to outsourcing
Needs communication to management
No value for Money
Outsourced staff over stepping mandate
Outsourcing expectations not realised
Parties involved in outsourcing process
Pay for performance
Performance monitoring
Political influence in outsourcing
Poor quality of outsourced service
Pre financing by contractor
Prepare and launch advert
Prioritisation and budgeting
Provider evaluation
Quality Monitoring
Responsibility for outsourcing process
Review of pros and cons of outsourcing
Saves management time
Scope of outsourced service
Service critical to improving hospital environment
Supplier lock in due to contract duration
Supplier monitoring
Theft by contracted staff
Tours to other hospitals
Un met vendor expectations
Wanted value for money
ANNEX H: PARTICIPANT CONSENT FORM

OUT SOURCING BY HOSPITALS IN UGANDA

Dear research participant,

Thank you for participating in the earlier phase of this research study entitled “Outsourcing by hospitals in Uganda” that is being conducted in selected hospitals in Uganda. The study addresses the practices, motivations, perceived benefits and barriers to outsourcing by hospitals in Uganda.

During the earlier phase you indicated your willingness to be contacted to further explore your responses. Your participation in this second phase of the study is voluntary, and you will not be penalised or lose benefits if you refuse to participate or decide to withdraw from the study after you have agreed to participate. Your participation will involve answering questions during an interview session. The interview will not be longer than is necessary. A tape recorder will be used to tape the interview, but the tapes will be discarded at the end of the study.

The information you provide will be kept confidential and you will not be identified as the person from whom the information was obtained. On request, a written summary of the research results will be availed to participants.

Your participation is important because it will help the researcher to get the necessary information to achieve the study objectives. The information you provide will also be used by the researcher to make recommendations that can help improve management of health services in hospitals in Uganda.

Should you have any questions regarding the study or your participation, please contact Mr. Mujasi Paschal on telephone number 0753-339760.

Consent

The nature of the study “Outsourcing by hospitals in Uganda” that is being conducted in selected hospitals in Uganda has been described to me orally.

I understand what my involvement in the study means and I voluntarily agree to participate.

_________________________  ________________________  __________
Name of participant   Signature of participant   Date
ANNEX I: CONFIDENTIALITY BINDING FORM

CONFIDENTIALITY BINDING FORM

Whereas the researcher and informant wish to enter into a discussion relating to Outsourcing by hospitals in Uganda; during the discussions, the disclosure of confidential information may become necessary. The Informant is willing to disclose and the researcher is willing to receive information.

To ensure that the disclosed information is treated as secret and in consideration of such disclosure, it is hereby agreed as follows:

- Information may only be used for the purposes of the study relating to Outsourcing by Hospitals in Uganda
- Information disclosed will at all times remain the property of the disclosing party
- The recipient shall keep information in the strictest confidence for a period of five years from the date of its receipt
- The recipient shall not without the prior written permission of the disclosing party disclose information to any other party save for the parties involved in the study e.g. the Researcher's doctoral supervisor
- Any presentation of the information in study report will be in such a way that the information cannot be traced back to its provider

____________________  __________
Name of informant                          Signature of Researcher

____________          __________
Signature of informant

____________
Date
REPORT: Scientific Review Committee

Date: 29 September 2014

Dear Prof J Maritz

TITLE OF THE STUDY: Outsiders moving in: Outsourcing by hospitals in Uganda

Candidate: Mujasi, PN
Student number: 35620293
Supervisor: Prof ZZ Nkosi
Co-Supervisor: N/A

DLitt et Phil. X MA Nursing □ MPH □
Non-degree proposal □

Members of the review group who have participated in the review process:

Dr ES Janse van Rensburg
Dr MM Ramukumba
Prof ADH Botha
Prof SP Human

Comments:

Amendments were made as requested on 17/6/2014. Approved to submit for Ethics approval.

Final Recommendation:

Pass the proposal module □

Approved to submit for Ethics approval X □

Signed: [Signature]
Date: 29/9/14

Scientific Review Committee Leader
ANNEX K: ETHICAL CLEARANCE CERTIFICATE-UNISA

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

Date: 4 November 2014  Student No: 3562-029-3

Project Title: Outsiders moving in: Outsourcing by hospitals in Uganda.

Researcher: Mujasi Paschal Nicholas

Degree: D Litt et Phil

Supervisor: Prof ZZ Nkosi
Qualification: PhD
Joint Supervisor: -

Code: DPCHS04

DECISION OF COMMITTEE

Approved ✓ Conditionally Approved

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES
To Mujasi Paschal Nicholas  
University of South Africa  
P.O Box 34539  
Kampala  
Contact: 0753339760  
E mail: pmujasi@yahoo.co.uk  

Re: LHIREC No.: 073/12/14. Study Title: Outsiders Moving In: Outsourcing By Hospitals in Uganda

This is to inform you that Lacor hospital Institutional Research and Ethics Committee (LHIREC) reviewed the above research proposal on the 27th February 2015 and approved it pending minor corrections. These corrections have now been made and full approval is therefore granted.

Please note that your study protocol number with LHIREC is: 073/12/14. Please be sure to reference this number in any correspondence with LHIREC. Also note that your study was first approved by LHIREC on 27th February 2015 and therefore approval expires at every annual anniversary of this approval date. The current approval is therefore valid 27th February 2016. If it is necessary to continue with the research beyond expiry date, a request for continuation should be made in writing to the secretary LHIREC.

Continued approval is conditional upon your compliance with the following requirements:

1) No other consent form(s), questionnaire and/or advertisement documents should be used other than the one approved. The approved consent form(s) must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.

2) All protocol amendments and changes to other approved documents must be submitted to
LHIREC and not be implemented until approved by LHIREC except where necessary to eliminate apparent immediate hazards to the study subjects.

3) Significant changes to the study site and significant deviations from the research protocol and all unanticipated problems that may involve risks or affect the safety or welfare of subjects or others, or that may affect the integrity of the research must be promptly reported to LHIREC.

Please send progress report after six (6) months, also complete and submit reports at completion, termination, or if not renewing the project - send a final report within 90 days upon completion of the study to LHIREC.

You are also advised to register with Uganda National Council for Science and Technology (UNCST).

Below is a list of document approved with this application:

<table>
<thead>
<tr>
<th>No.</th>
<th>Document Title</th>
<th>Language</th>
<th>Version</th>
<th>Version Date</th>
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<td>1.</td>
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<td>Informed consent form</td>
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<td>3.</td>
<td>Study Questionnaire</td>
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<td>4.</td>
<td>Interview guide</td>
<td>English</td>
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</table>

Yours sincerely,

Dr. Martin David Oewing
Chairman LHIREC
PRACTICES, MOTIVATION, PERCEIVED BENEFITS AND BARRIERS TO OUTSOURCING BY HOSPITALS IN UGANDA

By

PASCHAL NICHOLAS MUJASI

Submitted in accordance with the requirements for

The degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

In the subject

HEALTH STUDIES

At the

UNIVERSITY OF SOUTH AFRICA (UNISA)

SUPERVISOR: PROFESSOR Z Z NKOSI

JANUARY 2016
ANNEX M: APPROVAL-UGANDA NATIONAL COUNCIL OF SCIENCE AND TECHNOLOGY


Our Ref: 28.3743

3rd April 2015

Mr. Mujuni Patrick Nicholas
John Snow International
Uganda

Re: Research Approval

I am pleased to inform you that on 23/03/2015, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of 23/03/2015 to 23/03/2016.

Your research registration number with the UNCST is SS 3743. Please cite this number in all your future correspondence with UNCST in respect of the above research project.

As Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. All investigators must be kept informed of the status of the research.
2. Changes, amendments, and additions to the research protocol or the consent form (where applicable) must be submitted to the designated Research Ethics Committee (REC) or Local Agency for re-review and approval prior to the activation of the changes. UNCST must be notified of the approved changes within two working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local REC for review with escalation to the National Drug Authority.
4. Unanticipated problems involving risks to research subjects/patients or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST review.
5. Only approved study procedures are to be implemented. The UNCST may conduct unannounced audits of all study records.
6. A progress report must be submitted electronically at UNCST within four weeks after every 12 months. Failure to do so may result in termination of the research project.

Below is a list of documents approved with this application:

<table>
<thead>
<tr>
<th>Document Title</th>
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<tr>
<td>Interview guide</td>
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</tbody>
</table>

Yours sincerely,

[Signature]

Leah N Omonoro

Executive Secretary
Uganda National Council for Science and Technology
Chair, St. Mary’s Hospital Lacor REC, Gulu

COMMUNICATION

On:-Phone: 27(2) 434-70749
FAX: 27(2) 434-70749
EMAIL: info@uncst.go.ug
WEBSITE: http://www.uncst.go.ug

LOCATION-CORRESPONDENCE

Plot 476 Katoma Rd. Ninde
P.O. Box 4466
KAMPALA, UGANDA
TO:
Director General, Ministry of Health, Uganda

Dear Sir/Madam,

**Re: Request to collect data from selected general hospitals in Uganda**

I am a doctoral student registered with the University of South Africa, focusing on Health Services Management. My Doctoral research is about **Outsourcing by Hospital in Uganda** and will be conducted through two phases, a quantitative and qualitative Phase. The study objectives are to:

- Identify the current outsourcing practices by hospitals in Uganda
- Identify determinants of outsourcing by hospitals in the Uganda context
- Identify perceived benefits and drawbacks to outsourcing by hospitals in Uganda
- Conduct a cost effectiveness analysis of an outsourced service in one of the study hospitals
- Identify interventions to increase adoption of outsourcing by hospitals in Uganda where appropriate, as part of strategic management and to specifically develop supporting policy guidelines for outsourcing by hospitals

This study will provide useful information on current practices, motivations and barriers to outsourcing by hospitals in Uganda generating awareness among health planners, policy makers and health services managers. The results will be useful to health planners, policy makers, health services managers and other stakeholders by contributing to the evidence base to guide efforts to increase use of outsourcing as a strategic management tool for improving hospital performance.

The purpose of this letter is to request permission to be allowed to collect data from the attached list of hospitals that have been randomly selected to participate in the study. After the study, findings will be shared with your office.

Attached to this letter is a copy of the research proposal, data collection tools and the Ethical Clearance certificate from the University of South Africa (UNISA) and the Lacor Hospital Ethical review Board.

Any support you can provide to facilitate access to and data collection from the selected hospital will be highly appreciated. Please contact the undersigned in case of any questions.

Yours Sincerely,

[Signature]

ANNEX N: PERMISSION REQUEST LETTER TO MINISTRY OF HEALTH

MUJASI PASCHAL NICHOLAS
P.O. BOX 34539 KAMPALA
UGANDA
March 20, 2015
24th March 2015

The Medical Superintendent/Hospital Administrator

Dear Sir/Madam,

Re: Introduction of a study on Out Sourcing by Mr. Paschal Nicholas Mujasi

Mr. Paschal Mujasi is a registered Doctoral student at the University of South Africa (UNISA), department of Health Studies. He is conducting a mixed methods study on “Out Sourcing by Hospitals in Uganda” which focuses on the practices, motivations, perceived benefits or advantages and barriers or disadvantages to outsourcing by hospitals in Uganda. The aim of the study is to contribute to the evidence base to guide hospital managers in determining whether outsourcing is appropriate and feasible for their hospitals and to increase adoption of outsourcing by hospitals where appropriate as a strategic management tool for improving hospital management in Uganda.

The study has been approved by the Ethics committee of UNISA, the Lacor Hospital Institutional Research and Ethics Committee, and the Uganda Council of Science and Technology. The purpose of this letter is to introduce the study to you and to request you to provide the necessary support for data collection in your hospital. Your cooperation with the data collectors is greatly appreciated.

Yours Sincerely,

Prof. Anthony Mbonye
Director Health Services - Clinical & Community
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JANUARY 2016
ANNEX P: PICTURES FROM THE FIELD

- Research assistant crossing river to collect data
- Research assistant on boat going to collect data
- Research assistant frustrated after bouncing from a data collection visit
- Arriving at hospital to collect data
- Respondent filling questionnaire
- In-depth interview with key informant
- Exiting hospital after data collection
- Posing with key informant after data collection
- Premises of a rural hospital in the study sample
The End 😊