Outsourcing in the Australian health sector

The interplay of economics and politics

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Abstract

Purpose – The paper discusses the reasons and approaches used at three health organisations in introducing outsourcing. It specifically answers the question: why have managers of health organisations outsourced some functions in preference to others?

Design/methodology/approach – This research employs a case study method making use of qualitative analysis. The health organisations were chosen first as representatives of their type, and secondly due to the nature of the outsourcing decisions made. The first health organisation operates in the rural sector; the second is a metropolitan network; and the third is a large metropolitan hospital, which, in contrast to the other two case study organisations, had made only one decision to outsource, producing the largest outsourcing contract in health in Australia. Furthermore, this situation was distinctive as the contract was terminated and re-issued to another private sector organisation.

Findings – The reasons for outsourcing varied within and between health organisations. Although generally they were made on the bases of the characteristics of the labour market, employee skill levels and the nature of industrial relations, the perception of what was core, the level of internal management skills, the ability of internal teams to implement change and the relationship between management and staff. Even though cost savings and a downsized labour force resulted, generally these occurred even when services were not outsourced, through the use of other change processes, such as introducing new technology, changing structures and promoting workforce flexibility. The interplay of political reasons and economic effects was evident along with the political nature of the decision-making and processes used. The paper concludes that the power of managers was a moderating factor between the desire for outsourcing and whether outsourcing actually occurred.

Research limitations/implications – Although this research was conducted solely within the health sector it has implications for other public sector bodies and the private sector.

Practical implications – Managerial decision making can be enhanced with the exploration of the full complement of reasons for the outsourcing decision.

Originality/value – The paper has value to both academics researching in the public sector and public sector managers.

Keywords Outsourcing, Health services sector, Australia, Resource management

Paper type Research paper

Introduction

In April 1995, the Council of Australian Governments agreed to implement the National Competition Policy (NCP) as a means of ensuring that government business enterprises resembled private sector counterparts and were subjected to similar

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efficiency incentives (State Government of Victoria, 1996, p. 5). In Victoria, outsourcing became a key part of the this program, and, it was claimed (Fairbrother *et al.*, 2002, p. 11) that Victoria made the greatest privatisation advances of all Australian states, introducing a new dimension with the break-up and sale of utilities and other government monopolies and the wide use of contracting out. In applying NCP, government agencies were encouraged or required to market test their services by exposing them to competitive tender whilst allowing in-house bids (State Government of Victoria, 1996, p. 7). The Government stated that the primary consideration was the selection of a supplier best able to deliver the service, whether internal or external to the organisation (State Government of Victoria, 1996, p. 35).

In abiding with NCP, the Victorian Government (1996, p. 21) declared that significant business activities undertaken within public hospitals, such as non-clinical services of car parking, computing, laundry, engineering, cleaning and catering, and clinical services, including medical imaging, pathology, pharmacy, allied health services and general practitioner, were to be benchmarked against private sector practices, with the possibility of outsourcing.

It is generally agreed that outsourcing has advantages in allowing organisations to reduce costs, introduce labour market flexibility, and focus on core competencies (Industry Commission, 1995; Hodge, 1996; Young, 2000). However, others have looked to international evidence, and suggested that merely transferring ownership from the public to the private sector achieves limited results, and may even be counterproductive (Ernst, 1997, p. 14 as cited in CDIH & HIC, 2001). With the introduction then of NCP, noting its pervasiveness and effects, why have managers outsourced some functions in preference to others?

Reasons for outsourcing

Overall, six reasons can be gleaned from the theoretical and empirical literature to account for the adoption of outsourcing. The first is that managers have wanted to reduce costs and increase efficiency, which the economic literature argues can be achieved by adopting certain structural forms (Williamson, 1979; Eisenhardt, 1989).

Focusing on core competitive advantage is a second reason discussed. In this instance, the specialised nature of an organisation's competitive advantage is raised by Porter's (1980) corporate strategic theory as important when choosing which governance structure is put in place. In this regard, those functions or activities regarded as non-core can therefore be outsourced.

The third reason, being to introduce workforce flexibility by outsourcing the peripheral workforce, is based on Atkinson's (1984) flexible firm model. In contending that labour be divided into core and peripheral segments, workforce flexibility is maximised with the core segment providing functional skills and the peripheral segment providing numerical skills.

The labour market and political literature (Burgess and Macdonald, 1990; Pfeffer, 1992; Benson and Ieronimo, 1996) suggests that a fourth reason for outsourcing is to reduce the problems of managing industrial relations. In this regard, the use of outsourcing is said to increase the power of management over labour and weaken the power of trade unions.

The personal objective of decision makers is a fifth reason for outsourcing and is primarily found in the political and public choice literature dealing with this issue

(Pfeffer, 1994; Downs, 1967). One example is the use of outsourcing to increase the proportion of white-collar employees at the expense of blue-collar employees, a move aimed at improving the status of managers (Dunleavy, 1991). Public choice theory (Hanke and Walters, 1990) asserts that public sector decision makers are motivated by self-interest which Downs (1967) maintains is divided into self-interest, through a desire for power, money and prestige as well as more broader interests of maintaining loyalty to work groups, agencies, government or nation.

In this vein, a sixth reason is the desire to align public sector agencies with the ideology of the government providing the funding (Downs, 1967; Feigenbaum and Henig, 1994). The reasoning here assumes that decision makers are motivated by a desire for power and see this being fulfilled by acting in the interests of the government. Three aspects of this argument are important in relation to the events in Victoria. First, when cost benefits were found on market testing, even if the analysis was parsimonious, the accountability of managers to the Government made it difficult to avoid outsourcing. Second, key personnel placed on boards of management had strong links with the ruling Liberal Party. And third, business-minded managers were congruent with market efficiency ideas. The ideology advocated outsourcing, alongside private sector competition, a reduction in the size of the public sector, and a decrease in the power of labour.

Methodology

Case study research operates within an interpretivism paradigm and is used in the present research to uncover why outsourcing decisions are made. Such research aims to study real-life experiences by examining the way people think and act and, in contrast to positivism, allows the interviewer to participate to understand the details and features of the experiences.

Initially, interviews were conducted with the chief executive officers of each of the three health organisations, using semi and unstructured questions to ascertain the extent of, and processes used in outsourcing specific services, and in services that have not been outsourced. Further interviews with decision makers and staff in both outsourced and non-outsourced areas were then conducted. Interviews were held over a two-year period, covering all levels of hospital management, both line and support, as well as proprietors and staff of the outsourced areas, and union officials. Data was obtained from the hospital and network's annual reports, and internal financial and consultant's reports, which are not cited fully in the reference list to maintain anonyminity and confidentiality.

Case study one: rural public hospital

At the time outsourcing was considered, the healthcare campus served a population of 59,606 (ABS, 1996), being the key provider of healthcare in the region, whilst providing support services for other hospitals and health-related organisations. The hospital is one of the region's major employers of labour with 543 effective full-time staff employed in 1996. In 1999, its bed numbers amounted to 179, treating approximately 13,000 acute inpatients, 73,000 outpatients and serving 250,000 meals. Turnover amounted to $45 million with total assets of $55 million.

Within this hospital the services considered for outsourcing included radiology, pathology, dental technician, garden and ground maintenance, engineering and

equipment maintenance, and food services. The hospital was subjected to decreased recurrent funding and operated within an environment which witnessed numerous hospital amalgamations. As such, political factors were important in setting the context in which each decision was made. The fiscal environment was also important as there was a lack of government funding for equipment replacement, whilst the characteristics of the rural labour market placed added pressure on the hospital through the inability to obtain professional staff.

The impetus for outsourcing pathology was a change in government funding which rendered it profitable for the private sector to provide pathology services to the public sector. This occurred alongside a difficult industrial relations environment where a strong medical scientist union was attempting to push up wage rates whilst resisting demands for increases in work flexibility. The result of outsourcing this service was a saving in recurrent costs of $200,000 to $300,000 per annum.

The outsourcing of radiology was due to a problematical relationship between hospital management and the radiologists, causing reduced patient numbers and conflicts of interest between public and private patient needs. The outsourcing led to improved relationships and staff morale, and produced economic benefits through increased patient numbers and a private sector injection of over three million dollars to upgrade capital equipment.

These outsourcing decisions produced considerable union and staff angst. However, the staff were simply transferred from hospital employment to private employment and, hence, problems involving capital replacement and managing staff were also transferred. In doing so, this produced economic benefits in reducing costs, whilst the likelihood of returning the services to in-house production is negligible due to the sunk capital costs.

The major reason for investigating the outsourcing of non-clinical services was the Board of Management's commitment to market test all peripheral services in adherence with government ideology. In addition, the outsourcing of dental technician services was due to a desire to increase workforce flexibility and focus on core patient services. As the service had low and variable demand, its outsourcing resulted in increased numerical flexibility. The garden and ground maintenance service was outsourced with a reduced scope of service in order to reduce costs.

Even though consultants' recommended the outsourcing of food, and engineering and equipment maintenance services, hospital management rejected the reports, and, rather, reduced costs through downsizing and changes to workforce flexibility and accountability, rosters, structures and technology. Engineering and equipment maintenance services proceeded to use a mix of internal and external tradespersons, depending on the nature of the task; a successful arrangement due to the need for specialised staff, the difficulty in attracting them to a rural area and the special requirements of the hospital in relation to quality and response times. Food services were kept in-house due to management's desire to repay the loyalty of staff who had been subjected to downsizing and had made substantial changes to work practices in response to the difficult financial situation. In addition, the rural nature of the hospital was an impetus in retaining in-house staff, as management did not wish the public, who cared deeply for their local hospital, to see local staff replaced by people drawn from outside the district. Even so, in food services the downsizing resulted in staff numbers falling from a high of 72 in 1989, to 35 in 2000. Between 1992 and 1997,

engineering and maintenance staff numbers also fell from 25 to 11, although by 2000 they had increased to 15 due to the realisation that some tasks were better handled by internal staff. Hence, in rejecting the outsourcing of food services and engineering and maintenance, personal objectives were important in management's desire to maintain control of the department and staff, and political tactics were used to reject the outsourcing option.

Case study two: city public health network

The network has experienced a number of configurations, from ten hospitals and health services at the time of market testing and outsourcing in 1995, to six health care programs and services in July 2000. In 2000, the health network operated 1,200 beds, served a population of nearly one million people living in two metropolitan areas, as well as offering a range of specialist services for the whole state. In 2000, the network serviced approximately 67,000 acute inpatients and 232,000 acute outpatients.

Since the early 1990s, the network, under the umbrella of NCP, embarked on a review of services in the infrastructure division, and pathology and pharmacy departments. This review was conducted in an environment where turbulent network amalgamations and restructures had been experienced, operating losses were common and benchmarking exercises numerous. The result of the review process was that car parking, garden and ground maintenance, and supply management were outsourced to external contractors. Internal teams won the contracts for food services and engineering, whilst pharmacy and pathology continued to operate within the internal hierarchical structure.

In outsourcing car parking to a national private organisation the network aimed to reduce costs and increase efficiency, and counter the threat of fraud. This was believed to be achievable through introducing expertise in systems, technology and management, with the employment of an external auditor in a monitoring role. The outsourcing of gardens and ground maintenance was due to its peripheral nature and a belief that by outsourcing to a specialist contractor, costs could be reduced. However, it was unsuccessful due to problems with quality and excessive monitoring. As a consequence, the contract, with a reduced scope of service, was subsequently awarded to a person who had previously been employed by both the hospital and the private contractor.

Supply management was outsourced to a multi-national organisation that specialised in logistics. It was believed that efficiencies through changes to management and work processes, could be introduced. The contractor was responsible for downsizing the department by four managers, plus reducing operational staff from 65 to 35, which resulted in savings of three million dollars. When the contract comes up for renewal the network plans to bring the service back in-house; the desired changes to work practices and updating of management skills having been achieved.

The contract for the provision of food services was awarded to the internal team, based on the belief that they could increase efficiency through changing work practices and introducing new technology. This was due to the previous changes the in-house team had made in reducing staff numbers from 320 to 160, which occurred during the aggregation into the network structure. Savings amounted to $5.5 million per annum. Similarly, the contract for engineering services was awarded to the internal team as

management believed that efficiency could be improved, costs decreased and workforce flexibility promoted. Management contended that the internal team had the capabilities to downsize, using contractors for specialist tasks, whilst retaining corporate knowledge. The result saw staff numbers reduced from 160 in 1995 to 35 in 2000, with over 30 specialist services contracted out, with a resultant saving of over three million dollars.

With regard to cleaning services, changes were made to work practices, and downsizing and numerical flexibility were achieved even without market testing. Pharmacy services were also retained internally after market testing due to a lack of provable benefits in efficiency, and the heightened risk factor associated with private sector involvement. In this regard, the patient contact, teaching and research components utilised specialist knowledge, and reflected the core nature of these services, which it was believed was not available to the same extent in the private market. Rather, centralising purchasing functions reduced costs, whilst new managers were employed. Pathology was not outsourced due to the high prices submitted in each of the bids, and the subsequent realisation that costs could not be reduced through outsourcing. However, the aim of changing the department manager was eventually realised as he exited after continual change was foisted upon him.

Even though increased efficiency and reduced costs were the stated rationale for testing all services, management believed this was only achievable by outsourcing the non-clinical services. The effect on morale throughout these processes was mentioned frequently, with staff "bunkering down" because of change being continually thrust upon them.

Case study three: city public hospital

The case study hospital is a leading provider of acute care in the state's major city, with extensive medical research and health care education components. Whilst its catchment area is the metropolitan city area, it also provides specialist services for the state, including heart-lung transplants, trauma care, a cystic fibrosis unit, and haemophilia and HIV/AIDS treatments. In 2000, it employed more than 3,500 staff and treated in excess of a quarter of a million patients.

The hospital outsourced the support services of catering, cleaning, security, ward support, distribution, and garden and ground maintenance as a single "prime vendor" contract. However, due to problems with the initial contractor not meeting the contract specifications, the contract was terminated. The price the hospital was willing to pay for these services was reviewed and the contract was awarded to another party, with savings of approximately two million dollars per annum made.

The stated reasons for outsourcing related to a desire to reduce costs and increase efficiency, improve the management of industrial relations problems and adhere to government ideology. The hospital was operating in a political environment where it had been subjected to decreased funding and a government ideology, strongly endorsed by the board, which pushed outsourcing. As such, it could be claimed that decision makers acted in a self-interested fashion by aligning their decision with government ideology. Another political imperative was the volatile industrial relations between management and labour.

Management's previous actions in downsizing had reduced trust, and staff were wary of its motives. The prospect of another round further reduced trust and morale.

However, the relationship between employees and the hospital was generally long-standing and the transfer of internal staff to the contractor provided for the relationship to continue.

Economically the intention was to save money. Management believed this could be achieved by outsourcing non-core service areas. A labour force of low-skilled, blue-collar workers who were easily replaceable, or transferable to the contractor, staffed these areas. The Board of Management believed large savings could be made as staff moved to different awards and changed work practices under private sector administration. However, despite these staff being regarded as peripheral to patient care, a number of managers referred to the importance of their relationships with nurses, patients and families. Savings did not occur through wage reductions, but rather by changing work processes, rosters and technology.

The hospital was willing to take a gamble with service quality and traded-off quality for financial gain in the first contract, with diverging opinions raised about the level of quality in the second contract. Often the output specifications only became explicit once the decision was made to market test the service, and, indeed, the contract manager claimed that if the same output specifications had been given to internal staff, the financial results would have been similar. In the next contract, in order to re-establish an emphasis on quality, inputs will be specified, in addition to outputs, as would occur in a normal employment relationship. For instance, the number of times a ward is to be cleaned per day would be specified, in contrast to simply measuring the cleanliness of the ward at the end of the week.

Due to inexperience and/or not costing the contract correctly, the first contract was terminated and the second was thought to be unfinancial for the contractor. Not as precise, though, was the effect on the hospital of decreased staff morale and increased monitoring and contract management costs, which were not taken into account in the initial move to outsourcing, nor costed in deliberations.

In addition, management positions were lost which may have been a cause of the management problems that surfaced over the first two years of the contract. However, a lack of internal management skills was said to be one of the factors which led to the non-acceptance of the internal bid.

With the outsourcing arrangement, divergent culture between the public and private sector organisations and within the private sector organisation, was raised as a difficulty, as were problems of staff morale, job insecurity and trust. There were improvements in establishing a shared culture between hospital and contract staff as the hospital began to include contract staff in their committees and ceremonies.

The categorisation of activities as either core or peripheral was shown to be subjective and management began to argue that those activities which required communication with patients and nursing staff, such as ward clerks should be staffed by internal staff in future contracts.

Further outsourcing was not considered, especially in clinical areas as the teaching and research nature of the hospital heightened the risk of failure. Furthermore, the change of Government reduced the ideological drive to favour outsourcing over other change mechanisms. The chief executive officer argued that he "sees outsourcing as a change management mechanism. The process produces change, but it is not necessarily that the private sector does things better or smarter".

Cross-case comparisons

Clinical areas

The increase in government payments for the private provision of pathology and industrial relations issues provided the impetus for market testing pathology. Even so, outsourcing of this service only eventuated at the rural hospital whilst the complex nature of the teaching and research profile precluded this option being taken at the city health services. Similar reasoning was made in relation to the city network's pathology and pharmacy services which were not outsourced after market testing due to the belief that they were core patent care services.

One of the rationales in the market testing of pharmacy services at the city network was the potential of outsourcing to remove departmental management. Of the three health organisations, the only radiology service outsourced was at the rural hospital, and this was due to conflicts of interest and problematical relationships between the hospital management, the radiologists and the technical staff. Thus, relationships between upper and middle management cannot be ignored as an impetus in market testing clinical services.

No other clinical areas were outsourced at the three health services, as managers believed staff provided a value-added service and cost savings were unable to be found. Hence, clinical areas were only outsourced if political factors intervened in the decision making, through either problems with managing staff or changes to external funding. Economically, savings were not apparent in outsourcing such areas, whilst risks to patient care were believed to be heightened.

Non-clinical areas

Gardens and grounds. Gardens and grounds were outsourced at all of the case study health organisations, due to its peripheral nature, in the belief that economic advantages would eventuate. Decision makers, in selecting it as one of the first to be investigated, were adhering to government ideological pronouncements. However, at both the rural hospital and city network, costs were only reduced through reducing the scope of the service, whilst the network eventually terminated the first contract due to the excessive monitoring required and problematical relations with the contractor.

Car parking and supply management. Car parking was another service outsourced at the city network to align with government ideology and reduce costs. The management of supply was also outsourced at the city network. This was undertaken to reduce costs through changing work practices, downsizing and increasing management skills. In both cases, it was believed that internal management skills were lacking and outsourcing was used to promote improvement in this area. Hence, these decisions both related to the lack of internal management skills and managements' inability to effectively train staff and reduce pilfering.

Food services. Food services were contracted out at the city hospital (as part of support services) and the city network to reduce costs, increase workforce flexibility, and abide by government ideology, notwithstanding the contract being awarded to an internal team at the city network. Other impetuses at the city hospital included the service's peripheral nature and the inability of middle managers to persuade directors that change could be made using other methods. Outsourcing of the food service was not proceeded with at the rural hospital, and alternatively costs were reduced through the introduction of workforce flexibility and downsizing. In this case, the middle

managers used political tactics to persuade directors and the Board of Management to not outsource by discrediting the consultant's report and introducing new processes to show that internal staff were capable of change. The very threat of outsourcing allowed such changes to occur, without industrial action, whereas the city health organisations both relied on the contractor to introduce new technology and changes to work practices, thereby increasing numerical and functional flexibility. Furthermore, trust and loyalty between management and staff existed at the rural hospital, whereas it was not evident at the city health organisation. Downsizing had occurred and the nature of the rural community, with its lack of employment opportunities, increased the reliance of staff on employment at the local hospital and raised issues surrounding the public perception of introducing external contract labour into the rural area. The lack of employment opportunity was also linked to the acceptance of change by the staff. In essence, all three cases used different methods to introduce similar changes, but whether outsourcing was used depended on the power of the middle managers, their perceived ability to realise the changes, and their relationship with both upper management and staff. The city health organisations also had a capacity to tap into a large external labour force.

Engineering services. Engineering at the network was outsourced to the internal team and accompanied by downsizing, contracting out of specialist services and the introduction of advanced technology. The aim was to reduce costs, focus on core services, introduce expertise when required and promote workforce flexibility. Similar aims were evident at the rural hospital, but engineering was retained internally. This was due to the nature of the rural labour market, with deficiencies in the skills of local sub-contractors, the hospital's isolation, and the ability of the line manager to persuade decision makers of the capability of internal staff to make similar changes.

Support services. The outsourcing of all non-clinical support services at the city hospital was due to a desire to reduce costs and the belief that this would be assisted by its peripheral nature. Industrial relations imperatives were also an important factor, and it was believed that outsourcing could be used to introduce workforce flexibility and therefore reduce costs. This viewpoint filtered down from the Board of Management as they wholeheartedly adopted the government's private sector ideology. However, some managers claimed that the employees made significant changes when the service was initially market tested, and the outsourcing process could have been deferred with similar financial outcomes. Questions about the long-term nature of the savings and the problems of specifications and quality have raised the idea of returning the services, which displayed close contact with nursing staff and patients, to internal provision.

In contrast, the market testing of the city network's non-clinical services resulted in a variety of structural arrangements. Industrial relations' imperatives were not as prevalent and the director of infrastructure displayed power in the decision-making processes, in contrast to the Board of Management which made the decision to outsource all support services at the city hospital.

Conclusion

The six reasons for outsourcing initially proposed in the literature review focused economically on the desire to reduce costs and improve labour flexibility and, politically, the desire to satisfy personal objectives, adhere to Government ideology and

improve industrial relations problems. This research has found that there was always an overarching view that in outsourcing to adhere to government ideology, costs could be reduced. However, specific decisions about which areas were to be outsourced were made on other bases, namely the characteristics of the labour market, including employee skill levels and the availability of labour, the nature of industrial relations, and the perception of what was core in relation to patient care; albeit that the perception was inconsistent.

But throughout these case studies, another reason has come to the fore, that being a desire to improve department management. Although management/staff relations was highlighted in the literature as a reason for outsourcing, it tended to focus on the industrial relations imperatives or problems associated with changing work processes. This research has exemplified the problematical relationship between upper and middle management and the use of outsourcing to change or improve the relationship. In some cases this was achieved by removing the managers in question and in others by removing the middle-management layer altogether, whilst in still others the threat of outsourcing induced managers to change or, by threatening their power bases, induced them to leave. But the lack of middle-management skills, their unwillingness to change, their use of political tactics to stop change and the problematical relationship with upper management have certainly been highlighted as a major reason for outsourcing.

As found in research in other industries (Young and Macneil, 2000), the effects of outsourcing did not always align with managers' expectations, with a number of contracts being eventually terminated due to poor quality, excessive monitoring or the contractors' inability to meet the specifications. Cost savings and increases in efficiency generally resulted, alongside a downsized labour force. But even when outsourcing did not proceed after market testing, the results were similar with the use of other change processes such as introducing new technology, changing departmental structures and promoting workforce flexibility. As Young (2002) states, the research "points to the complex interrelated nature of the use of downsizing to change worker's acceptance of change, which includes outsourcing, and the use of outsourcing to reduce employee numbers". In still other cases, not all transaction costs were included in the analysis. For instance management costs, voluntary departure packages and the risk of increased contract costs on subsequent tenders were not generally taken into account. Often managers did not have a clear understanding of internal processes and required outcomes, and outsourcing was used to develop all of these through the process of writing the contract specifications. Furthermore, the use of outsourcing to solve problems of managing staff was not always effective, as contract managers were often unaware of the specific requirements of hospital services. There was also evidence of reduced morale and trust, and divergent cultures. However, in cases where problematical relationships existed internally, outsourcing generally improved relationships and staff morale, and alongside long contractual terms, culture and values began to be shared.

The interplay of political reasoning and economic effects was also evident. In many cases where management problems were an impetus in outsourcing, the process led to reduced costs, changes to work practices and downsizing. Similarly, the use of outsourcing to solve industrial relations issues and take up government funding opportunities also produced financial benefits, through the injection of private sector

capital funds, changes to work practices, and higher rates of pay. The political nature of the decision making was linked to the health sector's fiscal environment, and, indeed, the industry's public sector characteristics were fundamental to the political nature of the decision making, as the bureaucracy were able to affect the decision making at individual organisations through board composition, and changes to network structures and budgets. The attainment of personal objectives was relevant in the context that managers could exert power to obtain a decision that reflected their needs, such as maintaining staff levels, retaining their own position, introducing new technology, and restraining or fostering change. In this regard the power of managers was a moderating factor between the desire for outsourcing and whether outsourcing actually occurred.

References

Atkinson, J. (1984), "Manpower strategies for flexible organisations", *Personnel Management*, August, pp. 28-31.

ABS (1996), *1996 Census of Population and Housing*, Vol. 1996, Australian Bureau of Statistics, Canberra.

Benson, J. and Ieronimo, N. (1996), "Outsourcing decisions: evidence from Australia-based enterprises", *International Labour Review*, Vol. 135 No. 1, pp. 59-73.

Burgess, J. and MacDonald, D. (1990), "The labour flexibility imperative", *Journal of Australian Political Economy*, Vol. 27, pp. 15-35.

CDIH & HIC (2001), "Privately providing public hospital care: a brief critique of privatisation", *Health Financing, Health in the Marketplace*, Centre for Development and Innovation in Health and the Health Issues Centre, available at: www.cdih.org.au/marketplace/privatis.html (accessed 4 April).

Downs, A. (1967), *Inside Bureaucracy*, Little Brown, Boston, MA.

Dunleavy, P. (1991), *Democracy, Bureaucracy and Public Choice: Economic Explanations in Political Science*, Harvester Wheatsheaf, Hemel Hempstead.

Eisenhardt, K.M. (1989), "Agency theory: an assessment and review", *Academy of Management Review*, Vol. 14 No. 1, pp. 57-74.

Ernst, J. (1997), "Public utility privatisation and competition: challenges to equity and the environment", *Just Policy*, No. 9, March.

Fairbrother, P., Paddon, M. and Teicher, J. (2002), "Introduction: corporatisation and privatisation in Australia", in Fairbrother, P., Paddon, M. and Teicher, J. (Eds), *Privatisation, Globalisation & Labour: Studies from Australia*, ch. 1, The Federation Press, Sydney, pp. 1-24.

Feigenbaum, H.B. and Henig, J.R. (1994), "The political underpinnings of privatization: a typology", in Wright, V. and Perotti, R. (Eds), *Privatization and Public Policy: Volume II*, The International Library of Comparative Public Policy, published 2000, Edward Elgar, Cheltenham, pp. 3-26.

Hanke, S.H. and Walters, S.J.K. (1990), "Privatization and public choice: lessons for the LDCs", in Wright, V. and Perrotti, L. (Eds), *Privatization and Public Policy: Vol I*, The International Library of Comparative Public Policy, published 2000, Edward Elgar, Cheltenham, pp. 331-42.

Hodge, G. (1996), *Contracting out Government Services: A Review of International Evidence*, Monash University, Melbourne.

Industry Commission (1995), *Competitive Tendering and Contracting by Public Sector Agencies: Draft Report*, October, Industry Commission, Canberra.

Pfeffer, J. (1992), "Understanding power in organizations", *California Management Review*, Vol. 34 No. 2, pp. 29-50.

Pfeffer, J. (1994), "Competitive advantage through people", *California Management Review*, Vol. 36 No. 2, pp. 9-28.

Porter, M. (1980), *Competitive Strategy: Techniques for analyzing Industries and Competitors*, The Free Press, New York, NY.

State Government of Victoria (1996), *Competitive Neutrality: A Statement of Victorian Government Policy*, Department of Premier and Cabinet, Melbourne.

Williamson, O. (1979), "Transaction-cost economics: the governance of contractual relations", *Journal of Law and Economics*, Vol. 22 No. 2, pp. 233-61.

Young, S. (2000), "Outsourcing: lessons from the literature", *Labour & Industry*, Vol. 10 No. 3, pp. 97-118.

Young, S. (2002), "Outsourcing and downsizing: processes of workplace change in public health", *The Economic and Labour Relations Review*, Vol. 13 No. 2, pp. 244-69.

Young, S. and Macneil, J. (2000), "When performance fails to meet expectations: managers' objectives for outsourcing", *The Economics and Labour Relations Review*, Vol. 11 No. 1, pp. 136-68.