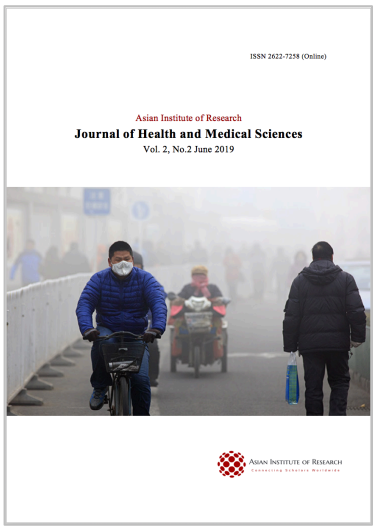

Journal of Health and Medical Sciences

Sanusi, Bolanle Mistura. (2019), Assessment of Factors Influencing Outsourcing Strategy in Teaching Hospitals in South-Western Nigeria. In: *Journal of Health and Medical Sciences*, Vol.2, No.2, 153-166.

ISSN 2622-7258

DOI: 10.31014/aior.1994.02.02.32

The online version of this article can be found at:
https://www.asianinstituteofresearch.org/

Published by:
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The Asian Institute of Research
Journal of Health and Medical Sciences
Vol.2, No.2, 2019: 153-166
ISSN 2622-7258

DOI: 10.31014/aior.1994.02.02.32

Assessment of Factors Influencing Outsourcing Strategy in Teaching Hospitals in South-Western Nigeria

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Abstract
This study investigated factors influencing outsourcing strategy in South-Western Nigerian teaching hospitals. The study utilised primary data which were collected through questionnaire and key informant interviews. The data collected were analysed using descriptive and inferential statistical techniques. The paper found that cost reduction, greater flexibility, reduced manager's burden, improved services, efficient use of resources, reduced staff workload and innovation and creativity, are the most factors influencing outsourcing strategy in Nigerian teaching hospitals. The study, however, revealed that technical convenience and efficiency, increased productivity/performance, the need to focus on core activities, Improvement of service delivery and quality, as well as to meet changing customers' needs is the major rationale for outsourcing in Nigerian teaching hospitals. In addition, the study concluded that reduced manager's burdens, reduction staff workload, are the major benefits of outsourcing in the Nigerian teaching hospitals. The study, however, concluded that outsourcing is an emerging process in Nigeria. Therefore, the Nigerian health sector needs to pass through a learning phase before outsourcing is recognized as an efficient management and regulatory tool.

Keywords: Outsourcing Benefits, Strategic Management, Nigerian Teaching Hospital

1.0 Introduction

The need for outsourcing has grown over the last two decades due to some factors which include among others, global competition, downsizing, the move to flatter organization, the need to reduce cost, improved quality services and delivery, increased flexibility which facilitate change and the emphasis on core competencies (Dyer and Ouchi, 1993; Huber, 1993; Fan, 2000). Hospitals and healthcare subsystems in Nigeria have been criticized as inefficient owing to factors of underfunding, use of obsolete equipment, low-quality patient care, poor leadership capabilities and inappropriate management (ref). In view of the observed phenomenon, hospital management has evolved a new management strategy termed "outsourcing" with the hope that better service delivery will be guaranteed.

There are three major categories of motivations for outsourcing: cost, strategy, and politics. The first two commonly drive outsourcing by private industry. Political agenda often drive outsourcing by the public organization (Kakabadse and Kakabadse, 2000a). While there may be three categories, outsourcing activities are likely to be initiated for more than one reason and in fact, may be driven by elements from all the three

categories. For example, the outsourcing of taxing and health services for the British government was driven by elements from both cost and political categories (Willcocks and Currie, 1997a).

Since 2006, outsourcing had become a key thrust of government policy in Nigeria, provided for under the "Generic guidelines for the reform of parastatals" as directed by the Bureau of Public Service Reforms (BPSR, 2006). Although the strategy of outsourcing has long been used in the private sector this policy shift by the government has made it compulsory for the public sector to outsource. This practice is not new in the Nigerian private sector as was pointed out by Adeleye (2004) that outsourcing is becoming a prominent strategy in service-related businesses in Nigeria (Adeleye, 2004).

While a sizeable number of studies have investigated the management practices associated with the outsourcing of services in sectors like banking, oil, and gas, less attention is paid to the healthcare sector. There is, therefore, a need to investigate the factors influencing the outsourcing strategy adopted by the teaching hospital in Nigeria, most especially those teaching hospitals that enjoy some level of independence and autonomy in their management and service delivery policy, as a critical step towards enhanced performance; hence this paper explores the factors determining outsourcing practices in the tertiary health sector in Nigeria with the specific of identifying the services outsourced in selected teaching hospitals in South-western Nigeria and then examining the factors influencing outsourcing of services in the hospitals. The study is restricted to the health sector in South – Western Nigeria. A large concentration of teaching hospitals is present in South-Western Zone and whatever is happening in the zone is a reflection of what is likely to happen in the tertiary health sector in other zones in Nigeria all things being equal.

The paper is divided into five sections. Apart from this introduction, section 2, review the salient concept and empirical studies on outsourcing and lay the background for the empirical methodology in section3. Section 4 presents the empirical results and finding while the paper concludes with policy implications in section 5

2.0 Literature Review

There is much debate in management literature defining outsourcing (Gilley and Rasheed, 2000). Outsourcing is defined by Espino-Rodriquez et al; (2006) as a "strategic decision that entails the external contracting of determined non-strategic activities or business processes necessary for the manufacture of goods or the provision of services by means of agreements or contracts with higher capability firms to undertake those activities or business processes with the aim of improving competitive advantage". It is the transfer of one or more internal activities of an organization to an external vendor. Sharpe (1997) defines outsourcing as turning over to supplier those activities outside the organization's core competencies. Generally, outsourcing can be defined as the "transfer of previously in-house activities to a third party (Lonsdale, 1999). Wasner (1999) defines outsourcing as "…turning over to an external vendor the control of an in-house activity or activity for which an immediate ability exists of performing it internally." Wasner (1999) states that outsourcing is composed of a make or buy decision with the transfer. Gilley and Rasheed (2000) claim that "...outsourcing represents the fundamental decision to reject the internationalization of an activity…"

Nonetheless, despite an abundance of literature which looks into outsourcing, there appears to be a lack of a common definition of the term outsourcing (Deavers, 1997; Wasner, 1999). Domberger 1998 defines outsourcing "… as the process whereby activities traditionally carried out internally are contracted out to external providers…" Gilley and Rasheed (2000) provide clarification for the definitional confusion position and therefore defines outsourcing as procuring something that was either originally sourced internally (i.e., vertical disintegration) or could have been sourced internally notwithstanding the decision to go outside (i.e., make or buy). This includes arrangement and concepts which have been termed – internal vs external sourcing strategic make or outsource decisions contracting out (Gustafsson, 1995), contractorization (Hood, 1997), sub-contracting, purchasing, privatization (Seidenstat, 1996) compulsory competitive tendering, market testing liberalization (Beaumont 1991) and make or buy and focus. (Knight and Harland).

Wasner (1999) and Gilley and Rasheed (2000) emphasize that defining outsourcing in terms of procurement limits the definition – "defining outsourcing simply in terms of procurement of activities does not capture the

true strategic nature of the issue … outsourcing is not simply a purchasing decision". (Gilley and Rasheed, 2000). To better capture the conceptual basis of outsourcing it has been argued that the definition will be more meaningful if it incorporates the notion of transfer of activities that previously have been governed internally to external source (Greaver, 1999; Wasner, 1999; Gilley and Rasheed, 2000; Ellram and Billington, 2001; Heywood, 2001). Ellram and Billington (2001) define outsourcing as "…. the transfer of the production of goods or services that had been performed internally to an external party".

Along a similar line, Heywood (2001) defines outsourcing as "… the transferring of an internal business function or functions plus any associated assets to an external supplier or service provider who offers a defined service for a specified period of time at an agreed but the probably qualified price". Similarly, Gilley and Rasheed (2000) claim that outsourcing "… represents the fundamental decision to reject the internalization of an activity…" Outsourcing is an important aspect of health sector reform programmes in many countries, because it provides the government with a management and regulatory tool that creates incentives for improved performance and accountability (WHO, 2006). Therefore, outsourcing in the context of this study is defined as the process whereby activities traditionally carried out internally are contracted out to external body or bodies. It is, therefore, the transfer of activity from the internal governing body to the external governing body.

Young (2003) also observes that in outsourcing the major elements are first, the third party should be outside the normal employment conditions that govern traditional employees of the organization, and second, the functions should have been previously conducted in-house. Mylott (1995), Pearlson (2001), and Butler et al.; (2001) distinguished two forms of outsourcing namely full outsourcing and selective outsourcing. In full outsourcing, all the services are outsourced to the vendor. This according to Pearlson (2001) happens when the organization does not see outsourcing of their services as a "strategic advantage" that should be developed internally. Arguments for full outsourcing usually involve the allocation of organizational resources to areas that can add value to the organization value chain or reduce cost per transaction due to economies of scale. In selective outsourcing, only a range of services is selectively outsourced or contracted out to a third party. It often results in greater flexibility and better services (Pearlson, 2001). Thus outsourcing in the context of this study is more related to transfer than procurement and is the transfer of activity from internal governance to external control.

According to Quinn and Hilmer (1994), maintaining a competitive edge means focusing on intellectual skills and management systems, not products or functions which can easily be duplicated or replaced. Therefore, in determining which activities should be outsourced, it is widely suggested that core activities should be in-sourced and none-core activities outsourced. None-core activities are peripheral to a company's competitive advantage (Quinn and Hilmer, 1994). Flexibility can also be achieved as outsourcing enables access to rapidly developing new technologies or complex systems (Kakabadse and Kakabadse, 2000b). Thus, outsourcing allows for the possibility to fully exploit competencies and technologies of the outside sources which would be difficult and costly to develop internally (Quinn and Hilmer, 1994; Gilley and Rasheed, 2000). By this outsourcing can contribute to enhancing the quality of products/service (Canez et al.; 2000).

In an era of rapid technological change and short product life cycles, companies were trying to reduce cost and maintain quality at the same time which implied that companies would need to specialize in what they did best and de-emphasize management attention from business processes that did not directly impact the business. Outsourcing is a means by which the organizations improve their businesses by enabling them to handle specific business processes – better, faster and at a lower operating cost (Krishna, 2001). It was defined as the transferring one or more internal functions of an organization to external service providers. Outsourcing has become an alternative, which all major corporations must consider in order to remain competitive. Outsourcing helps to increase efficiency, improve service quality, accountability, values, decreased headcounts and cash infusion and gain access to world-class capability and sharing risk (Outsourcing Institute, 2006).

3.0 Methodology

The study was conducted in two selected teaching hospitals, namely: Obafemi Awolowo University Teaching Hospital Complex (OAUTHC), Ile-Ife and University College Hospital (UCH), Ibadan.

Study Design

Both primary and secondary data were used. The primary data employed included a closed-ended questionnaire. The questionnaires were sent to senior staff members of UCH and OAUTHC respectively. Prior to the hospitals surveyed, the questionnaire was discussed independently with some staff of OAUTHC Ile-Ife for validation. Based on their comments the questionnaire was modified and finalized.Interviews were also conducted with some of the top management staff of the hospital, including the Chief Medical Director (CMD), the Director of Administration (DA) and the Deputy Director of Finance (DDF) of each hospital to enhance the richness of the study. Questionnaires were used to elicit information for OAUTHC and UCH. Secondary data were also collected through records from the hospitals. Thus, the study adopted the usage of a questionnaire as a way of collecting information.

Study Population

The study population for this study consisted of senior staff of the two hospitals, i.e., OAUTHC and UCH.

Sample Size Determination

A total of 700 questionnaires were distributed equally in OAUTHC and UCH. The questionnaire has 12 items divided into four sections. Section one relates to the background information while section two covers issues on awareness and types of service outsourced. Section three deals with perceived benefits and risks of outsourcing and section four ask questions on the outsourcing management practices.

Out of 350 questionnaires distributed in OAUTHC, 330 (94%) of the questionnaires were returned duly filled with 20 questionnaires (6%) that were not returned. In the case of UCH Ibadan, 323 (92%) of the questionnaires were returned as filled while 27 (8%) were not returned. In all 93% (653) of the questionnaires out of the 700 were finally analyzed.

Sampling Technique

The samples of 700 respondents were selected through non-probability technique. Primarily, purposive sampling technique was used because the specific information required could only be provided by a well-defined set of people. Therefore, random or stratified sampling or any other probability sampling would not have been effective. The questionnaire was designed to elicit information on outsourcing management practices in hospitals. Each construct was represented by a set of indicators, which form the questions in the survey. The opinions of the respondent were captured on a positive to negative five-point Likert Scale while information relating to the personal attribute of respondents was captured using gender, age, level of education and position on the organizations.

Questions on the level of outsourcing of services were captured by the extent of outsourcing, i.e. totally outsourced/partially /not outsourced. Questions on perceived risks and benefits gave a statement and asked for the level of agreement on the following scale: Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D) and Strongly Disagree (SD). Data collected were processed using the SPSS (Statistical Package for Social Science). Data were analysed using descriptive statistics with the application of inferential statistics.

4.0 Empirical Results

Social Demographic Characteristics of the Respondents

Table 1 depicts the demographic characteristics of the respondents. Basically, three key variables of the respondents were presented: Gender, Age and Religion.

Gender

Out of the 330 respondents from OAUTHC, only 130 (39.4%) were male while the remaining 200(60.6%) were female. The similar distribution pattern was observed in UCH, where 151(46.2%) were male, and 172(53.8%) were female. In all 281(42.8%) were male while 372(57.2%) were female. This implies that there were more female respondents than male. Generally, one would have expected the male to be dominating especially in a country like Nigeria where almost all professions were traditionally male-dominated. Nursing Cadres was responsible for this distribution pattern because the nursing profession was mainly dominated by female and

their entry point was senior staff. Also, statistics showed that they formed one-third of the total population of senior staff in each hospital. This pattern notwithstanding, the representation of the gender still seems balanced and sufficiently representative of the gender composition of the respondents.

Age

The age composition of the respondents in table 1 shows that the bulk 104(31.4%) and 162 (50.2%) of the respondents were between the age of 30 years and 39 years in OAUTHC and UCH respectively. Eight-nine (26.8%) and one hundred and twenty-one (37.3%) of the respondents were between the age of 40 and 49 years while 74 (22.7%) and 32 (9.9%) are above 50 years respectively in the two teaching hospitals. Only a small proportion of 63 (19.1%) and 8 (2.6%) of the staff surveyed aged below 30 years respectively in the two teaching hospitals. However, the pattern was similar, but the proportions were different across the age bracket in the two teaching hospitals. The respondents were more evenly distributed in OAUTHC than in UCH. For instance, while more than half (50.2%) of the respondents in UCH were between 30 and 39 years, only 31% in OAUTHC were within this age bracket. There seems to be younger and elderly staff in OAUTHC than UCH. Of all the respondents, 19% in OAUTHC as against 3% in UCH aged below 30 while about 23% of respondents from OAUTHC as against 10% from UCH aged above 50 years. There were more middle-aged workers in UCH than OAUTHC. About 88% of the respondents from UCH were between the age of 30 and 49 years while only 58% in OAUTHC are in this age bracket.

Overall, only 11% of the respondents were below age 30, 41% are between ages 30-39, 32% are between ages 40-49years while 16% aged above 50% years. The preliminary survey of the civil service of the federation in 2002 revealed an aging service of 60% of officers within the age bracket of 40 years and above. Therefore, part of the reform of 2006 is that the civil service is expected to have an organization that is competently staffed and well managed. Thus, the survey revealed that the problem of ageing service is gradually being solved, because 50.5% of the respondents in OAUTHC and 52.8% of the respondents in UCH are between ages 1-39 years while 49.6% of the respondents in UCH aged above 40 years. Overall, 51.6% of the respondents are between ages 1-39years while 48.4% of the respondents are above 40 years in age.

Religion

As shown in Table 1 most (508) of the respondents who responded to the issue of religion claimed either Christianity or Islam. The survey revealed that among those who responded to the question of religion, the dominance of Christianity is noticeable and apparent. Two hundred and seven (80.8%) and two hundred and seventy-three (74.6%) of the respondents from OAUTHC and UCH respectively were Christian while only 30 (9.2%) and 50 (15.4%) were Muslims respectively. In total 508 (87.7%) of the respondents are Christians while 80 (12%) are Muslims. Thirty-three (10%) and thirty-two (10%) failed to pick either Christianity or Islam.

In all 65 (10%) failed to respond to this question; 34(10%) and 32(10%) in OAUTHC and UCH respectively. Two reasons may be apparent. They might be reluctant to disclose their religion since they might believe that it was too personal and may not want to give too much of their personal information on the official response to the questionnaire. Two, they might be wondering what additional value their religions would add to the quality and authenticity of their perceptions and responses they provide to the issues raised in the questionnaires. They rather believed that if the interviewer cannot trust them without stating their religion, then they are not fit to respond; that religion has no bearing on the issues raised in the questionnaires and hence is immaterial to their perception of the outsourcing. This argument notwithstanding, it is interesting to note, however, that none of the respondents claimed to be a traditionalist or other religions.

Table 1: Socio-Demographic characteristics of the respondents (%)

		OAUTHC (obs=330)	UCH (Obs=323)	Total (Obs=653)
Gender	Male	130(39.4%)	151(46.2%)	281(42.8)
	Female	200(60.6%)	172(53.8%)	372(57.2)
Age	less than 30	63(19.1%)	8(2.6%)	71(10.85%)
	30-39	104(31.4%)	162(50.2%)	266(40.8%)

	40-49	89(26.9%)	121(37.4%)	210(32.2%)
	50+	74(22.7%)	32(9.9%)	106(16.3%)
Religion	Christianity	267(80.8)	241(74.6)	508(77.7)
	Islam	30(9.2)	50(15.4)	80(12.3)
	No Response	33(10.0)	32(10.0)	65(10.0)

Source: Author Field Survey 2018

Employment Profile of the Respondents

Table 2 present the distribution of the responses according to the employment profile of the respondents. Four categories of employment traits were identified, Educational level attained, employment status in the hospital, Job status and years of experience as a staff.

Educational Qualification

Among the 330 and 323 of the OAUTHC and UCH staff who responded to the question on the level of education, about 20 (6.2%) and none (0%), of staff from OAUTHC and UCH were primary school certificate holders. Eighteen (5.5%) and 27 (8.4%) were the holders of WASC or Vocational Certificate holders in the two hospitals respectively. Forty-seven (14.2%) and seventy-two (22.3%) are OND/HND holders. The University (first) Degree holder accounted for about 197 (59.7%) and 159 (49.1%) in OAUTHC and UCH respectively while about 48 (14.5%), and 65 (20.1%) were postgraduate (second Degree) holders. Overall 20 (3.1%) and 46 (7%) were primary and Secondary school certificate holders respectively. Approximately 119 (18%) of the staffs are holder Polytechnic certificate while the 355 (54.4%) and 113 (17.3 %) were university first degree and second-degree holders respectively. The distribution patterns show that the bulk of the workers were graduates and indeed more than half of the respondents held at least a university degree. This implied that the respondents were well educated, with 71.7% holding at least a university degree while the remaining 28.3% were junior staff who rose to become senior staff.

The problem identified in the reform of 2007 that the civil service consists of junior staff largely unskilled and constitute about 70% of the workforce was also solved because more than half of the respondents are university degree holders. This implies that most of the staff in the two teaching hospitals are senior staff, are well educated and are professionals in the various field of endeavour.

Job Status

The issue of outsourcing has a direct implication on the job duties of the staff. Once the services in the teaching hospital are outsourced, there would always be a change in staff duties and responsibilities. Some of the staff may even lose their jobs, redeployed and change jobs completely. So the views of these vulnerable staff are very crucial in the appraisal of the outsourcing activities in a teaching hospital. Seven types of Job categories in the teaching hospitals were identified in the survey: Management, Administration, Medical Doctor, Pharmacist, Nurses/Midwives, Laboratories Scientists, and General Staff. The distribution patterns of these job categories as presented in Table 4.2 show that 12 (3.6%) and 16 (5.1 %), constitute the management staff, 42 (12.8%) and 104 (32.2%) are in the administration staff, 70 (21.3%) and 68 (21.2%) are Medical doctors and 164 (49.5%) and 73 (22.7%) are Nurses/Midwives, while the Pharmacists accounted for 17 (5.2%) and 5 (1.5%) of the respondents from OAUTHC and UCH respectively, The distribution pattern also shows that the laboratory scientists constituted about 17 (5.2%) and 23 (7%) while General staff 8 (2.4%) and 34 (10.3%). In both Teaching hospitals, the Nurses/Midwives account for the largest proportion 237 (36.1%) of the respondents, followed by administration 146 (22.5%) and Medical doctors 138 (21.3%). The least represented is Pharmacist 22 (3.4%) followed by Management 38 (4.4%) and Laboratory scientists 40 (6.1%).

Length of Service

The years of experience of the staff in the hospitals is another factor considered important in gauging their perception about the desirability and relevance of outsourcing in the healthcare sector. As shown in table 4.2, 144 (43.7%) and 99(30.6%) of OAUTHC and UCH staff had spent less than 5 years on the job. 35(10.6%) and 81(25.2%) of the respondents from the OAUTHC and UCH claimed to have spent between 6 and 10 years while

72 (21.8%) and 80(24.7%) had between 11 and 20 years of experience. Seventy-nine (23.9%) and sixty-three (19.5%) of the respondents had more than 20 years of working experience as the staff of the teaching hospitals respectively. This pattern of distribution shows that most of the staff (37.2%) has spent less than years in the hospital which implies that a sizeable proportion of the respondents are less experienced and matured staff in the system. Interestingly, it was within these five years that outsourcing begun in the two hospitals. This increasing proportion of the staff with less than 5 years might be as a result of outsourcing that might have led to an upsurge in the number of staff engaged in the hospitals. However, a remarkable proportion of the workers in both hospitals between 11 and 20 years, showing that a sizable proportion (23.3%) of the health care workers are experienced and matured.

Table 2: Employment Profile of the Respondents (%)

		OAUTHC	UCH	Total
Level of education	Primary	20(6.2%)	0(0%)	20(3.1%)
	secondary/Vocational	18(5.5%)	27(8.4%)	46(7.0%)
	Polytechnic	47(14.2%)	73(22.3%)	119(18.3%)
	University First Degree	197(59.7%)	159(49.1%)	355(54.4%)
	Postgraduate	48(14.5%)	65(20.1%)	113(17.3%)
Job Status	Management	12(3.6%)	16(5.1%)	28(4.4%)
	Administration	42(12.8%)	104(32.2%)	146(22.5%)
	Medical Doctor	70(21.3%)	68(21.2%)	138(21.3%)
	Pharmacist	17(5.2%)	5(1.5%)	22(3.4%)
	Nurses/Midwives	164(49.5%)	73(22.7%)	237(36.1%)
	Laboratory scientists	17(5.2%)	23(7%)	40(6.1%)
	General Staff	8(2.4%)	34(10.3%)	42(6.4%)
length of services	Less than 5	144(43.7%)	99(30.6%)	243(37.2%)
	between 06 and 10 yrs	35(10.6%)	81(25.2%)	116(17.9%)
	between 11 and 20 years	72(21.8%)	80(24.7%)	152(23.3%)
	above 20 years	79(23.9%)	63(19.5%)	142(21.7%)

Source: Author Field Survey 2018

4.1 Identification of Services Outsourced in the Teaching Hospitals

In this section, the level of awareness of the respondents about the services being outsourced in their hospitals was inquired about. The types of services being outsourced and the numbers of years outsourcing activities have taken place in those services.

As depicted in Table 3 most of the respondents 578 (89%) were aware of the introduction of outsourcing in their teaching hospitals. Compositional distribution of these people, who claimed to be aware of outsourcing, shows further that more people in UCH 293 (90.8%) are more conversant with outsourcing than OAUTHC 287 (87%). The possible reason for this might be the fact that outsourcing had been implemented in UCH much longer than in OAUTHC.

How long the respondents have been aware of outsourcing is considered a crucial factor in determining their ability to appreciate the benefits and challenges of outsourcing. Among those that reported being aware of outsourcing, only 146(22.3%) of the respondents got to know about outsourcing within the last one year. 463 (70.9%) became aware of outsourcing in the last 5 years. A small proportion of 43 (6.7%) had heard about outsourcing for more than five years. Between OAUTHC and UCH, the pattern is similar, except in the case of those who knew about outsourcing in less than a year, UCH respondents are relatively larger in the proportion that OAUTHC. The reason is that UCH started outsourcing before OAUTHC. The concentration of the respondents in the 1-5 years bracket is due to the fact that outsourcing really started in these teaching hospitals

just five years ago. Obviously, most of them would have got to know about outsourcing after it started in their hospitals

Outsourcing is being implemented with caution in the teaching hospitals surveyed. Not all services have been outsourced. As shown in Table 4.3 and Figure 4.3, Administration remained the most outsourced department in the two teaching hospitals with 10 units in the department being outsourced while 4 units in account/treasury and 5 units in clinical services having been outsourced.

In terms of compositional distribution of the units outsourced among the two hospitals, Table 3 showed that more units were outsourced in UCH than in OAUTHC. Specifically, 8 units in contrast to 2 units (in OAUTHC) of administration department were being outsourced in UCH. A similar pattern is observed in account/treasury and clinical. This, therefore, implies that outsourcing is just emerging in OAUTHC while it is more established in UCH.

Table 3: Awareness and Types of Activities Outsourced

Items	Responses	OAUTHC	UCH	Total
Awareness of outsourcing	Yes	287(87%)	293(90.8%)	580(88.9%)
	No	43(13%)	30(9.2)	73(11.1%)
Years of awareness	under 1 yr	86(26%)	60(18.6%)	146(22.3%)
	1 to 5years	225(68.2%)	238(73.6%)	463(70.9%)
	5 to 10 years	18(5.4%)	25(7.9%)	43(6.7%)
	10 to 15 years	1(0.4%)	0(0%)	1(0.2)%
No. of Services Outsourced	Administration	2	8	10
	account/treasury	1	3	4
	clinical services	1	4	5

Source: Author Field Survey 2018

4.2 Degree of Outsourcing

Outsourcing could be full or partial. Outsourcing is said to be full of all the activities/services are outsourced to the vendor, and it is partial or selective if only a range of services is selectively outsourced or contracted out to a third party. The study also examined the degree of outsourcing in these departments. All the 4 units being outsourced in OAUTHC were fully outsourced. In the case of UCH, out of the 15 units being outsourced, 7 were fully outsourced while 8 are partially outsourced. (See table 4).

In administration, a total of 10 services were outsourced in the two teaching hospitals. In OAUTHC, only 2 units: Environmental Health and Security units were fully outsourced. As shown in table 4 all the 10 units identified in administration are being outsourced either partially or fully in UCH. Of these 8 services outsourced in UCH, five (5) (i.e., security, laundry, kitchen, cafeteria environmental health) services are fully outsourced. The remaining 3 units are partially outsourced. Both OAUTHC and UCH fully outsourced environmental health and security.

Generally, in teaching hospitals, general administration work consists of basic non-clinical activities/services. Most of the activities that are fully outsourced by the teaching hospital have been identified in the literature (See Kakabadse and Kakabadse 2001) as the most frequently outsourced functions in both private and public institutions. In effect, outsourcing in public healthcare delivery/teaching hospitals tends to concentrate on the basic non-clinical services such as management of canteen, record keeping, general maintenance work, laundry, car parking, computing and general practices that have no direct bearing on the overall mandate of efficient and effective healthcare delivery. Also, environmental health which comprises of the gardeners, labourers and cleaners and security are non-core services and hence are easily outsourced by the hospital management in order to concentrate on the core administrative work.

In the account and treasury, four basic units were identified. Out of these four units, OAUTHC outsourced only one (cash point) unit partially while UCH partially outsourced two (expenditure control, recurrent) unit and fully outsourced cash point unit. Treasury and account section of any organization is very sensitive and highly prone to abuse and unethical practices. It is the life of the business, and any awkward practice can jeopardise the efficient and smooth running of the organisation. Therefore, most organisations when outsourcing is careful and even reluctant to allow such sensitive unit to be in the hand of an organisation that is not directly under the scrutiny and control of the organisation. However, in spite of this fact and concern, some of the activities in the treasury and account section of the two teaching hospitals are being outsourced. Especially the cash point where the staff gets in contact with raw cash. This shows that there is a possibility of other overriding benefits for outsourcing that override the fear with the risk involved. Or that there might be some mechanisms put in place to prevent the possible unwholesome activities by the subcontractors in charge of this sensitive unit in the hospitals. Therefore Reconciliation/Auditing Unit is intact, i.e. not outsourced. This may be because of the critical role the internal audit unit plays in the organization. It is interesting to note that even some of the core clinical services are also being partially outsourced in both hospitals. As shown in fig 4.4 and 4.5; of the 18 activities identified in the clinical services only one (Nursing Assistant) is being outsourced fully by OAUTHC, while UCH outsourced fully nursing assistants and partially the management of pharmacy, radiology, and dialysis.

Overall, the analysis of this section revealed that cleaning and security are the most outsourced services in the two hospitals. However, the finding also revealed that UCH went further by outsourcing laundry, kitchen/cafeteria fully, while Electrical, Mechanical, Civil and Maintenance were partially outsourced. Also, radiology and pharmacy were partially outsourced.

Table 4: Services Being Outsourced

Department	Services	OAUTHC	UCH
Administration	Establishment	N	N
	Servicom	N	N
	Public Relation Department	N	N
	Medical records	N	N
	biomedical Department	N	N
	Electrical and Mechanical	N	P
	Civil and maintenance	N	P
	Store and Supply	N	P
	Laundry	N	F
	Kitchen	N	F
	Cafeteria	N	F
	Pension	N	N
	Environmental health	F	F
	Security	F	F
Accounting/ Treasuring	Expenditure	N	P
	Cash point	F	F
	Recurrent	N	P
	Internal/Audit	N	N
Clinical	Paediatrics	N	N
	Medicine	N	P
	Surgery	N	N
	Mental Health	N	N
	Morbid Anatomy	N	N
	Chemical Pathology	N	N
	Pharmacy	N	P
	Nursing Services	N	N
	Physiotherapy	N	N
	X-ray Clinic	N	P
	Dental Surgery	N	N
	Nursing Assistants	F	F
	Schools	N	N
	Orthopaedic	N	N

	General Outpatient	N	N
	Consultant	N	N
	Adult casualty	N	N

Source: Author Field Survey 2018. Note: F=Fully, P= Partially and N = Not Outsourced

Factors Influencing Outsourcing of Activities in the Teaching Hospitals

Outsourcing the services in any organization is a policy issue that is usually taken at the highest level of management. To some, it is a political decision but with economic motive. Therefore, the decision to undertake to outsource is based on the benefits that outsourcing will bring to the organization. In this study, we equate the potential and actual benefits as the driving forces behind outsourcing. Yet, there could be political, social and expedient factors behind outsourcing. Such factors are recognized, but economic factors remain the main driving force behind outsourcing. The challenge facing most organizations is usually how to reduce cost, increase efficient and effective service delivery as well as expand the knowledge frontiers. These are issues raised as factors that may be behind outsourcing in the teaching hospitals. However, possible drawbacks of outsourcing are also considered to balance the view.

4.3 Benefits of Outsourcing as factors influencing Outsourcing

As noted in the literature, outsourcing is a concept that is evolving. It evolvement must result in a paradigm shift from the orthodox public sector perspective to a corporate governance strategic perspective which views the outsourcing as a way for an organization to be focused and be more productive (Velma 2001). In corporate governance where outsourcing has become more relevant, managers view their organisation operations as a value chain designed to provide value to the clients. The managers determine what service to be eliminated, outsourced, or joint ventured so that the organisation can become efficient and more relevant to meeting the social challenges it is established to address. The activities that remain in the organisation are the core competencies that are activities that are critical to the delivery of services to the client. These core activities become the focus of strategic attention, and they are not considered for outsourcing. Teaching hospitals as a risk-sensitive sector, most of their activities are core and as such only a few none-core activities are outsourced. In view of the above, there is a need to gauge the extent the outsourcing of this none-core activity has impacted on the overall performance, efficiency, and productivity of the teaching hospital staff. Also, it is equally important to gauge the perceptions of the staff both management and none-management, on the benefits from the outsourcing of some of the hitherto internally provided services.

The results of the questionnaire analysis of the responses to the perceived benefits of outsourcing are shown in Table 5. A remarkably significant proportion of the respondents generally agreed with the notion that outsourcing brings many benefits to the teaching hospitals. The health care workers were almost unanimous in agreement with the benefits identified in the questionnaire. None of the 10 listed benefits received less than 50% of the proportional distribution of the respondents. For instance, 79% and 85% of the respondents from OAUTHC and UCH respectively considered cost reduction as one of the major benefits of outsourcing. One of the major challenges of public institutions in Nigeria is the overhead cost; such as staff emoluments, office maintenance, general administration expenses. These costs are usually unrelated to the level of activities carried out by the organisations. Whether the workers work fully or not, their full salary will be paid, and the office must be maintained whether work activities take place or not. With outsourcing, all these staffs may have to be engaged on the basis of needs. The use of discretion and political consideration in staff employment and keeping over-bloated size will drastically change, and the size of the workforce will be as moderate as required. The overall effect of this is a drastic reduction in the cost of running the hospital and possibly greater efficiency and effectiveness of the workers.

A lower but significant proportion of 54% and 62% of the respondents cited greater flexibility as potential benefits of outsourcing. This lower response only reflects the fact that the activities outsourced are basic none-core activities, and these may not have a direct bearing on the greater core services that are still be done using the in house staff. The proportion of respondents, 80% and 75% for OAUTHC and UCH respectively that cited reduction in staff workload was also high and remarkable. This reduction in workload will also bring about increased productivity, the concentration of more attention to patients needs and indeed boost staff and patients

morale to the activities of the teaching hospitals. It will also lead to efficient utilisation of the resources as waste that usually result as a result of lack of concentration and fatigue will indeed reduce, the issue of fatal error usually made by doctors and another health professional when working under severe pressure will also be mitigated.

Increased focus also received a relatively high percentage of responses 61% and 63% from OAUTHC and UCH respectively. It shows that the staffs are also becoming conscious of the advantages of outsourcing as it made them leave trivial and unimportant distractive activities for the core activities. It allows them to concentrate and remain the focus. Focused brings greater efficiency, effectiveness and high productivity. It prevents frustration and disappointment. As the staff now concentrates on their best core strength and competences, this will give them greater accomplishment and fulfilment that will propel them to do more. Increased focus will not only lead to greater efficiency but also may result in new discovery and invention. It may also lead to the development of an alternative strategy for handling critical cases as the staff will now have time to think on a narrow and more specific area that they have competences.

A higher proportion of 81% and 80% of the respondents from OAUTHC and UCH respectively cited access to new technology as the major benefits of outsourcing. This high proportion is a reflection of the perception of the hospital staff to the improvement in equipment and hospital machines that were noticed since the introduction of outsourcing. In these teaching hospitals, some of the equipment being used is obsolete and none-functional. The introduction of outsourcing resulted in the subcontractors bringing in new and modern technology as they have the required technical know-how. The existing workers of the teaching hospitals were trained in the act of using this equipment and thus increasing their proficiency. The service delivery improved with the new technology, and they become more efficient. This has significantly affected the staff perception of outsourcing and indeed could have helped in disabusing their possible wrong impression about outsourcing.

Also, a high proportion of 81% and 80% of the OAUTHC and UCH staff, are of the view that outsourcing leads to more efficient utilization of resources. Similar proportion 86% in both OAUTHC and UCH cited improved services while 86% and 87% respectively from OAUTHC and UCH also cited a reduction in management burden as the major benefits of outsourcing. This implies that with outsourcing the worries of the hospital management about none core activities will be taken care of and this gives them the opportunity to worry only on the core activities. With this leeway, they will avoid wasting unnecessary time on issues that have no direct bearing of the core activities of the hospital and thereby increasing the management efficiency and concentration.

As expected, the reduction in industrial unrest received the least proportion. 52% and 64% of the respondents were of the opinion that a reduction in industrial unrest is a benefit of outsourcing in these hospitals. The events in the public services in recent times made this point more glaring. The negative effects of civil servant reactions to the introduction of monetisation and consolidation of salary and pension schemes all at the time of introducing outsourcing exacerbated the industrial unrest in public institutions including the health care sector. Many of the unions in the health care industry had to embark on industrial action to resolve their grievances over the implementation of the public sector reform agenda; especially on the issues of monetisation and consolidation of salary. It is on record that none of the industrial strikes was as a result of the introduction of outsourcing; therefore the relatively low responses to the potential benefits of outsourcing in terms of reduction in industrial unrest may be due to the difficulty of the respondents to disentangle outsourcing from other reforms in the hospital. So outsourcing possibly might have even reduced unrest because management would have been able to concentrate more on the welfare of the staff as they now have more focus and less distraction which affect them overall operation before.

Innovation and creativity were also considered as a major benefit of outsourcing. Seventy-two per cent and 695 of respondents from OAUTHC and UCH cited creativity and innovation as benefits from outsourcing. This is not surprising as the staff is now focused and with new technology and reduction in workload, they can develop and adopt new strategies that will result in greater efficiency and effectiveness. Indeed, the impact of outsourcing on creativity and innovativeness of staff may just be evolving. This is because outsourcing is a long term strategy, which the short term is just a tip of the iceberg.

Table 5: Perceived Benefits of Outsourcing

	U	SD	D	A	SA
PANEL A	**OAUTHC**				
Cost Reduction	42(13%)	13 (4%)	17(5%)	148(45%)	109(34%)
Greater Flexibility	36(11%)	66(20%)	50(15%)	105(32%)	73(22%)
Reduction of staff workload	23(7%)	20(6%)	23(7%)	172(52%)	92(28%)
Increase Focus	39(12%)	42(13%)	49(15%)	138(42%)	62(19%)
Access to new technology	30(9%)	33(10%)	30(9%)	138(42%)	99(30%)
Efficient use of resources	30(9%)	20(6%)	17(5%)	188(57%)	75(23)
Improved Services	30(9%)	10(3%)	07(2%)	184(56%)	99(30%)
Reduced Manager's burdens	20(6%)	10(3%)	17(5%)	172(52%)	111(34%)
Reduces industrial unrest	46(14%)	56(17%)	56(17%)	109(33%)	63(19%)
innovation and creativity	46(14%)	26(8%)	20(6%)	119(36%)	119(36%)
PANEL B	**UCH**				
Cost Reduction	42(13%)	38(12%)	32(10%)	128(40%)	83(25%)
Greater Flexibility	36(11%)	67(21%)	22(7%)	121(38%)	77(24%)
Reduction of staff workload	25(8%)	42(13%)	14(4%)	135(42%)	107(33%)
Increase Focus	48(15%)	62(19%)	10(3%)	122(38%)	81(25%)
Access to new technology	28(9%)	19(6%)	16(5%)	183(57%)	77(24%)
Efficient use of resources	32(10%)	28(9%)	03(1%)	153(47%)	107(33%)
Improved Services	19(6%)	10(3%)	16(5%)	168(52%)	110(34%)
Reduced Manager's burdens	16(5%)	16(5%)	10(3%)	162(52%)	119(37%)
Reduces industrial unrest	35(11%)	71(22%)	13(4%)	125(39%)	80(25%)
innovation and creativity	35(11%)	52(16%)	13(4%)	152(47%)	71(22%)

Source: Author Field Survey 2018

5.0 Conclusion and Policy Implication

The broad objectives of the study examine the factors influencing outsourcing practices in two main teaching hospitals in southwest Nigeria. Specifically, the study identified the types and nature of outsourcing practices in the selected teaching hospitals and examined the factors influencing outsourcing of services in these hospitals. This is in a view to establish whether outsourcing policy has been effective in improving the healthcare delivery services in the selected teaching hospitals in south west Nigeria. As part of the background to the study and in fulfillment of the objective of the study, the demographic and socioeconomic characteristics of the respondents were analyzed and examined. It is established that most of the respondents were matured and experienced staff of the teaching hospitals and they had required qualification to be an employee of the hospitals. The following are the highlights of the findings from the data analysis: The two teaching hospitals are at different stages of outsourcing. While UCH started in 2004, OAUTHC started in 2007. Empirical evidence from the study also indicates that the three main driving forces; cost, strategy, and politics; for outsourcing identified in the literature were also found to the motivating factors for the introduction of outsourcing in the two teaching hospitals (OAUTHC and UCH).

Outsourcing is an emerging process in the Nigerian health sector. Therefore, the Nigerian health sector needs to pass through a learning phase before outsourcing is recognized as efficient management and regulatory tool. Thus the health sector needs time before the capacities of managers and providers are adequately developed and streamlined. Outsourcing is complex and cannot be the solutions for all problems of healthcare services not

everything can or should be outsourced. When outsourcing is applied judiciously, it could contribute to the improvement of the health system performance. It is also vital for the continued success of the hospital and its services to regularly review and update its outsourcing process. The management team should be actively involved in the supplier selection and management of the suppliers.

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