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Using Outsourcing as a Competitive Edge: the Case of Medical Aid Schemes

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Abstract: Since the introduction of the Medical Schemes Act (Act 131 of 1998), many Medical Aid Schemes have been placed under curatorship. Boards of Directors are facing challenges in meeting the needs of members and the requirements of the Act. This article aims to investigate whether outsourcing is being used as a strategy to improve competitive advantage within the Medical aid industry to provide value to scheme members. The research endeavors to comprehensively highlight the areas of management and governance competencies that are included in outsourcing decision making in order to ensuring cost-effective, conflict-free, risk-free outsourcing and the sustainability of the schemes in facilitating and meeting the needs of members most economically. A qualitative research approach was employed with an in-depth analysis of literature and empirical research methods making use of a cross-sectional research survey with data collected from 15 Medical Aid Schemes. The findings of this research will reveal if there is any void in knowledge and competence needed by members of Boards of Trustees of Medical Schemes to facilitate outsourcing decisions. The findings suggest that outsourcing decisions are in the interest of schemes resulting in the relinquishing of non-core functions, improved service delivery and greater compliance with legislative requirements.
Outsourcing can no longer be seen as a tactical maneuver to remain competitive but as a more strategic function led by competent and experienced individuals appointed to serve on the Boards of Trustees and employed in senior management.

Keywords: Scheme, Add-on, Fiduciary responsibility, Reserves, Solvency, Corporate governance

1. Introduction

Geaver (1999) states that the transferring of recurring internal organizations functions to an outside provider can be regarded as outsourcing when captured in a contract. The operational action is transferring major tasks to a third party, a decision that may pose some risks. Risks taken by Medical Aid Schemes have advantages and disadvantages for scheme members that could result in prosperity or poverty and even liquidation for the scheme. In the process of transferring activities to a third party it is expected that the third party, will provide skills knowledge and expertise that the medical Aids Scheme cannot supply internally. The principles of popular outsourcing initiatives used in the nineties developed around technological advances that computer networking and the balk storage of information has made possible. Many Medical Aid Schemes are not able to invest in exorbitantly priced software that facilitates the storage and manipulation of member information. Very highly qualified and skilled personnel are often required to execute very elaborate computer information manipulation that is not always available in Medical Schemes. Outsourcing was initially concerned with activities that were remote from the nerve center of the company. Classical outsourcing suggests that companies must decide on what activities give it a competitive advantage and what does not. In the medical aid administration and industry outsourcing are based on trust and security of information one party will gain on service delivery and the other in income. The expenses for the development of advanced technology are very high, thus, the logic of outsourcing is advanced.

Linking your company name to that of an established and reputable organization through outsourcing is a strategy that could hold advantages for the organization. An outsourcing agreement with a well-known brand places your organization in a favorable position as future buyers or partners see this as a strength and a guarantee for excellent service and quality products. The access to knowledge and skills resulting from outsourcing exposes medical schemes to, new technology, more focused staff, faster response times and competitive pricing. Medical Schemes have as a result of outsourcing enjoyed greater flexibility regarding, deciding who it does business with and being able to negotiate discounted prices with competing service providers. The majority of medical schemes outsource because it is too expensive for them to

perform all tasks internally. Hill (2002) alludes to three pricing strategies. Predatory pricing that is used to ensure that weak competitors do not survive. A process in which pricing is very low resulting in low-profit margins ultimately resulting in the closure of the business. Multipoint pricing is used where two or more competitors are competing for business. In the provision of service agreements in outsourcing, contractors may offer one medical scheme an "add-on" service such as clinical advice to members while for competitors they provide medical-response services, such as professional medically qualified staff providing medical advice.

Experience curve pricing is used by companies endeavoring to increase their experience by not exposing their lack of experience. These service providers generally quote very low. Medical Schemes must make outsourcing decisions in the interest of their members while being confronted with issues of competency, management, and limited financial resources. Shocker and Sethi (1974) indicate that companies and in particular companies such a medical aid schemes providing services have social contracts with their members, with a legal obligation to act with authority, making use of the resources they are provided with, and as such they must work in the interest of members. Deegan (2002) alludes to the fact that no company has an inherent right and competency to behave without good judgment.

2. Literature Review

Sako (2006) states that outsourcing is a demonstration of an organization contracting with another for deriving benefit from the other while Lacey and Blumberg (2005) see it as having utmost confidence in the capacity of another organization to perform an in-house function so as to add value to the organization in order to create stability.

Medical Schemes in South Africa have to make outsourcing decisions in the interest of their members while being confronted with issues of competency, management, and limited financial resources. Shocker and Sethi (1974) indicate that companies, in particular companies such a medical aid schemes providing services have a social contract to their members, with a legal obligation to act with authority, making use of the resources that they have and as such they must always conduct themselves in the interest of members. Deegan (2002) alludes to the fact that no company has an inherent right and competency to acquit themselves without good sense.
The responsibility to act with good judgment within medical schemes when making outsourcing decisions rests within management and the board of trustees appointed by members. According to Friedman (1970), the purpose of employing managers is to ensure an increase in profits for the benefit of shareholders; this is contradicted by Drucker (1993) who states that profit is not the only goal of an organization but views income as a measure of how well an organization serves the needs of its clients. The monitoring of performance is an essential element in the management of outsourced contracts. Friedman and Drucker identify three areas that measure the success of an organization, namely: market success, profit, and the market share and their return in equity.

Boards of trustees, appointed by members of the medical aid schemes who have a fiduciary responsibility to act in the interest of members must without any contradictions know what the scope of their accountabilities is. The extent of onus must define a purpose and be reasonably comprehensive but must not move into the task level details trap as alluded to by Greaver (1998). The task level occurs when boards of trustees what to get involved in the day-to-day management of the schemes. Hatton (2000) indicates that organizations and customers do not exist in a vacuum. They are both influenced by a rapidly changing internal and external environment. Members of medical schemes are exposed to information and are not always of the trends within the business as information made available to them is written in medical jargon in voluminous newsletters.

Greaver (1999) mentions the following reasons why organizations embrace outsourcing as a management strategy: Organizations realize that their large size is no longer a competitive advantage as small niche and agile competitors can change an industry and influence cost structures. Suppliers and technical specialists are plentiful, and the employment of specialists is very expensive. Cutting edge technology and knowledge are now recognized as weapons of competitive advantage but are too costly to acquire. Pricing strategies used to remain competitive and also to ensure survival in a very competitive market where members are allowed to change their options and medical aid schemes annually.
Boards of Trustees govern Medical Schemes of which at least 50% being selected by the members and managed by a principal officer appointed by the board. The members appointed to serve on the board of trustees must be "fit and proper" and must exercise due diligence and always act in the interests of beneficiaries as prescribed within Chapter 12 of the Medical Schemes Act. (Act 131 of 1998), and the Regulations to the act as promulgated on 20 October 1999 including all subsequent amendments.

Chapter 7 of the Medical Schemes Act requires that schemes, "shall at all times maintain its business in a financially sound condition." Schemes are required by Circular 68 of 2015 from the Council for Medical Schemes to maintain a solvency rate that ensures the financial stability that will promote completion amongst competing schemes but vitally to ensure the just application of member contributions. Solvency levels of above 25% have been used to encourage good governance by boards of trustees to contain the risks to which medical schemes are exposed. Dearlove (2000) alludes to the fact that client companies suffer when suppliers falter, and adequate contractual protection needs to be embedded in contracts to protect organizations. The Medical Schemes Act (Act 131 of 1994) thus mitigating against the risks to which members of schemes are exposed, by ensuring that a minimum reserve of 25% of member funds are retained.

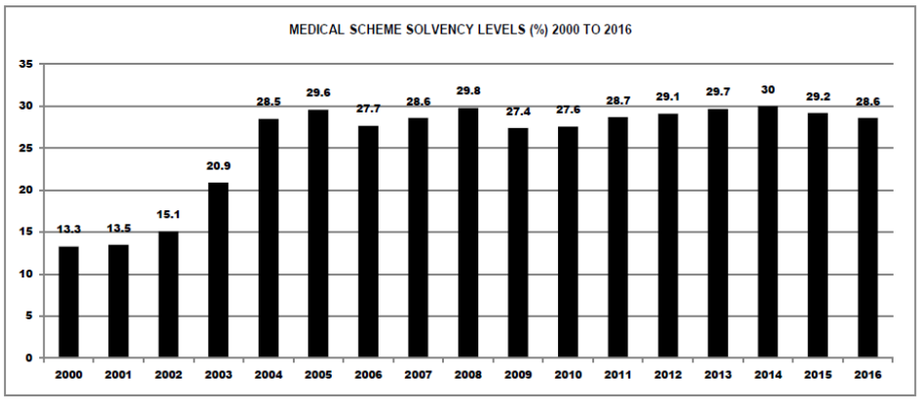

Figure 1: Solvency Levels of Medical Aid Schemes from 2000 to 2016 Council for Medical Schemes Annual Report 2015/2016

The solvency ratio's amongst open schemes have since 2000 moved from 13.8% to 28.6% in 2016. According to Fry (1998), the necessity of risk cannot be overlooked when an organization is active within a dynamic economic environment, where risk-takers have the highest growth. Good governance requires boards of trustees of Medical Aid schemes to be circumspect when making decisions. Mintzberg (1996) identifies three strategic risks to outsourcing.

1. The loss of critical skills within organizations or the developing of inappropriate skills that are not required.
   In medical aid schemes where valuable member information is passed on to external service providers, sophisticated manipulation of data takes place.

2. The loss of cross-functional skills
   With the proliferation of outsourcing taking place particularly with regards to the payment of suppliers and medical advisory services, the employees do not develop cross-functional skills and will thus not be multi-skilled in order to service the full needs of the members.

3. The lack of control over suppliers.
   Supplier priorities may not always be the same as the organization, resulting in schemes having difficulty in managing the agreements they have with suppliers.

Harris et al. (2015), state that good governance reduces the possibility of asset diversion. Boards of trustees will be less likely to make outsourcing decisions that are not in the interest of members if they have good governance structures in place, thus utilizing member contributions for the purposes for which it is intended. Three fraud categories include: (i) Asset misappropriation, (ii) corruption and (iii) falsification of financial statements. He alludes to the fact that within non-profit organizations asset misappropriation covers at least 95% of reported fraud.

Berghe (2012) in his review on corporate governance standards states that there are no international standards or model for corporate governance, indicating that every country has criteria influenced by local factors.

Using Michelberger's (2017) Factor Model of good Corporate Governance one can make the conclusion that the quality of the board of trustees and the corporate governance regime to which they are exposed are intrinsically linked. The structure of your governance structure is influenced by the quality of members selected to serve as trustees. Board members must be adequately qualified and have the requisite experience so that they could be able to deal with the risks

to which the schemes are exposed. Subcommittees of boards must reflect the required competencies. To attract the best skills to serve on these boards, prospective candidates of high quality must be incentivized with market-related compensation. Synergy between a competent board of trustees and good corporate governance results in improved performance indicated by revenue growth, profitability, increased shareholder return in which members benefit by reduced annual subscription increases and ultimately sustainable financial leverage due to increasing the solvency levels for the medical scheme.

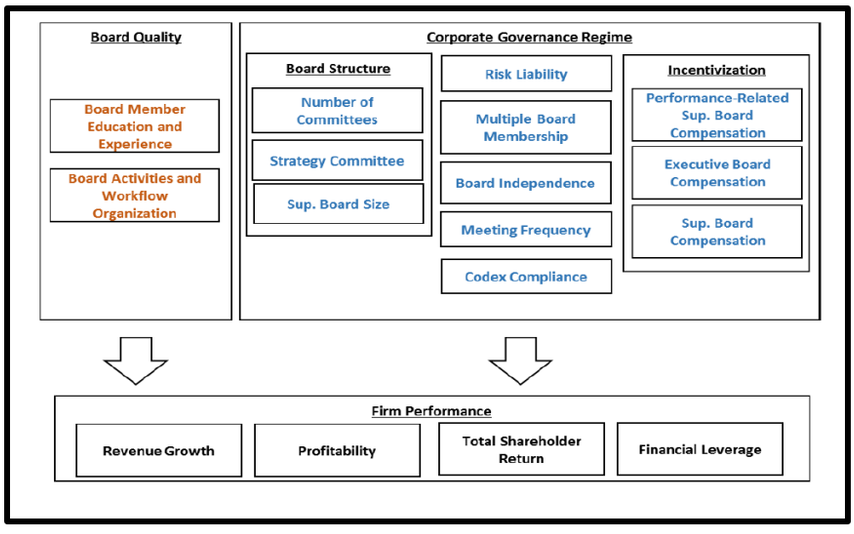

Figure 2: Factors Research Model of Good Corporate Governance. Michelberger (2017)

According to Cook (2013), the term bioethics is being used liberally while drug companies are outsourcing critical activities to bypass cost escalations and local red tape. These kinds of pursuits are vulnerable to fraud resulting in kickbacks being received from companies to do business with medical schemes. The limitations placed on organizations defined by the medical schemes act creates the assumption that businesses operate as a homogeneous group in their adherence to the rules and laws that govern them. The contrasts in individuals serving on boards create differences in their approaches to business and governance. Hsaio (2003) questions if there are homogeneous values prevalent within governance practices across many companies while Ertuna and Ertuna (2016) argue that organizations seldom modify their governance policies. According to the Medical Economics (2017) a survey conducted by Deloitte (2016), 59% of schemes outsource while 57% outsource core functions.

3. Methodology

The methodology applied consists of literature analysis and empirical research. The literature analysis provides an understanding of the environment in which medical schemes operate. Current articles, legislation, and associated literature, were used to draw inferences from to make conclusions. The qualitative approach employed for this research required an in-depth analysis of research done by experts in the field of ethics. The primary source of information was derived from the questionnaire while the secondary source provided books, journals, computer searches, and other industry related publications. A cross-sectional research survey was used collect data from a representative portion of a homogeneous population to determine the common risks prevalent amongst schemes within the medical aid industry. Collins (1998) emphasizes the fact that the most favourable way of learning about large groups or extended populations is to look at small samples of that group and that the population is not the totality of everyone but will reasonably represent the target group. The target research sample was made up of 15 "open medical aid schemes," in existence for longer than ten years. A questionnaire was used to collect data from the respondents. Each participant was randomly selected to receive the survey questions. Anonymity was vital as medical aid scheme information involves sensitive issues about personal ethics and organizational value systems. The integrity of respondents is highly rated as they occupied middle and senior management positions. A cover letter that explained the purpose of the research and also about the author's commitment to confidentially as the information of medical schemes is very much restricted to employees and members preceded the research instrument. Biographical information relating to gender and age was collected but was not regarded as material to the research as the research is more focused on outsourcing tendencies associated with board competencies. The respondents years of employment had to be above five years as this was regarded as a reasonable period for

respondents to have familiarised themselves with the organizational culture and policies of their employer and have adequate exposure to the norms and standards set out within the associated legislation and industry. The research is supported by grounded theory providing information assisting in the exploration of solutions for the guiding of boards in future outsourcing decisions.

4. Results and Discussion

The biographical results highlighted that the majority of the respondents have a tertiary education indicating that the respondents had an understanding of what governance and outsourcing was.

Table 1: The Operational Designations of Respondents

EMPLOYMENT DESIGNATION	%
Claims processing	0
Finance	40
Marketing	13
Managed Care	7
Information Technology	13
Brokerage/Sales	0
Principal Officer	27
TOTAL	100%

Table 1 indicated that 100% of the medical schemes targeted employed 50 or more employees. Claims processing staff was not earmarked as respondents as their tasks do not involve outsourcing functions.

Table 2: The Importance of Managing Outsourced Contracts

	Not Important	**Less Important**	**Important**	**Very Important**
Having a contract servicing division	0.00	0.00	46.67	53.33
Involvement of technical staff in a contract servicing division	0.00	6.67	33.33	60.00
Appointing contracts servicing managers	6.67	20.00	63.33	20.00
Having formal outsourcing contracts	0.00	0.00	6.67	93.33
Having regular meetings with contractors	0.00	0.00	0.00	100.00
Involvement in contract controlling	0.00	6.67	53.33	40.00
Having the Board of Trustees making contracting decisions	26.67	40.00	20.00	13.33
AVERAGES	**5.05%**	**11.11%**	**32.32%**	**51.52%**

Table 2 shows that on average the schemes do regard the management of outsourced contracts (83.84%) and having contracts-servicing divisions (100%) as vital to organizational success. The appointment of a contract servicing manager is not important or less important by 26.67% of the schemes, due to this function not being part of the key performing areas of the Principal Officer. Medical Aid Schemes that had in-house contracts-servicing managers indicated that the individual made no contracting decisions but only manages the operational functions of contracts. A serious concern is the fact that 67.67% of respondents shows that it is not or less significant having the board of trustees making contracting decisions, resulting from operational staff having the perception that trustees are not competent enough and lack the requisite experience to understand the operational needs of the organization. The long periods that elapses between board meetings creates delays in decision making that resulting in protracted discussions involving follow-up meetings that retard operational progress.

4.1 Outsourcing Trends among Medical Schemes

Medical Aid Schemes have core business areas which they must perform in compliance with the Medical Schemes Act (Act No.131 of 1998). Medical Aid Schemes who want to be competitive will have to improve their core functions or consider outsourcing some of their business. Respondents were asked to indicate what the possibility was that would result in them considering outsourcing some of their core functions. The graph shows what the future trends will be, highlighting that the majority regard outsourcing as paramount to the provision of improved services to members.

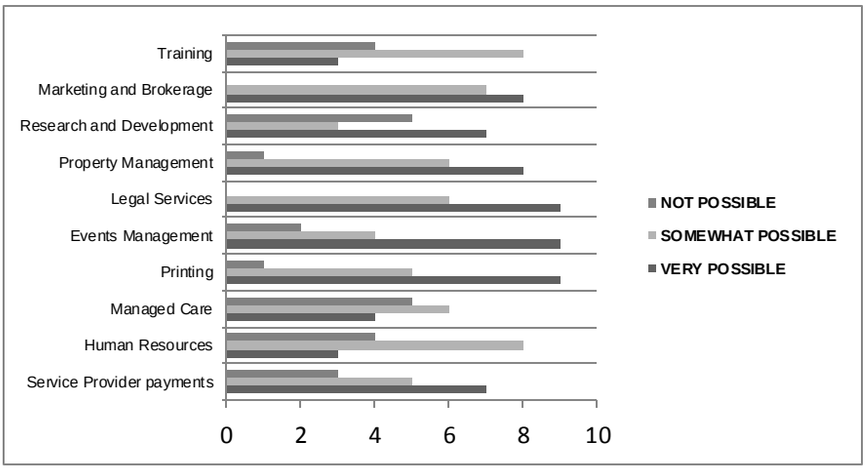

Figure 3: Possibility of outsourcing core functions

In summary, the results show 44,6% Very Possible, 38,7% Somewhat Possible and 16,7 Not Possible an indication that most schemes regard outsourcing as a viable option in their quest to be more efficient, effective and economical. 70% of the respondents indicated that they have in the last five years engaged in non-core function activities with 20% reporting failure in these ventures. These non-core function or activities included property development, in-house brokerages, investments in fitness programmes and medicine delivery projects. Schemes are continuously seeking ways on how to cut administration costs by outsourcing functions that are labor intensive and that require expensive computer software. The identification of which services are outsourced in a manner that will not negatively impact on the sustainability of the scheme is related to the external environment that impacts on the business. The following factors taken into consideration when motivating to outsource:

1. Increases in product and service value: Medical administrators have found that they are now able to provide clients with a service that includes an array of functions, such as payment of accounts, medical advice, and patient profiling.
2. Organizational transformation: The phrase "leaner-organization" was adopted in the 90's to indicate that schemes can work better by reducing wasteful and unnecessary processes. The employment of temporary staff to reduce human resources costs. Companies were also able to outsource functions to vendors who have been previously disadvantaged.
3. Freeing up of fixed assets: Through the process of outsourcing many schemes could sell their fixed assets in order to generate capital to improve their reserves and thereby comply with the requirements of a 25% reserve.
4. Labor risks: The constant threat of labor unrest placed many schemes at risk of not meeting payment dates. Outsourcing freed schemes from this risk as service providers had to ensure that payments are made on time.
5. Innovation: As service providers constantly compete for new business they continually improve their systems, technology, and software, providing schemes with innovations that they may never be able to change as rapidly as outside service providers can.
6. Improved management and control: With many of the minor functions being outsourced managers can focus on more essential obligations within the schemes.
7. Improved credibility: The resultant improvement in service delivery by specialist outside the schemes providing services in which the business have failed the reputations of the organization improve.
8. Business development opportunities: Improved services equate to increased interest in business offerings. Improvement in service delivery results in membership growth.

The demands on schemes to remain relevant in a very competitive environment are increasing. Activities demanding competencies not central to the core business are best left to those who are specialists. A need to determine a clear understanding of what they are good at and what generates the best income, is not only fashionable but of strategic importance. Schemes have always believed that if they develop competitive benefit packages, they will be at the pinnacle of administrative competence and as such capture the market. Discovering that it was not the case, as schemes that concentrated too much on the development of benefit packages but neglected their core functions soon found themselves under curatorship or liquidated. Laura du Preez (2017) mentioned that small Medical Aid Schemes will always be under threat by being taken over by larger schemes demonstrated by the 144 schemes that existed in 2001 and only 82 surviving in 2017. Open Medical Aid schemes pose the greatest threat to smaller ones, as they offer a larger variety of benefit options as do smaller competitors.

5. Conclusion

Outsourcing in the medical aid industry in South Africa has advanced beyond only outsourcing the administrative functions that include the payment of service providers for medical treatment provided to members, hospitals and pharmacies. Outsourcing trends are continuously changing. Talented and highly skilled persons no longer want to be bound to one organization and opt to work as consultants where they earn more and their working hours are flexible. These consultants know what is happening in the industry and have experience in a variety of areas affecting the medical aid industry. Medical Aid Schemes are thus forced to make use of these specialist services. Schemes have tapped into the value that these consultants are adding and thus longstanding relationships have been established. In the medical aid administration, function outsourcing covers the manipulation of data by making use of sophisticated software programmes and elaborates computer hardware.

Outsourcing trends have changed in the past decade to include, brokerages that sell medical aid cover, marketing, advertising and media communication, product design and development, research, accounting, and auditing, managed care and human resources management. Large schemes outsource a significant portion of their functions while still retaining the full accountability to members, such as choosing not to make use of outside service-providers, spending excessive amounts of money on the development of software or the renting of license agreements with software developers. Individual employees who are very skilled and experienced opting to work from home are also contracting by employers within the medical aid industry. This trend is increasing as computer technology improves. Outsourcing to ex-employees who work at "virtual offices" from their homes results in a cost saving for the schemes.

The areas that medical aid schemes need to focus on when making outsourcing decisions:

1. Having a comprehensive understanding of the strategic advantage that outsourcing has for the organization. Boards of trustees making these decisions must be aware as to how the scheme will benefit and what the future implications are for the security of members.
2. Outsourced contracts must be managed by experienced staff, thus improving the relationships with contractors and protect the interest of members.
3. Security of data is of utmost concern to all schemes and as such membership information must be safeguarded.
4. The appointment of contractors is the most crucial step in the outsourcing process.
5. Medical schemes must invest more time and money in research and development not only regarding managed care but also on checking the backgrounds and competencies of service providers.

The objective of this paper was to examine the factors that influence decision making with the intention to assist medical schemes in avoiding ethical problems due to ignorance and nepotism when boards of trustees make outsourcing decisions.

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