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Inter-Organisational Cooperation in Services on the Example of Health Care Market

Summary

Inter-organisational cooperation in the private service sector is broadly recognised in the literature dedicated to relationship management. It does not apply to the public sector, including health care. Therefore, the purpose of the paper is to discuss the reasons, conditions, and benefits of developing inter-organisational cooperation among health care entities, financed from public sources. The author also analyses the benefits of such cooperation, including economic and non-economic advantages. To meet the goal, the critical-descriptive analysis was performed. The paper is mainly literature review in its form.

Key words: inter-organisational cooperation, service sector, public sector, health care, relationship management.

JEL codes: I11

Introduction

The issues of relationships between entities have been a subject studied by organization theoreticians since at least the 1980's, but the 21st century has brought a veritable explosion of interest in the subject matter (Rudawska 2013, p. 88-93). Two basic theoretical perspectives, on the grounds of which the phenomenon of inter-organizational relationships is explained, involve a resource-based view as well as a transaction cost theory. The third approach, called co-opetition, also plays no small part and it is based on game theory and referring in fact to cooperation between market competitors.

Cooperation is typically defined in terms of inter-organizational relationships that develop as a result of long-term communication processes and which are based on coordination mechanisms other than market and hierarchy (Hardy et al. 2003, p. 323). Cooperation means that the parties involved communicate most often via a contract (agreement) with regard to their undertakings aimed at achieving a common goal. Example solutions of that type include consortia, alliances, joint ventures, networks and associations, whereas the deliberations featured in this paper are limited to networks only. The inter-organizational network theory of C. Alter and J. Hage perceives a network (here: organizations of various health care levels) as a complex form comprised of numerous separate organizational structures contributing complementary competencies to such a network (Wadmann 2009, p. 7). A wide-ranging cooperation, including a system of providing feedback and task-based integration, is essential to ensure coordination. Inter-organizational networks may also signify

the establishment of a new form of activity, which is then referred to as a network structure (Niemczyk et al. 2012, p. 9). However, they do not constitute the core of the considerations presented in this paper.

A majority of papers dedicated to inter-organizational relations deal with cooperation in the private sector. The issue has already been well documented, also in Polish literature (Sak-Skowron 2009; Krawiec 2005; Szulik 2004; Czakon 2013; Stosik 2016). Some of the mentioned work refer even to heath sector, still - to private part of it. The research findings highlight the positive and negative results of entering into relational contracts by health entities in private sector as well as the mechanisms of reducing the business risk in such contracts (Stosik 2016, p. 548-550).

The cited findings have definitively great value contribution to exploring the inter-organizational cooperation in health care, but they do not consider the specifics of public sector in health care. The literature regarding the inter-organizational cooperation in public sector itself (including health care) is extremely limited. K.G. Provan's team is considered to be a pioneer of publications on the subject, aptly observing that the achievements of cooperation networks from the private sector must not be directly transferred to the public sector (Isett, Provan 2005, p. 151). The basic reasons for that is the disparate nature in which the entities of that sector are financed and their resultant reliance on public funds, as well as the different manner in which the operations of such types of organizations are regulated. Referring it directly to health care, one needs to note that many health care systems, including the Polish one, allow for non-public entities to be financed through public funds. It is not the very ownership form of a service provider, but its share in the distribution of public funds allocated to health care that play the key role. One needs to concur with a proposition that the multitude of regulations, which publically financed health care entities are subject to, will affect the nature of cooperation between them. What is more, a non-profit status of many health care entities causes them to disclose other purposes than profit for operation in organizations based on cooperation. Such a purpose could be guaranteeing oneself involvement in contracts with a payer and thereby survival on the market. In any case, the tendency of engaging in relationships of inter-organizational cooperation will be a resultant of the perceived integration costs (including costs of lost profits on account of autonomous decision-making and operations) with respect to perceived benefits of cooperation.

Economic and non-economic benefits of cooperation

The expected effects of inter-organizational cooperation can be grouped in two dimensions: an economic one (comprising strategic benefits and those related to knowledge creation) as well as non-economic ones (chiefly of political nature).

The economic dimension is based on striving to achieve a competitive advantage. And although in the public sector it has a different dimension, still its significance needs to be appreciated. In health care, where – apart from the private market of health services – we deal with managed care, the goal is to achieve a better position in negotiations with the payer,

thereby a higher share in the pool of public funds (it refers to the systems such as the Polish one, in which the function of a service provider and the payer are separated according to the legal status as at 30.10.2017). A competitive advantage is thus the resultant of the bargaining power vis-à-vis the disposer of public funds allocated to health care. In the systems in which there is a multitude of payers, a competitive advantage of that type is a direct derivative of patients' choice. Institutions of coordinated health care in the United States, where it is the patients who, by stating their preferences through enrollment to specific health plans, decide on the stream of funds flowing through a system of contracts to individual service providers, could serve as an example of such a solution.

A competitive advantage resulting from cooperation must be considered to be a consequence of a strategic nature. It is based on a resource transfer and access to the so-called shared resources. They can be of material character, such as equipment and medical devices as well as non-material character, such as human skills, innovative thought, or knowledge and experience. As a result of the exchange of such resources within the network of cooperating entities, a rent is generated, called a relational rent (Rudawska 2009). Apart from it, D. Lavie (2006, p. 644) differentiates three subsequent types of rents, i.e.: an internal rent, constituting a share of a given entity, a an additional rent as an "external effect" with reference to the benefits obtained by either a partner in the relationship or by a given organization.

An internal rent may be a result of using own resources of a health care organization, defined by the classics of economics as scarce, unique resources. With regard to a relational view of the competitive advantage, this type of rent has its origins in shared resources, understood as additional (supplementary) components, resulting from the fact of remaining within a relationship network with partner organizations. The phenomenon of relationship also includes the phenomenon of rents, which are specific, "external effects" viewed as benefits obtained, either by a relationship initiator or by the entities entering a partnership relationship. In the former case a rent, being an "external effect", becomes an unintended part of a partnership relationship. It follows from a transfer of material and non-material resources from the relationship forerunner towards its remaining participants. In the latter case the main beneficiary of a rent, being an "external effect", is the initiator of the relationship network (in health care it may be, for instance, a general practitioner's practice).

The possibility of adapting the above-specified propositions, referring in fact to the market of enterprises, to the non-profit sector, also in health care, is currently the subject of significant interest, chiefly voiced in foreign literature. It is emphasized that despite the lack of market pressure typical to the enterprises sector, the grounds for cooperation in the non-profit sector and the public sector lie in the need to compete for public funds, clients, approval of the authorities or the control and supervision entities (Hardy et al. 2003, p. 325). Therefore, the key is to raise organization competences by sharing resources, particularly knowledge. It enables solving problems, such as, for instance, satisfying comprehensive demand of chronically ill patients, which could not be achieved through efficient activities of a single entity. The above observations refer to networks of cooperating organizations in the public health care sector (although saying that it involves entities operating within the framework of public financing would be more adequate). Apart from networks of that type,

which D. Lucke and J. Harris call organizational networks, the researchers differentiate social support networks and transmission networks in public health care (Luke, Harris 2007, p. 17). Social support networks in fact refer to cooperation between the health care sector and social welfare. In turn, transmission networks are limited only and solely to sending medical records by electronic means between individual service providers, which is the domain of e-health.

Knowledge as the main resource of a new economy as well as technological advances favor the emergence of network solutions based on cooperation. In health care, particularly in developed countries, a phenomenon of "medical arms race" (Gaynor et al. 1998, p. 29) is observed, which may lead to the escalation of costs in macro scale. The phenomenon may also constitute a real threat to economization – an objective set to health care systems. In this perspective network forms constitute an advantage – as they use an effect of synergy by enabling the cooperating entities access to external resources, quick information distribution inside the network and innovation spread. Porter points out to these elements as being fundamental in gaining competitive advantage in health care (Porter, Olmsted-Teisberg 2006, p. 34). For service providers it means a change in their competitiveness model and the need to redefine organization culture, typically based on professional autonomy, so as to enable partnership and cooperation within a network. In turn, for patients it means redefining a set of benefits. Furthermore, an "inter-clan" as a mechanism coordinating operations in a network creates a strong demand for trust between the cooperating parties, where the degree of information scope and specificity prevented its swift verification. Inter-organizational trust is based on professional norms and values. The greater the trust, the lower the demand for formalized solutions, enclosing a given relationship into a framework. Therefore, trust in a relationship contributes to the reduction of transaction costs.

One needs to concur with the view presented by many researchers of the network approach that inter-organizational cooperation favors knowledge transfer, but also new knowledge development, which stimulates innovations. The approach is close to social constructivism, a social theory considering knowledge not as a singular subject, but as communal property (Powell et al. 2006, p. 121; Hardy et al. 2003, p. 326). New knowledge is thus created as a result of cooperation, interaction continuum that occurs in a relationship. As Powell emphasizes, these interactions are frequently of non-formal and unplanned nature. The approach may be deemed as opposing to the views presented in the literature of strategic management, enclosing any cooperation within the framework of a contract or formal arrangements (as to objectives, partner selection criteria, action monitoring and control). Therefore, cooperation is viewed not as a tool compensating deficiencies in the internal resources of an organization, but rather as a source of synergic partnership, leading to knowledge development. Such a slightly socializing approach is strongly propagated by Scandinavian researchers, such as C. Anderson, H. Hakansson, or J. Johnson. The result of their work is transferring the perspective of social exchange and social interaction networks onto the ground of market relationships and networks (Anderson et al. 1994). In the service sectors, of which health care is a part, this approach seems to be highly adequate, chiefly on account of the interpersonal nature of a majority of interactions. Knowledge development as an effect

of cooperation between health care providers is particularly beneficial to service beneficiaries, namely patients, whose health problems could not have been solved by a single service provider. Creation of such new solutions, innovativeness, being the effect of team work, is the fundamental advantage of cooperation between service providers and patients. What is more, knowledge development is also an element sought after and desired by medical professionals, chiefly physicians, who can thus develop their professional qualifications.

A political dimension can be attributed to non-material effects of cooperation. It is understood as the impact of a given organization on the environment for the purpose of fulfilling its own objectives. It relates to a changing position of an organization in the network (leadership versus submission) and its capacity to influence other entities being part of network relationships. Therefore, cooperation is viewed here as a means of protecting the interest of a given service provider, gaining a position of privilege in relation to other entities, or even weakening the position of others (Hardy et al. 2003, p. 327). Such an approach to the issue of cooperation has a calculating, sophisticated character, in which trust as a coordinating mechanism is of marginal significance. The idea is rather to assume a central position of a given service provider, where the power of an organization is not a function of direct control over resources, but it rather stems from a set of resources (economic, social, cultural ones) released by existing network relations. It is worth emphasizing that leadership in a network may be a result of the reputation of a given organization, which becomes a fundamental factor determining the relationships between the entities undertaking cooperation. The reputation results, above all, from the manner of conduct and previous interactions. The significance of the element seems to be highly important in the health care environment, where high value is attributed to professional autonomy.

Stakeholders' perspective

A frequent, slightly provocatively posed question regarding potential benefits resulting from inter-organizational cooperation, is a question about "benefits for whom?", or "efficiency from whose point of view?" (Provan, Kenis 2007, p. 229). Operating on the basis of formalized cooperation causes a new perspective to emerge – the perspective of a network and not its individual participants. In a network of cooperating entities benefits may also be considered from the perspective of other stakeholders in health care, such as payers (the party financing a cooperation network), control and supervision entities (for instance: the ministry of health) as well as clients (patients). It is relatively the easiest to assess the benefit that this form of operation brings to clients in health care environment, i.e. to patients. A network of cooperating service providers contributes to the reduction of care fragmentation and it stimulates service coordination, leading to greater efficiency of a system so functioning. K.G. Provan's team presents an interesting proposal of inter-organizational relationship evaluation in the public sector, whose adaptation to health care environment is given in Table 1.

Such a multi-faceted approach to cooperation effects is, in the author's opinion, highly accurate. The number of stakeholders in health care, the multitude of their interest, at times

being at odds with one another, as well as an occasional incompatibility of those goals, speaks in favor of such an approach. It is hard to directly compare the economic effects (such as the increase of operation efficiency) to the results of social nature (such as the increase of accessibility to health care services).

Table 1

The level of efficiency evaluation of inter-organizational relationships based on cooperation in health care

Evaluation level	Key stakeholders	Evaluation criteria
Beneficiaries and the society as a whole	– patients – patients' representatives (third sector organizations) – public opinion	– quality and service accessibility indicators – treatment results (clinical efficiency) – perceived image in the environment, reputation – social capital building
Superiors	– payers – politicians – regulators (quality monitoring agencies, medical technology valuation agencies)	– direct costs – service prices – cost effectiveness – treatment results (clinical efficiency)
Network	– individual participants – leader in the network	– network growth (development) indicator – scope of services rendered (comprehensiveness) – elimination of service duplication – relationship strength – costs of network maintenance – involvement in achieving common goals (interoperability)
Individual organizations in a network	– management – directors – personnel	– survival on the market – access to resources – direct costs – mandate for exercising care over a given population – minimization of conflicts in the network

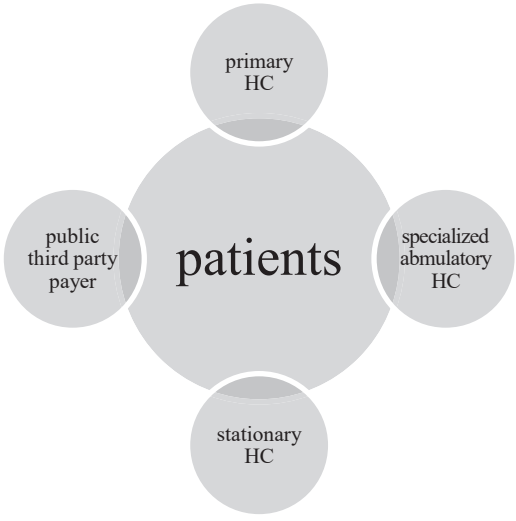
Source: own work based on: Provan, Milward (2001).

Subjective structure of the sector is one of the most important determinant of developing inter-organizational cooperation. In case of Polish health care sector this structure incorporates key stakeholders that deliver health care financed under the public funding and the public third party payer (Figure 1).

The cooperative relationships can be established among all mentioned stakeholders, i.e.: primary health care, specialized ambulatory health care and stationary health care level. The proposed framework assumes that all these health care providers focus on patients and their needs (patient-centered health care) and are financed by public third party payer (NFZ right now). The owner (private company, local government unit, rector of the medical academy) seems to be of the secondary importance, although the ease of entering into inter-organiza-

Figure 1

The subjective structure of inter-organizational cooperation in public health care in Poland



Source: own elaboration.

tional cooperation is bigger in case of the common owner. In-depth analysis of the scope and the range of health care delivery can reveal the potential for cooperation of engaged stakeholders.

Conclusions

To conclude the considerations on inter-organizational relationships it is worth quoting S. Kagan's view that cooperation may in fact be treated as an initial and necessary condition for the emergence of more complex systems engaging service providers (Selden et al. 2006, p. 413). Such solutions may be presented as a continuum, where on the one hand we deal with informal cooperation and at the opposite end of the scale – with service providers' integration.

Therefore, the origins of integration in health care ought to be sought in informal cooperation between personnel and in relational ties of social type. Formalization of such cooperation through a contract, imposing time and objective frameworks, results in service coordination at a later stage. This in turn provides for a strong cooperation through a system of referrals. The most advanced inter-operational form in this perspective is the integration of service providers, which triggers many mechanisms simultaneously, such as planning, joint budgeting, or common treatment programs for patients.

In case of Poland the most possible way of introducing inter-organizational cooperation among health care providers lays within regional networks of health care entities, ensuring patients smooth continuity of care, financed by public funding. The benefits of such cooperation are mainly economic and non-economic in their nature.

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Współpraca międzyorganizacyjna w usługach na przykładzie rynku opieki zdrowotnej

Streszczenie

Współpraca międzyorganizacyjna w sektorze prywatnym jest szeroko opisywana w literaturze z zakresu zarządzania relacjami. Zdecydowanie mniej publikacji odnosi się do sektora publicznego, w tym opieki zdrowotnej. W związku z tym celem artykułu jest dyskusja na temat źródeł, determinant i korzyści rozwoju współpracy międzyorganizacyjnej między podmiotami opieki zdrowotnej, finansowanymi ze środków publicznych. Autorka poddaje analizie korzyści z takiej współpracy, w podziale na efekty ekonomiczne i pozaekonomiczne. Jako metodę zastosowano krytyczno-poznawczy przegląd literatury. Artykuł ma głównie charakter przeglądu literatury.

Słowa kluczowe: współpraca międzyorganizacyjna, sektor usług, sektor publiczny, opieka zdrowotna, zarządzanie relacjami.

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Межорганизационное сотрудничество в услугах на примере рынка услуг здравоохранения

Резюме

Межорганизационное сотрудничество в частном секторе широко описывается в литературе по управлению отношениями. Значительно меньше публикаций касается публичного сектора, в том числе здравоохранения. В этой связи цель статьи – обсудить источники, детерминанты и выгоды от развития межорганизационного сотрудничества между субъектами здравоохранения, финансируемыми за счет публичных средств. Автор проводит анализ выгод от такого сотрудничества, разделяя их на экономические и неэкономические эффекты. В качестве метода применили критико-познавательный обзор литературы. Статья в основном имеет характер обзора литературы.

Ключевые слова: межорганизационное сотрудничество, сектор услуг, публичный сектор, здравоохранение, управление отношениями.

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