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Blueprint for an Efficient Health Care Supply Chain

Introduction

The health care industry is at a crossroads. Medical innovation has provided the United States with the ability to provide health care services that are second to none. Today the federal government wrestles with how to fund health care services for a senior population that is poised for explosive growth in the next twenty years. Health care organizations are and have been under intense pressure from all sides. Cuts in reimbursement, the proliferation of regulations including the implementation of HIPAA, and a serious nursing shortage have left many providers in a precarious position. Patient care itself is at risk. Health care systems must find new ways to reduce their costs or face extinction.

Within the health care supply chain, layers of inefficiency, waste, and cost have become so ingrained into the fabric of health care that they are viewed as essential. This inefficiency has been allowed to thrive almost unabated as product price has dominated supply chain relationships. The health care supply chain is in need of a sweeping overhaul that will improve efficiency at all levels and result in a lower total cost of doing business for all links in the chain, but especially for the health care services providers. In so doing, the supply chain will contribute directly to the ongoing availability of high quality patient care.

Most players readily admit that change is necessary, but few are willing to subject themselves to change. It is always the “other” links that must change. The reality is that the creation of the efficient health care supply chain will require every link to make changes in how it does business, how it defines and delivers value, and how it relates to the others in the chain.

This paper will present a framework for an efficient health care supply chain, examine the hard realities that have created inertia toward change in the current supply chain, and discuss specific strategies for each link in the chain to maximize its efficiency and the value that it brings to its customers and the supply chain as a whole. The role of manufacturers, distributors, Group Purchasing Organizations, and health care providers in the efficient supply chain will be discussed.

The good news is that it is unlikely that any link will be disintermediated from the supply chain. Rather, any link that fails to define its value and deliver on that value will, in effect, disintermediate itself from the supply chain. There is still time for every link to define and deliver its value to the chain, retain an important role, and improve its prospects for the future.

An Efficient Health Care Supply Chain

The health care supply chain is broken. But it is not broken in the sense that it does not work at all. If that were the situation, it would be much easier to make a strong case for the need for change. Everyone could easily agree that products were not moving through the chain.

The existing situation today is in fact, worse than that. The health care supply chain appears to work. After all, products are able to move through it and be used in the provision of patient care. Other than an occasional disruption such as a periodic latex shortage, there are few significant supply chain interruption issues.

The real problem is not that the supply chain seems to work. Rather, the problem is in *how* it works. Each link in the chain operates solely in its own best interest with little or no concern for the overall efficiency of the chain. This “every man for himself” approach has created deep-seated distrust among the links in the chain who, though they should be partners, usually function more like adversaries. For example, contracting relationships are almost completely about price. Long-term relationships, supply chain efficiencies, and value proven value added services have been relegated to the back burner.

The overarching competing priorities of the various links in the chain have led us to this place where most know something must be done, but all fear the potential fallout of making the first move. As each link in the chain struggles in its own silo of frustration, a valuable opportunity may be slipping away. Either the players in the chain will change themselves, or the natural -- and often devastating -- forces of the market will change the players. What is required is

a vision for change and a blueprint for what the results of the change could look like and how it could operate.

The Patient as the Ultimate Consumer

As each link in the supply chain attempts to find its own way, it is easy to lose sight of the ultimate goal of health care -the patient. Few, if any, in the supply chain think about that on a daily basis.

In his very popular book, The 7 Habits of Highly Effective People, Steven Covey suggested that Habit #2, “Begin With The End In Mind,” is the correct approach to any endeavor. If the welfare of the patient is to be the goal of health care, then all of the links in the chain and the processes they employ must also somehow support this goal. Inefficiency consumes dollars that could be used in the provision of care. Removing waste has the potential to make more dollars available for use in patient care. Therefore, it is the patient who should and will become the primary beneficiary of the efficient supply chain.

Demystifying the Supply Chain Concept

The term “Supply Chain Management” may be the most overly used and most misunderstood concept in the health care industry. The supply chain is the path that products take as they make their way from the raw material state into the hands of clinicians and others where they are finally consumed. Every stop along that path is a link in the chain.

While the term “supply chain” refers to a path, the term “Supply Chain Management” refers to the intervention of supply chain links and players in determining the cost and value of exactly when and how a product moves, in what quantities it is moved, who moves it and how it is moved, who stores it and how it is stored, and when and how it is made available to those who consume or use it. Everything that happens to a product as it moves through the chain either adds cost or reduces cost. It either adds value or it reduces value. The ultimate goal for any product moving through the chain is to reduce cost and add value at the same time.

Most thoughtful discussions of supply chain management talk about push versus pull. In the health care industry the term “Supply Chain Management” is used more to apply to selling product than to reducing cost and/ or adding value.

Selling is often about push, that is, pushing products to customers regardless of the value they offer or the cost they can reduce. Push is what companies do to meet their quarterly sales goals. Push, when combined with poor data

management and poor forecasting on the part of the customer, results in customers with bulging warehouses and poor cash flow. Push can create a false impression of demand and encourage manufacturers to overproduce, resulting in massive efforts to move inventory even if markdowns are required to do so.

Pull, on the other hand, represents the true product demand or actual usage by the customer. Pull allows the supply chain to operate efficiently by reducing inventory investment at all levels, freeing those monies for other purposes. For the health care provider the money could be used for everything from paying for HIPAA implementation to nursing staff retention programs. Unfortunately, because accurate and timely information is such a rare commodity at the point of consumption, upward links in the supply chain are forced to hedge their bets to avoid the negative outcomes associated with stock outs on their part. They must build or hold more inventory than is necessary in order to meet unknown demand intensity. Each of these tactics adds cost to the product, which ultimately must be passed on to the end user.

What It Looks Like and How It Will Work

The efficient supply chain is driven by value and powered by information. On its journey from raw material to utilization, a product will make only a few stops, far fewer than in the past. (It should be noted that in some health care facilities there are more stops than in the rest of the supply chain put together.) Each of those stops will be well defined and purposeful. No more time than is absolutely necessary is spent at each stop.

In the efficient supply chain each of these stops has been carefully planned to ensure that it creates high value for a reduced cost. The chain and the stops are monitored and measured frequently to ensure compliance to predetermined metrics that will be the true evaluator of efficiency.

E-Commerce and a variety of Application Service Provider (ASP) software programs will form the backbone of both information management and product movement transactions. Point-of-use devices or ASP programs or MMIS/ERP systems will record product utilization at the provider location. Within a matter of minutes, the data will be impacting the product manufacturer's demand planning module and adjusting production schedules accordingly. As providers, distributors, and providers move away from just in case inventory to a demand-cycle-balanced just in time inventory, all links in the chain will benefit from lower costs of doing business. Rather than suppliers pushing product at their customers, customers will pull product from suppliers in the quantities required to ensure availability at the point of consumption.

The price of a product will be a function of its value to the customer (plus a reasonable profit to cover the critical function of research and development)

and not simply a function of what the market will bear. Distributors will be paid for the value of the service they provide, not merely for taking title to the product. Value will be measured in two ways. First, what is the value of the product or service to the end user? Second, what is the value of the product or service related to managing the product's movement through the supply chain to the supply chain as a whole?

Beyond EHCR: The End-to-End Value Imperative

The Efficient Healthcare Consumer Response initiative (an industry wide study sponsored in 1995 and 1996 by the American Society for Healthcare Materials Management, Health Industry Business Communications Council, Health Industry Distributors Association, National Wholesale Druggists' Association – now the Healthcare Distribution Management Association -- and Uniform Code Council) essentially began the process of creating efficiency in the healthcare supply chain. Unfortunately, the emphasis on efficiency was limited to the silos of the individual companies who implemented Activity Based Management and were able to reduce many of the costs that they themselves controlled.

The initiative did prove to be extremely valuable for a number of companies, especially some of the larger national distributors. But the efficiency gains were limited, because companies do not conduct business only within their own silos, but with other companies upstream and downstream in the supply chain. Real efficiency gains require taking the same concepts, moving across and into other silos, and applying those concepts to the cost and waste associated with activities that start in one company and continue or end in another.

For example, a distributor can become as efficient as it wants, but if its customers order too frequently and create large numbers of small orders with a small dollar value, the distributor will either lose money or be forced to adopt a different pricing strategy for such a customer. Distributors, and to some extent manufacturers, have about reached the limits of improving their own efficiency and now need to focus on working with their customers.

One major national distributor, Owens and Minor, Richmond, VA, has led the field by implementing Activity Based Pricing for its customers. Pricing is based upon the actual work performed by Owens and Minor and not simply on what the market will bear. Owens and Minor has also worked with its customers to implement Activity Based Costing within the customer's supply chain function to identify and remove waste.

Future industry efforts to reduce costs must focus on the inefficient processes within health care provider operations. Efficiencies gained in the provider operation can be passed up the chain to improve information transfer, reduce

inventory investment, and improve coordination of demand planning. In exchange, the provider should expect to receive lower product costs and lower service-based add-on costs as well. At the same time suppliers may be able to create additional earned revenue by providing services to customers that the customers currently provide for themselves. If any link in the chain has the ability to perform any essential activity at a lower cost than an immediate upstream or downstream link, it should have the opportunity to perform that activity, provide a cost savings to the neighboring link, and profit from it. The effort today and in the future must focus on developing end-to-end solutions.

The Failure of Single Link Solutions

Most attempts to develop supply chain solutions have focused only on the two links in the relationship and have done little to promote efficiency from end to end. These single link solutions may, in fact, add cost to the entire supply chain. As the links become more responsible citizens of the supply chain, they will learn to study the potential impact of their solutions, both upstream and downstream.

Moving From a Transaction Focus to a Process Focus

Historically, buyers have focused their efforts on reducing the price they pay for the products they buy. For years health care providers have found their reimbursement shrinking. Every year buyers are asked to find ways to reduce product acquisition costs. Every year suppliers take a deep breath and figure out what, if anything, more they can afford to give. And so it goes year after year. While no provider can afford to pay more for products than the market as a whole, simply reducing product costs will not be enough to bring financial stability to most hospitals and other providers.

But there is much more to this story. As buyers -- materials managers, to be more precise -- become educated about the cost savings benefits of improving their own internal product movement, they will more readily adopt methodologies such as Activity Based Management and discover the cost of their internal inefficiency. With this information firmly in hand, they will be able to move beyond the pricing of a single transaction and into the movement of product through the part of the supply chain that they control.

Two things are holding them back from doing this right now. First, buyers have not been fully educated about the cost savings available through process redesign. They need to be educated, but the question remains, who will do it? In lieu of education they are more inclined to rationalize the value of saving pennies on the products they buy. Second, the fact that buyers can still often

find suppliers who will give them lower prices reinforces the notion that this product price dog can still hunt.

The Role of Technology in Creating the Efficient Health Care Supply Chain

The original study (by CSC Consulting Inc.) that launched EHCR pointed to the importance of technology in creating efficiency in the health care supply chain. Clearly, technology will play an important role. For example, the technology that brought us E-Commerce is literally just scratching the surface in terms of what is really possible on the software front. However, E-Commerce should have also taught us that technology without knowledge and validation is of little use in creating an efficient health care supply chain. Hundreds of hospitals are signing up with dot.coms, but very little buying is taking place. The reason for this lies in the lack of knowledge on the part of the buyer and the lack of validation of the intended results of E-Commerce by the dot.coms.

Believing that the benefits of E-Commerce were self evident, the dot.coms splashed on to the scene touting how wonderful online buying would be. In their quest to create revenue and maximize the value of their stock options, they addressed the needs of everyone except their customers. They have failed to educate their customers about the real benefits of doing business on the Internet. Now, in their frustration, some dot.com personnel are blaming the customer's lack of knowledge.

At the same time, most, but not all, of the dot.coms have failed to develop a value model for the services they offer. By failing to give buyers a clear picture of the process cost savings that can result from E-Commerce, they have instead played to the buyer's preoccupation with securing lower product acquisition costs. So far the most significant success stories from E-Commerce have everything to do with lower product costs and almost nothing to do with lower process costs.

Suppliers, who are often being asked to pay for both their participation and that of their customers, on top of being expected to provide lower product costs to create "success stories," are not being treated much better by the dot.coms. They have yet to be clearly shown how E-Commerce can reduce their cost of doing business and thereby create some margin that could be used to offset any pricing reductions they may feel compelled to offer to online buyers.

Instead of being the salvation of the industry, then, E-Commerce has largely become a portrait of much of what is wrong in the health care supply chain. Overzealous investors who sought large returns on investments far too early in

the game have also fueled this early rough going in E-Commerce. Many dot.coms have been placed in positions they could not have ever foreseen, forcing many to abandon their once grand plans and replace them with stripped down versions, which offer little to the supply chain as a whole, but might just produce enough short term revenue to ensure their survival.

However, that does not have to be the end of the story; nor will it be. The health care industry is gifted with plenty of bright people who will figure out how to educate customers and create the value that E-Commerce was intended to bring. That value is part of a larger plan to move information quickly, accurately, and efficiently between supply chain partners to reduce the total cost of moving products from manufacture to the point of consumption. The technology used to power E-Commerce is the engine that will drive efficiency in the supply chain.

The Threat of Self-Disintermediation

No discussion of the future of the health care supply chain is complete without dealing with the specter known as disintermediation. Most view disintermediation as something that someone does to someone else. The advent of E-Commerce created much discussion about the future of distributors and Group Purchasing Organizations. Many were asking if either of these links or even both would be disintermediated.

The efficient health care supply chain will have only one cardinal rule: In order to remain viable, each link must be able to define and clearly demonstrate its value. Failure to follow these rules, whether willful or accidental, will result in its self disintermediation.

We're not talking about making victims of supply chain players. We're simply saying that the supply chain cannot afford to carry any player who cannot pay its own way. If the supply chain exists for the benefit of any one link it is the patient, the ultimate consumer of health care products and services. Although it seems safe to assume that manufacturers and providers would be safe, no such assumption can be made about the other links, including distributors and GPOs. However, the good news is that neither is automatically excluded. Individual distributors and GPOs have every opportunity to strengthen and enhance their roles in the supply chain. It is theirs to win or lose

How Can We Get There From Here?

The journey from the current state of the health care supply chain to the efficient health care supply chain will be anything but easy. Each link in the chain must overcome its own inertia, reflect on its past successes and failures, and almost completely overhaul its fundamental business approach. As great as the challenge is, the reward for moving forward will be much greater. In this section each major link of the supply chain is discussed in terms of its current situation, ineffective practices, barriers to change, and critical path to success. The reader should note that in painting broad-brush strokes which outline some of the challenges, nothing written about those challenges is designed to ignore the reality that each link will have members who are exceptions to the characterization.

Health Care Providers

Although health care providers are not the only inefficient link in the supply chain, from all indications, they represent the most significant opportunity for dramatic supply chain cost reduction.

However, the situation is far from simple. Health care providers -- including hospitals, long term care facilities, outpatient care centers, home care organizations, physician practices and clinics -- face enormous challenges which go far beyond their level of perceived inefficiency. Those challenges include reimbursement cuts, regulation, multiple accreditation bodies and standards of compliance, HIPAA, a nursing shortage, and the need to modernize both equipment and facilities in the face of dwindling financial resources.

Hospitals and health systems account for the largest product consumption in the health care supply chain. They also face the most significant impact of the aforementioned challenges. Total annual product spend for hospitals includes not only medical products, but pharmaceuticals, imaging agents, diagnostic products, food, dietary supplies, housekeeping products, maintenance items, computer products, and a host of other smaller categories. Nursing homes are second on the list, although a distant second. Non-institutional-based providers make up the balance of expenditures in the health care supply chain. The institutional component also adds significant internal processing costs related to the supply chain. Non-institutional providers certainly mirror some of those processes but the magnitude of process costs is far smaller.

The first priority for any health care provider, especially acute care providers, is to have product available when needed. In retail, an out of stock situation creates customer inconvenience. In health care, it can be a matter of life and death. For this reason, hospitals go to great lengths to do whatever they believe will ensure the availability of product when it is most needed.

This rapid response framework has produced much of the inefficiency that exists within the hospital's internal supply chain. The activities of a significant number of materials management departments seem to be very much like the Emergency Departments in those same hospitals. Both departments share the adrenaline rush moments in providing services. Unfortunately, meeting the needs of the moment monopolizes the resources that could be used to plan and create efficiency. While it is not realistic to believe that every second of every day can be planned down to the last gauze pad, it is realistic to expect that a threshold of planning can allow the organization to focus sufficient resources for the emergencies without creating significant disruption for day to day operations.

Historically, hospitals have focused their materials management resources on securing lower prices for products consumed in the hospital. This preoccupation with product price has led to two unfortunate and perhaps unforeseeable results. First, it has, in fact, resulted in lower acquisition costs. Basic purchasing textbooks generally teach that a dollar saved on the cost of a product goes directly to the bottom line. That is true in retail and in other non health care industries. However, hospitals generally don't get paid for selling product. They get paid for providing a service, which uses products in the provision of that service.

While product prices have been falling, so has the reimbursement for the services. As a result, it is quite possible that the product cost savings so hard won by providers have been nothing more than a pass through to the payor side of the business. How much, if any, of these savings have actually stayed within the provider's organization? Are most price-based savings merely used to stem the bleeding caused by payor contracts, which defy the provider's ability to operate in the black?

The second result of the preoccupation with product price is a reduction of suppliers' profitability. Eventually, if it has not already happened, suppliers will slow the introduction of new products into the marketplace because monies formerly used for research and development will be directed toward product pricing concessions.

So often in health care, the discussion of profitability is viewed as a negative. Yet clinicians and the materials managers who support them must understand the reality that quality health care is a combination of clinical skill and judgment, as well as well-designed, easy to use and affordable medical products. Take away either of these vital components and the result is dramatically reduced quality and outcomes, with devastating effects on patients.

There is another significant issue related to product pricing from the provider's point of view. Many health care providers are operating under financial

pressures so intense that one wonders how many will survive the next few years. The Balanced Budget Amendment of 1997 is surely beginning to take its toll on the health care industry. For the most part, the expectations of providers, as communicated to the supplier community through the actions of materials managers, is that somehow the answer to these financial challenges lies in the price of products purchased and consumed. Yet given the need for research and development to spur innovation, it is clear that destroying a supplier's ability to innovate is not the answer. It probably never was. That is not to say that providers should not take every step necessary to ensure that their product costs are competitive with those they compete against. What it does suggest is that the partners in the health care supply chain must find another way to take cost out of the chain without exacerbating some of the negative outcomes of the past.

Traditional materials management tactics have largely failed. One of the clearest indications of this is the fact that precious few materials management people have found themselves occupying senior level management positions in hospitals and health systems. The "one-dimensional pricing beats all" approach has produced little of lasting benefit to hospitals. If it had, materials managers would not have to cover the same ground over and over again.

This narrow approach has produced two other negative consequences for materials managers. First, they generally feel that neither their peers nor their superiors respect them. Yet there is little chance to gain the respect they seek if they continue to operate in the old way. Second, while materials managers are constantly being directed by their superiors to get better prices, they are rarely asked to undertake other significant endeavors which would have more profound effects on the cost of doing business. They have willingly participated in lowering the expectations of senior management. Now their careers are limited by those same low expectations.

Around the world, supply chain management has become the hottest strategy for total cost reduction. Many major corporations have created and implemented supply chain management strategies that are achieving significant reductions in the total cost of doing business. For many companies, supply chain management is becoming their competitive edge. Yet hospitals and health systems continue their over-reliance on the old worn-out tactical approach to materials management. In so doing they are limiting their potential to take out cost.

Materials management as traditionally practiced is inwardly focused, product-price-centered and event-based. It fosters the notion that suppliers are adversaries. Supply chain management, on the other hand, is global in its outlook, total-cost-centered and process-based. It regards trading partners as allies with a vested interest in mutual success. Traditional materials

management must evolve into supply chain management for health care providers to maximize their opportunities for financial survival.

Up to this point, providers have focused their leverage on only two areas to minimize their supply management costs. The first is product volume. If a provider purchases a large volume of products, it can expect to get a better price, in most cases, than the provider who has a lower volume. Group Purchasing Organizations excel at aggregating volume of members and gaining lower prices.

The second area of leverage has been commitment. It is one thing to have product volume. It is quite another to be able to control that volume. Commitment is the reason that smaller providers are able to get GPO-like pricing. Volume can turn out to be an empty promise made to suppliers who -- unless a contract has some volume-based non-performance price escalators in place -- have little recourse in ensuring that the volume proffered by the buyer is actually realized. Commitment is a different story. If properly introduced, commitment creates leverage for both the buyer and the seller.

However, commitment has its limitations. Changes in census and case mix can negatively affect product usage. These same areas can affect the provider's performance in a requirements contract, not in terms of commitment, but in terms of the supplier's expectations of volume tied to that commitment.

Another area of leverage has been largely untouched, yet it forms the basis for dramatic improvements in the costs of moving product through the supply chain. This area is efficiency. As has been discussed earlier, inefficiency at the end of the chain can be felt all the way up the chain. Inefficient internal processes in procurement, inventory management, and physical distribution within provider organizations all create scenarios that require suppliers to meet urgent demands rather than plan to support continuity of supply for the customer.

These scenarios create costs and bumps in supply and demand for manufacturers and distributors. These costs have been absorbed by suppliers, but always come back to providers as a part of the price paid for products. If a provider is able to become measurably more efficient, it is reasonable to expect that the cost reduction produced up the chain would certainly result in more leverage for the provider. The provider would actually win twice. First, they would enjoy the lower internal cost of doing business that results from efficiency. And unlike pricing reductions, these savings would go directly to the bottom line. This would also become one more cost center where providers would know their cost of doing business and have a more sound assessment of how low they can go in negotiating contracts with payors. Second, they would be able to gain additional leverage with their supply chain partners by passing

some of the savings up the chain. *By focusing on improving internal efficiencies, providers can create substantial leverage for themselves.*

How Healthcare Providers Can Get There

In order to do their part to create the efficient health care supply chain, providers must do the following:

- ✓ Become educated about supply chain management.
- ✓ Implement Activity Based Costing.
- ✓ Quantify the cost of inefficiency.
- ✓ Focus on creating internal efficiencies.
- ✓ De-emphasize product price and emphasize total supply chain cost.
- ✓ Think strategically, long term about supplier relationships.
- ✓ Phase out expensive legacy computer systems and utilize more cost effective ASP-model-based software.
- ✓ Adopt E-Commerce as the primary method of product acquisition and replenishment.
- ✓ Value test every supply chain relationship.
- ✓ Measure patient care outcomes in terms of both cost to produce as well as clinical results.
- ✓ Align procurement strategy with reimbursement realities and recognize that the actions of payors have a direct impact on the supply chain.

Distributors

Prior to the discussion of distributors it must be restated that the health care provider customer base can be broken down into two primary categories: those that consume a high volume of products, including hospitals and, to a lesser extent, nursing homes; and those that consume a lower volume, or all other providers.

The volume of purchases is significant because, in most cases, higher purchase volumes are associated with organizations that have large internal supply management operations. At one extreme are the large multihospital systems

whose large internal supply chains may cause a single product to be touched or moved countless times before reaching the point of consumption. At the other extreme is the single physician practice, in which product is likely to be moved only once or twice en route to consumption.

Even though these two extremes share some commonalities in terms of procurement practices, it is what happens to the product after it is acquired that creates the differentiation. Because high-volume purchasers have so much potential to improve their internal process management, most of the discussion that follows will be directed at the relationship between distributors and their high volume customers.

Distributors provide a range of critical services. They hold inventory, thereby reducing their customers' inventory-carrying costs. They can deliver product on a consistent basis when and where needed. They extend the logistical reach for the manufacturers they represent. They provide a financial shield for manufacturers when they deal with slow paying accounts, while the manufacturers expect the distributors to pay them relatively quickly. Distributors are largely efficient themselves and are more likely to have invested in advanced business management technology and activity based management than their customers. These investments have increased their efficiency and make them well positioned to offer their customers the benefit of their efficiencies through a variety of outsourcing initiatives.

Unfortunately, the real value provided by distributors is often lost on the buyer. This is because the costs of the distributor's services are attached to the price of the products they distribute. It is all too easy for price-conscious buyers to focus only on the cost of the products or the markup applied by the distributor on a cost plus basis.

But the fact that customers often fail to fully appreciate the value of the distributor is largely the fault of the distributor. Like other players in the chain, distributors enjoyed higher profit margins in the past than they do today. In those days, they bundled the services component with the product component to cover those.

But along the way from then to now, several supply chain fundamentals have changed. Unfortunately, most distributors failed to change the way they did business. One of the things that changed was that prices on many products dropped dramatically, forcing more than a few manufacturers to consider bypassing their distributors and selling direct to customers. It is not that distributors lack value. It simply becomes a matter of cutting costs out of the chain. In other words, can the manufacturer meet the pricing demands of the customer, meet their own internal profit requirements and still have enough margin to be able to afford the cost of the distributor's involvement?

Distributors face the possibility of disintermediation on the customer side as well. Once again, the issue is not the distributor's value. Many customers like the convenience of working with a distributor. The real issue is product price, and whether the value of the distributor's services is equal to or greater than the potential cost savings of buying direct from the manufacturer. Materials managers must wrestle with this issue on a constant basis.

The fact that most distributors have yet to create a value proposition for their services makes the materials manager's job much more difficult and yet easier at the same time. It is difficult not because the materials manager does not perceive the distributor's value, but because he or she has not been persuasively presented with that value in terms of dollars and cents. When compared to an opportunity presented by a direct relationship with a manufacturer, it becomes no contest, especially for a hospital looking for every way possible to save money. It is important to remember that this fits nicely into the hospital's expectation of the materials manager, namely that he or she will bring quantifiable product-cost-based savings. If only the distributor had moved earlier in the game to demonstrate the full value of its services!

Can Distributors Be Freed From Their Attachment to Product Price?

There is another critical element in the discussion of distributor disintermediation. The issue is trust. Can the customer trust the distributor to operate as though it has a vested interest in the customer? Health care providers buy two categories of products from distributors: contract and non-contract. Distributors are generally quick to offer their customers a low (competitive) cost-plus markup on contract products. But not every product is purchased in sufficient quantities to warrant being on a contract. And this is where health care providers have their quarrel with distributors.

It is hard to understand how, if a distributor's internal cost of doing business runs in, say, the high teens as a percentage of revenue, it can possibly charge cost-plus-five on contract items and not expect to make up that shortfall elsewhere, such as in the pricing of non-contract products. And the making it up elsewhere is precisely what concerns hospitals that have decided to go direct.

Would it not make more sense for the supply chain as a whole for distributors to sell their services at a price commensurate with the value of those services to the end user? But in order for that to happen, distributors would need to free themselves from their long history of being bound to the prices of the products they distribute. Doing so would create opportunities and challenges for them.

The first opportunity is that distributors would finally be free to focus on their services and the value of those services. Distributors would likely be concerned that this would place them on the same footing as third party logistics

providers. One of the advantages the 3PLs have is that they are not functioning under the notion that they are free to get whatever the market will bear for their part in distributing the non-contract products they sell. Third party logistics companies have the advantage of clearly defining exactly what they do for their customers. They are able to bill and collect for only the value of the services they provide. There are no games that have to be played between the customer and the salesperson. It is all straightforward. If distributors offer more to their customers than the third party logistics companies, they would have ample opportunity to prove it.

Removing distributors from the pricing equation also provides an opportunity to finally do away with what is perhaps the most inefficient and insidious practice in all of health care -- rebates. While there are several types of rebates, the ones that continue to stick distributors in the middle are those that “make the distributor whole” when selling product on contract to a health care provider, where the contract price is lower than the dealer cost. The rebate is necessary because the manufacturer will not honor the contract price unless proof exists that the hospital that bought the product on contract was in fact authorized to do so. Once such is provided, the rebate can be issued.

At one time, the distributor was stuck being the manufacturer’s bank. Thanks to the use of prospective rebates, some of this burden on distributors has been lifted. The rebate process is so ingrained in the health care supply chain that there are companies, including E-Commerce companies, whose focus is the management of the rebate process. *Unfortunately, rebates do not treat patients, and they add significant cost to the supply chain.* If rebates can be eliminated, the resulting cost savings could be shared through the supply.

Of course, for distributors to be freed from their association with product pricing, both manufacturers and customers would have to be willing to agree to the change. The potential for cost reduction would likely be enough to win over both of them.

From Push to Pull

One of the challenges to distributors would be how to change their focus from selling product to selling services. Distributors have historically been a part of the push strategy to move product to customers. That is, after all, how they have made their money. The concept of selling is generally associated with push. Push works best when the requirements of the customer can be shaped or influenced by the seller’s offer. Unfortunately, materials managers essentially have no ability to increase the use of or demand for the products they purchase. That’s why the result of push is most often stockpiles of inventory and limited ability to pay for the products purchased. Given the limited resources of health care providers, it would seem to be in their best interests to acquire product only in the quantities required and as close to the time of use

as possible. The pull model itself would seem to demand that distributors change the focus of their efforts. *Pull requires meeting demand, not artificially stimulating it.*

Another related challenge comes in the area of the compensation of distributor sales representatives. Many distributors compensate their representatives on the basis of their ability to sell (push) product to their customers. In a commission-based compensation plan, the more product one sells, the more money he or she can make. While this approach certainly encourages selling, it places the sales representative in the position of pushing product even if that is not in the best interests of the customer.

It should be clear by now that historically, the interests of the selling organization and the interests of the health care provider have often been diametrically opposed. The efficient supply chain model will demand synchronization of the needs of customers and the goals of distributors.

If this is the case, then what will become of the traditional distributor sales representative? He or she will become more of a service advisor to the customer, and will ensure that promised services are indeed being delivered according to the terms of the relationship. But he or she will do something much more important and much more valuable – that is, work with customers to expand and enhance their relationships through the development of value-proven, value-added services. This means that reps will join with customers in a fully transparent way to create and manage services that reduce the customer's total cost of doing business.

In the process, the sales rep's primary value to their distributor employers will also be enhanced. This is because their role will be to create and manage long-term strategic relationships. Long-term relationships can have dramatic cost reduction benefits for both sides. Most sales organizations recognize the significance of customer acquisition costs. Longer-term relationships reduce these costs and spread them out over a longer period of time. These savings could be so significant that a portion of them could be made available to sales reps as a part of their compensation. It is conceivable that the distributor sales representatives of the future will be partly compensated for their ability to maintain and enhance customer relationships over the long term.

Differences clearly exist between large volume providers and small volume providers. The question is this: Should those differences be reflected in how distributors manage their relationships with those customers? Distributor initiatives such as the outsourcing of certain services or just-in-time delivery benefit larger volume purchasers more than smaller volume ones. Economies of scale mean less to smaller volume purchasers because they have a smaller impact on those customers' total cost of doing business. At the same time, the distributor has a difficult time justifying the cost of providing such services to

smaller customers. Until relatively recently, GPO contracts and the manufacturer rebates associated with them applied mainly to large volume providers. However, the growth in Integrated Delivery Networks has extended these contracts to a whole host of alternate site providers. Nevertheless, there is a need to customize distributor services and relationships to the type of customer being served.

The industry as a whole and distributors specifically would do well to consider the following relationship models and the results they could achieve.

Large Volume Purchaser Model

A new relationship model for distributors and their customers must be created. This model must support the lower prices required by large volume providers without subjecting distributors to undue financial pressure. The most effective - although not necessarily easiest to implement -- way is to remove the distributor from the pricing equation. Pricing in this model must be between the manufacturer and the large volume provider. This one change would eliminate the distributor from the detested rebate vicious cycle. The distributor would play a critical role in reporting end user usage, but end-to-end E-Commerce capabilities would improve the ease, accuracy, and timeliness of such reporting.

Removing the distributor from the pricing equation will mean significant changes for manufacturers. *Foremost among them are consigning inventories to distributors and dealing directly with customers in the area of accounts receivable.* This new approach allows the manufacturer and the distributor to each focus on what they do best. For the distributor this means validating the value of their services and billing hospitals for those services. For hospitals, the biggest change would be in terms of paying distributors for services and paying manufacturers directly for the products.

In reality, this model is just now becoming workable in the health care supply chain. Prior to the advent of E-Commerce, many of the changes suggested here would have been almost impossible to fathom, let alone implement. End-to-end connectivity in the wired supply chain will eliminate once manually performed activities. This includes the accounts payable activity that could increase for large volume providers with direct payment relationships with manufacturers.

Small Volume Purchaser Model

As far back as ten years ago, a number of medical manufacturers made an important decision. Rather than expend enormous resources to court and win national contracts with smaller volume purchasers, as they had done in the past, manufacturers decided to let distributors themselves determine those

relationships and set their own pricing. When this decision was first made, it seemed almost ludicrous. How could manufacturers simply walk away from locked-in relationships and let distributors decide which product line they would price lowest to the customer? Didn't they know that the larger distributor's private-label lines would almost always come in as the lowest price and produce the greatest margin for the distributor at the same time? Did they not care that the distributor might not give their brand top billing? What was going on here?

Only later was it clear that manufacturers had figured out that exerting a great deal of cost to win a very small (when compared with large hospital systems) account simply did not make financial sense in a fiercely competitive industry. They learned that revenue without cost management does not produce profit. This model has worked successfully for a number of years and there does not seem to be any significant advantage in changing it.

In the small volume purchaser model, product pricing does not need to involve the manufacturer. The volume is simply not there to warrant it. Pricing is between the distributor and the customer only, the recent efforts of GPOs notwithstanding. Manufacturers can and should provide product support where necessary but there should be few additional resources required.

Distributors are well suited to make the changes necessary. They already provide valuable services. The efficient health care supply chain requires that they now prove the value of those services in order to be fairly compensated for them. The changes laid out here will not be easy and there will be some pain along the way. However, for those distributors who can make it to the other side, the rewards will be significant. They will become trusted partners with their customers, and it is the trust relationships that will open the door to almost limitless opportunities.

How Distributors Can Get There

In order to do their part to create the efficient health care supply chain distributors must do the following:

- ✓ Become educated about supply chain management.
- ✓ Abandon the old push model and adopt pull.
- ✓ Fully implement Activity Based Management.
- ✓ Share the impact of ABM with customers.
- ✓ Validate the value of every service and eliminate those which do not stand up to scrutiny.

- ✓ Create new services that reduce the cost of doing business for both customer and distributor.
- ✓ Educate customers about the role of distribution in the health care supply chain.
- ✓ Re-educate the sales organization and train them to assume their critical new roles.
- ✓ Segment the marketplace into large volume providers and small volume providers.

Manufacturers

For all intents and purposes, manufacturers are the beginning of the health care supply chain. This is not stated to discount the role of raw materials suppliers or OEM manufacturers who actually manufacture a sizable portion of the products which move through the health care supply chain. It is simply to recognize the role played by manufacturers. Clearly, manufacturers do not invent every product that they sell. However, without manufacturers, the advancements in technology that play such a critical role in the high standards of health care enjoyed by Americans would never make it to market.

Historically, manufacturers have wielded a great deal of power in the health care supply chain. With few exceptions they have been able to maintain their ability to generate profits in spite of the fact that many of their end users are fighting just to survive. Manufacturers must remain profitable in order to continue the financially risky business of research and development. The challenge for the health care supply chain comes in balancing the needs of each of its links without placing undue financial pressure on the supply chain as a whole.

Manufacturers invest great sums of money in the development of new products. In order for that investment to pay off, they must sell the products they make. Sales efforts by manufacturers provide a valuable service to the industry in that they make clinicians and patients aware of new procedures, treatment options and improved products. Each is made possible by the development of the product being sold. Manufacturer sales representatives also often have the responsibility of providing some of the first line of training for users of new products.

Manufacturers are certainly a part of the push mentality that has dominated supply chain thinking in health care for years. Yet often they have had to push product because they did not really know what the demand for their product

was due to poor information within the supply chain. Manufacturers often made too much product rather than too little because it was easier to recover from their own inflated inventories than it was to recover from the wrath of customers who were left without the product they agreed to purchase from dedicated sales representatives.

As has been previously stated, the push model is certain to leave someone -- maybe several links in the supply chain -- with more product than they can sell or use. If timely and accurate demand information can be generated through end-to-end supply chain connectivity, manufacturers will have much more to work with in terms of planning and managing their production cycles. This synchronization of supply with demand will lead to less product in the pipeline and will ultimately reduce manufacturers' cost of doing business. However, initially, as demand information is being harvested, all links in the supply chain can expect to undergo some temporary corrections in sales and profits as hospitals use up the excess inventories that have been piling up as a result of the push economy.

There can be no doubt about the commitment of the health care manufacturing sector to protect its profits. The most recent example of this is the formation of the Global Health Exchange. This E-Commerce company has brought together some of the most well known names in health care manufacturing to create their own E-Commerce offering. And like the E-Commerce efforts of the GPOs and some distributors, the goal here seems to be to exert control over the customer. In the case of GPOs and distributors, the goal is to control the purchases of the customer. Here the goal is to offer some modicum of proclaimed efficiency to members to keep them from joining other E-Commerce companies where the risk of bidding wars that would lead to Internet-based manufacturer profit margin erosion would be higher.

Price Cuts Hurt, Not Help

Manufacturers have a great deal to lose and therefore a great deal to protect. Many manufacturers have invested millions of dollars and many years in the creation of valuable brand names. The fortunes of many manufacturers are tied directly to the value of these brand names. Threats from the Internet or any other source are treated very seriously.

Although the protection of brand value may seem out of place with the lofty goals of the efficient health care supply chain, it is a valid concern. The value of these companies is based on their performance over time. Their ability to produce innovative products that positively impact health care in this country is dependent upon having the resources to invest in research and development. Any pricing concession given to a customer has the potential to slow the rate of spending in new product development.

For the past ten years manufacturers have been the targets of a widespread effort to reduce product acquisition costs for customers. The logic is that the customers need lower product costs to win their battle for survival. If the price cuts that have been brought about over the last ten years or so had accomplished this goal, it is likely that manufacturers would have led the celebration over the survival of their customers. But the reality is that today providers are worse off than they were ten years ago when prices were higher. *So what happened to the money that was passed on to the providers to ensure their survival? It is gone.* In fact, one wonders if any of it actually stayed on the income statements of the providers, or if it was all given to payors in an effort to secure patients to serve.

So today, dozens of price concessions later, the industry is once again asking how suppliers can help providers survive. For years a small but vocal group of people in the industry have been talking about the importance of process costs. Yet almost no one has been listening. Hospitals keep asking for price concessions because they are energized by the results of the last time they asked. And the time before that. And so on. And what if each successive price decrease only served to empower the forces that are looking for any reason on which to base a reduction in the reimbursement provided for the procedure or service where the product was used?

Providers need help from their suppliers, but the help they need is not more price cuts. Price cuts are likely to be gone in a week with no visible effect on the industry. But quietly, another manufacturer's research and development budget will be slashed. Another new product introduction will be delayed for another quarter. And a product improvement will be scrapped altogether in hopes that there will be more money available to finish developing the product's successor in a few years.

What manufacturers need is a way to help their customers reduce their total cost of doing business without having to remove part of their own internal organs in the process. The concept of Value Proposition Modeling is exactly what the doctor ordered.

Value Proposition Modeling (VPM) is the process of defining the cost of any activity or process within the provider organization, proposing a service offering that would reduce or eliminate the cost, implementing the service, and measuring its financial impact. If the financial impact is favorable to the provider, i.e. if activity or process costs were reduced or eliminated, the service has value to the provider. If not, the service should be abandoned or revised and the analysis performed again. VPM is designed to allow manufacturers, distributors, GPOs, or E-Commerce companies to quantify the value of their services on the provider customer's bottom line.

Although a price based cost savings is easier to quantify, its impact may be of relatively short duration. But an activity or process cost reduction that could result in a lower procedure cost or the ability to perform more procedures without an increase in staffing would have longer lasting and more substantial benefits for the provider.

Manufacturers need to be profitable, but there are a number of alternatives that present them with choices in how to work with their supply chain partners to accomplish that goal while sharing the benefits of increased efficiencies and reduced costs through the chain. Manufacturers must act before they find themselves struggling as much as their provider customers. Finally, like distributors, manufacturers must consider the nature of the customers they serve and employ some segmentation in establishing pricing and service offerings.

How Manufacturers Can Get There

In order to do their part to create the efficient healthcare supply chain manufacturers must do the following:

- ✓ Embrace downstream supply chain management practices
- ✓ Evaluate the current roster of value added services and eliminate those that have little or no value.
- ✓ Become educated about supply chain management
- ✓ Abandon the old push model and adopt pull
- ✓ Fully implement Activity Based Management
- ✓ Educate provider customers about Activity Based Management
- ✓ Create a Value Proposition Model for every value added service
- ✓ Train the sales organization on how to create and enhance relationships through the use of Value Proposition Modeling
- ✓ Segment the marketplace with consideration given to which segments to focus on: large volume provider, small volume providers, or both

Group Purchasing Organizations

Group Purchasing Organizations came into prominence in the health care supply chain because of their ability to leverage member purchase volumes into

product price reductions from manufacturers and, to a lesser extent, distributors. These price reductions have served GPOs and their members. It is clearly easier for buyers to use pricing comparisons to demonstrate the value of the GPO relationship than to quantify any process cost reduction that may result from GPO membership. Recently a study was able to demonstrate the costs of traditional contract management processes employed at the hospital level. Indeed, GPOs are able to reduce their members' contracting costs.

Today individual hospitals are able to obtain competitive pricing on their own by committing their volume to the supplier offering the pricing. New technology is also making it possible to manage contracts in a more cost effective way.

Group Purchasing Organizations are recognizing that what attracted members yesterday may not work in the future. Perhaps with that in mind, a number of them are beginning to recast their future revenue models. The two largest GPOs – Premier and Novation -- have each created a vested interest relationship with an E-Commerce firm.

GPOs derive their substantial power from the aggregation and synthesis of information. More and better information becomes increased leverage for the GPOs, and ensuring a steady and timely stream of that information can only improve their ability to demand concessions from their suppliers. E-Commerce has the ability to be that source of information. At the same time, GPOs can use E-Commerce to cast a wide net over the buying habits of their members to increase contract compliance while discovering new product groups that might lend themselves to GPO contracting.

The Internet and E-Commerce are here to stay. That means that GPOs have their choice of up to four different sources of revenue:

1. Administrative fee rebates.
2. Membership dues.
3. E-Commerce transaction fees.
4. A portion of the process cost savings generated by E-Commerce.

It would appear that the more profit-oriented a GPO is, the more likely it would be to choose all four revenue sources. Indeed, if they took a piece from all four revenue sources, they could generate a revenue stream equivalent to about seven percent or more of the total product cost which passes through their organizations.

Members need to consider that GPOs originally were created to provide services to them. But over the past ten years, the financial fortunes of members have, in many cases, fallen sharply while the GPOs as a whole seem to be quite profitable and in far better shape than the majority of their members. Is it time

for GPOs to rethink their missions? Can the supply chain afford for GPOs to enjoy such a significant revenue take away when so many hospitals are struggling to keep their doors open?

It is a complicated question but one thing does seem clear. In the end, GPOs must play by the rules of the efficient supply chain. If a GPO can define its value and consistently deliver it, that GPO will have ensured its place in the health care supply chain.

At least one GPO is working to create value models for its E-Commerce offerings. This should provide additional information that will point to other inefficiencies that exist within the internal supply chains of its members.

In many cases, members will not have the resources to make the necessary improvements required to increase efficiency in these areas on their own. This situation will provide a significant opportunity for GPOs to assist their members in eliminating these inefficiencies by offering services beyond what they are offering today.

This situation, combined with the trends discussed earlier, is likely to provide the impetus for GPOs to begin a slow but steady transition from purchasing focused organizations into Group Services Organizations. Their primary value will shift from providing low product prices to providing and/or performing services that reduce the member's total cost of supply management. Although significant inefficiencies exist in the procurement process, the largest opportunities for savings lie in the areas of inventory management and internal physical distribution. It is expected that GPOs who are not providing such services will either work with distributors and dot.coms to create some of them or compete with distributors in offering such services.

Are GPOs Anti-Supply Chain?

Any responsible examination of GPOs must sooner or later address the question: Are GPOs anti supply chain? That is, do their efforts actually work contrary to the fundamentals of an efficient health care supply chain?

For all of the value that GPOs bring, a price must be paid. The following scenario should make this point abundantly clear. In order for XYZ GPO to maintain its market leverage, it must, on a regular basis, create winners and

losers. Creating winners and losers gets the attention of suppliers and instills some “healthy” fear into them.

In order for winning to mean something, losing must be painful. This year’s bid for distributor resulted in an award to an established industry player who previously did not have the business. Now, in order for ABC hospital to access XYZ’s contracts, it must switch distributors because XYZ has decided that the old distributor no longer is authorized to supply products to its members. Unfortunately for ABC Hospital, it had developed a relationship with the former distributor which, through a combination of outsourced services and technology interfaces, had successfully reduced ABC Hospital’s total cost of doing business. Now in order for the hospital to get the new pricing, it will have to abandon that relationship and expose itself to a new learning curve with a new supplier. Years could pass before the relationship will accomplish what the previous one was doing today. In order for the hospital to gain the benefit of what may be microscopic cost savings on product, it must risk an increase in the total cost of doing business.

Does it make any sense that a cash-strapped hospital would have to decide between managing its product cost and managing its process costs? Yet because the GPO needs to flex its muscle, the hospital must subject itself to this situation.

Part of the problem here is the current rebate administration process. In order for the hospital to actually get the new contract price, it must be purchased through an authorized distributor. An authorized distributor is recognized both by the GPO and the manufacturer of the contracted product. The rebate process, in part, serves to validate the quantity of products purchased by the member at the contract price. This information is forwarded to the manufacturer, who processes the “make the distributor whole” rebate to the distributor and the administrative fee rebate to the GPO. As beneficial as the contract pricing might be to the hospital, the cost of managing the pricing represents an enormous cost to the supply chain. In order for the GPO to maintain its hold over its customers and its suppliers, it must place these artificial constraints on its supply chain partners.

Relationships Destroyed by Bidding Calendars

Certainly, distributors can play an important role in the supply chain. Their value has already been discussed. Yet at almost every turn, distributors and GPOs seem to be at odds with each other. By anointing exclusive distributors, the GPOs dramatically limit the ability of both distributors and hospitals to build relationships that are not bound by the GPO’s bid calendar.

This is not to suggest the end of GPOs. Rather it does suggest that there must be some middle ground between GPOs and distributors. If distributors were taken out of the product pricing equation and permitted to sell their services to customers purely on the basis of their provable value, GPOs and distributors could peacefully co-exist.

Many of the services provided by distributors are relationship-based. In other words, trust must be established with the customer prior to the introduction of some of the distributor's most valuable services. These services can often take several years to develop and could take several more years to reach their full cost savings potential. The value of such services is minimized when they are controlled by price-bidding schedules that benefit only the GPO.

The improvements in technology referenced above should provide the GPO with access to product usage without the need for a "make the distributor whole" rebate. The Internet will play an important role here. Real time data transfer and real time pricing may significantly reduce the need for pricing relationships based almost solely on the GPO's need to reinforce its control over the process. *If one looks at the future value of GPOs, one thing seems abundantly clear: Any incremental decrease in product price that fails to recognize the pre-eminence of the need to reduce the total cost of supply chain management must ultimately be considered a failure in the efficient health care supply chain.*

Today, GPOs seek to control access to information for their own purposes. The information that is so important to GPOs is also vitally important to manufacturers for the setting of production schedules, and to distributors for the purpose of replenishing their own inventories and the inventories of their hospital customers. The supply chain of the future will be collaborative in nature. As each link in the chain defines its own unique value to the chain, it is less likely that one link will feel the need to compete with other links in the chain. Players within the same link will continue to compete, but that is much different than links competing with each other.

In order for GPO members to be able to take full advantage of the services offered by GPOs, they will need to be educated about the finer points of supply chain management, including how to isolate and define the costs of inefficiency. If GPOs will commit to providing education for their members, they will demonstrate the leadership necessary to win over their critics and create their own destiny. However, it should be noted that education has not been a priority for the GPOs. One wonders if GPOs fear that supply-chain-educated members are more likely to leave their GPO relationships. If GPOs have this fear they may be shortchanging themselves and their members. The rules of the efficient supply chain are clear: Produce value or perish.

Most-Favored-Nation Clauses Boomerang

Before concluding the discussion on Group Purchasing Organizations, there is one final issue that must be addressed. While there is much discussion among providers of the profit inequities that seem to exist in the supply chain, most of that discussion must be placed in the context of providers' general failure to address their total cost of doing business. It is much too easy to feel victimized by the profits of someone else if one's only focus is in the one area that will ultimately fail as the "deemed source of profitability," namely, product costs. If a business can operate more efficiently, then it deserves to profit from that commitment to efficiency. *Suppliers are not profitable necessarily because their prices are too high, but rather because they are operating at a higher level of efficiency. The same opportunity to improve profitability as a result of improved operating efficiencies is available to providers. However, they must make the effort to make it a reality.*

The advent of the relationships between E-Commerce companies and GPOs has led some to consider which entity needs the other more. A similar question can be asked about manufacturers and GPOs in their relationships. Who needs the other more?

It is true that GPOs need manufacturers to reinforce the power of the GPO. Manufacturers may believe that they need GPOs to access their customer base. But there is another need that may be much more troubling. Most, if not all, GPOs have what are called "most favored nation" clauses in their contracts. This means that if a contracted manufacturer offers a better price to a competing GPO or a member of a competing GPO, that manufacturer must come back and offer that same price to the first GPO. Clearly, this situation reinforces the leverage of the GPO. But it also may do something more.

A manufacturer that has GPO contracts with these clauses now has the ability to have a pricing floor below which it does not have to go. In effect, this clause plays a role in "fixing" a minimum price for all items contained in the contract. Does this not protect those manufacturers who have been awarded GPO contracts from having to compete in their markets on the basis of price? This pricing floor protection also helps to ensure that there is enough margin left over for the manufacturer to pay the GPO's administrative fee rebates.

The future of Group Purchasing Organizations rests in a swirl of questions which all links in the supply chain must ultimately answer for themselves. How can GPOs deliver value to their members without pre-empting the value produced by other links in the chain such as distributors? What will that value be? Will it be more pricing related or will it be more service related? Will GPOs continue to focus on reducing the cost of products, or will they focus on assisting members in reducing their total cost of supply management? And how

can they focus on helping their members reduce their cost of doing business if their members are not ready to work in that direction (at least partly because the GPOs themselves have failed to prepare them to do so)? Yet by adopting a total cost reduction strategy, GPOs can separate themselves from the troubling discussion on pricing gridlock and move forward in the service of their members. GPOs, like their counterparts in the health care supply chain, must define their value and deliver on it on a consistent basis.

How Group Purchasing Organizations Can Get There

In order to do their part to create the efficient healthcare supply chain, Group Purchasing Organizations must do the following:

- ✓ Evaluate current and future revenue models in light of their impact on total cost through the supply chain.
- ✓ Commit to educating members about supply chain management.
- ✓ Work with members in the implementation of Activity Based Management, especially in the areas of procurement, contracting, and pricing management.
- ✓ Develop service offerings that contribute to total cost reduction for members.
- ✓ Relax the standards on distributor exclusivity to allow members to maintain relationships with distributor partners regardless of changes in contracts and manufacturers holding those contracts.
- ✓ Advocate the abolition of the current rebate system in favor of a less costly method of member purchase volume verification.
- ✓ Adopt a collaborative approach to information management and sharing through the chain.

Critical Success Factors in Building the Efficient Health Care Supply Chain

The efficient supply chain assumes that the supply chain as a whole can no longer tolerate the inefficiency and waste associated with the status quo. Achieving the efficiencies necessary to ensure the ongoing availability of high quality care for every patient will require that every link rethink how it does business and then move in harmony with other links to create a more patient-friendly supply chain. The critical factors that will drive this industry's ability to successfully migrate into the efficient health care supply chain are presented below.

q **The Creation of a New Currency**

The rules that drove the old supply chain revolved around the notion that whatever the market would bear was considered legal and acceptable. This old approach viewed each link in the supply chain as a separate silo. While it was recognized that adjacent silos were part of a cause and effect relationship between them, it was not recognized that each link had a relationship with every other link.

The cause and effect relationship between silos does in fact reverberate up and down the chain. The recognition of this fact gives rise to the realization of the power that lies within the supply chain to affect its own destiny. The links in the supply chain are, in fact, in the same boat, and one link can no more control its own destiny to the exclusion of the other links than the passengers and crew on the Titanic could have saved part of the ship while allowing the rest to sink.

In the efficient supply chain the only currency that will matter will be the currency of value. If a product or service produces value that can be effectively quantified by buyer and seller, that product or service has value. If any product or service does not have value, then the supply chain will be neither able to justify its existence nor afford to carry it.

The same applies to individual players in the chain. The chain is much more important than any one player, and the patient is far too important to let any one player fail to define and deliver on its value and be allowed to survive while the rest of the chain struggles to keep that player afloat. The efficient supply chain has one rule: Define and deliver value or perish.

q **Defining and Measuring Value**

The health care industry has developed a penchant for measuring everything except the cost of producing clinical outcomes. Yet this one area holds the key to defining the value of the entire supply chain as a whole. *The ultimate value produced by the health care supply chain as a whole is the cost-effective positive patient outcome.* In order to maximize its contribution to this effort,

the supply chain must devote more effort to measuring and benchmarking supply chain practices. In fact, this effort must be much greater than the historical effort directed at measuring the cost of every widget purchased by the health care organization.

Supply chain inefficiency at any level can do and has done more damage to the financial condition of hospitals than the largest single product decrease has done good. *This industry has spent far too much time and devoted far too many resources to managing the pennies of product cost while ignoring the millions of dollars of inefficiencies that currently exist.* Suppliers must recognize that sooner or later they will have to work with their customers to help them become more efficient. The efficient supply chain demands partnerships within the supply chain. All links will have to pull back their generals and bring forward their statesmen. *Years of distrust and conflicting goals will not be solved by more product push.*

q **The Role of Education**

Change will not occur by itself. And people who do not accept that change is needed or understand what needs to be changed will never change. The health care supply chain will continue its aimless meandering toward the edge of the cliff unless the links in the chain step forward and commit to becoming educated and educating others. There is still time for individual players to put the supply chain on the right course.

Each day that passes without education moves all players closer to the day when they will have waited themselves into financial ruin. Most health care providers have reached the point where they cannot afford to fund this educational effort. That means that it is incumbent on suppliers and GPOs to lead it. The results of the failure to educate are most graphically demonstrated in the decisions of E-Commerce companies. They chose not to educate their customers, choosing instead to build expensive software that may never get used enough to pay for the cost of development. As the fortunes of these companies hang in the balance, they now want to blame their customers for not understanding the value of E-Commerce. The educational process will take several years. It is already late in the game. When will the statesmen of the health care supply chain join in this important cause?

q **Collaboration and the Role of Industry Organizations**

The changes required to create the efficient health care supply chain will not and cannot be the result of a single person, company, or organization's efforts. Rather it must be a collaborative effort.

There is a widespread belief that many of the answers to the problems in the health care supply chain lie in the nation's capital. There is a time and a place for lobbying. But this industry is so fragmented that there is no agreement on what Washington should do or for whom they should do it. Furthermore, there is no reason to believe that any government solution would even work.

Instead of waiting for answers or permission from Washington, this industry must harness its considerable resources to create its own future. There will continue to be intense reimbursement pressure until health care providers stop the madness and say no. And this will not happen until providers know their cost of doing business right down to the procedure level. It will also not happen until providers can know that their current product cost is as low as it can go and there are no hopes for making it go lower. Everyone says that reimbursement is too low, but they do not know what rate would be required for providers to make ends meet. The paperwork demands of payers are often ridiculous, but if the industry has not quantified the cost of compliance and the amount of care that must be withheld in order to afford to be in compliance, why should any of the paperwork requirements be changed? *When providers know their costs is when the real lobbying can start.*

q **The Pre-eminence of the Patient in the Supply Chain**

While each individual player in the supply chain works to create the best future they can make, they must recognize that the patient is pre-eminent. If the ultimate result of the supply chain is the assurance of high quality patient care, can the individual links in the chain afford to have lower standards for themselves? It is the health care provider organizations who are closest to the patient, and it is they who are the most direct targets of reimbursement cuts, regulations, and a serious nursing shortage. They need to have more control over their supply chain relationships, but they need a significant amount of supply chain education to fully equip them to shoulder that enormous responsibility.

Conclusion

The challenge of building the efficient health care supply chain is monumental. Yet this industry cannot and must not fail to fulfill its role in assuring the

availability of high quality patient care. The time and opportunity to bring this industry together is now. There is a big job to be done. Only statesmen need apply.

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About the Author

Lynn James Everard, C.P.M, CBM. is Co-founder of the Foundation for Healthcare Integrity, a nonprofit organization dedicated to restoring competition in the health care supply chain. Mr. Everard is a health care business educator and supply chain strategist.

Prior to entering the consulting field in 1994, Lynn spent thirteen years working in the health care supply chain, mostly on the buy side. His experience includes working with a medical/surgical distributor, a 750-bed tertiary care teaching medical center, a national long-term care company, and two national home care providers.

Mr. Everard holds a bachelors degree from SUNY at Buffalo and has done significant course work in Materials Management, Accounting, and Finance. He is one of a select few health care professionals to earn the Certified Purchasing Manager (C.P.M.) designation from the National Association of Purchasing Management. He is also a Certified Business Manager (CBM).

In addition to being an educator and strategist, Mr. Everard is the author of over 75 published articles and four white papers. In July of 2003 he testified before the U.S. Senate Antitrust Subcommittee as an expert in the health care supply chain. In September of 2003 he was also asked to testify before the Department of Justice and the Federal Trade Commission looking into matters related to health care Group Purchasing Organizations and marketplace competition.

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