Advanced purchasing mechanisms and GPOs in the Healthcare system

Implications for healthcare providers, suppliers and policy-makers

SANIT Course - 2004

Fernando Almansa
José Manuel Cueto
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Executive Summary

GPOs are playing an important economic role in the different health-care systems in which they operate. Their major contribution is to help hospitals and other providers in reducing their supplies expenditures.

Several models have been implemented to improve the purchasing mechanisms in Hospitals, which derive historically from public tenders and isolated purchasing by each hospital: unique supplier, unique catalogue (voluntary or compulsory) and unique catalogue plus logistics.

In some cases, the unique catalogue model has been institutionalized through a group purchasing organization (GPO), an entity that helps health care providers-such as hospitals -realize savings by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors. The future is in logistics management and in the Internet.

GPO models have evolved differently depending on the country and the region considered.

- The US has a very advanced model (with public and private initiatives competing in the market place), although the size of the GPOs (in some cases, national scope) has been contended.
- In Europe, purchasing mechanisms have usually evolved inside the public healthcare system and are less developed than in the US. However, in recent times, big efforts have been made to keep on improving these systems.
- In Spain, specifically, the Autonomias system has derived into 17 different purchasing systems (some more advanced than others). There should be incentives in place to share experiences and information from one region to another.

These advanced purchasing mechanisms have implications for the different players in the Healthcare system:

- Health-care providers. Apart from cost-savings that result from group purchasing, hospitals and other health care providers are increasingly relying on GPOs for sophisticated supply chain solutions to help manage and streamline the complex system of health care purchasing.
- Suppliers. Several factors associated with group purchasing and public tenders lead to an increase in price competition for suppliers.
- Policy-maker. GPOs could raise barriers to entry for potential small suppliers with a very good product offering. For these reason, it would be good for the industry as whole to set a minimum percentage of purchases to be made to small players (provided that they comply with quality and service requirements) and/or to foster non-compulsory models of GPO.
Introduction

GPOs are playing an important economic role in the different health-care systems in which they operate. Their major contribution is to help hospitals and other providers in reducing their supplies expenditures. In our GPOs analysis, we will review the Spanish health-care system, the US market, (currently, US hospitals channel approximately 72 percent of non-labor expenditures through GPOs), and also that of Europe.

Our motivation to choose this subject is to understand the role GPOs play and their implications for the different actors of the health-care system: health-care providers, suppliers and policy-makers.

Group Purchasing: typology and general characteristics.

Graph 1 - Typology of advanced purchasing mechanisms

Several models have been implemented to improve the purchasing mechanisms in Hospitals, which derive historically from public tenders and isolated purchasing by each hospital. The first of these models (implemented in the mid-nineties by Hospital Reina Sofía de Córdoba) is the unique supplier of several products model. The main characteristics of this model are the following:

- Suppliers are usually against this model because it limits free competence in the sense that there would be only one supplier of several products, many of which would not be produced by this supplier (it would act as a mere intermediary).
- The unique supplier may or may not be in charge of the management of the stocks.
- Prices are known (purchases are done through a catalogue).
- There is a unique speaker and a better control of the supply chain.
- However, it conveys risk and service control to an outsourcer.

The unique supplier model, but reduced to the supply management of one department or service area (e.g. Laboratories, Radiology, Kitchen), seems to give better results. Its main characteristics are the following:

- There is resistance to implement this model, because professionals are used to contact several suppliers.
- This model gives the possibility (sometimes obligation) for the supplier to introduce new technologies to guarantee the hospital’s service level agreements included in the contract.
- If the contract is signed for a long period (3 to 4 years), hospitals can obtain bigger value from suppliers by homogenizing the information systems of all the laboratories of the hospital and forcing the supplier to make the necessary investment. In these situations, the supplier is usually building a huge barrier to exit.

The unique catalogue model has been applied by the ICS since 1994 (also by Servei Valencia de Salut and Servicio Extremeño de Salud). The model can be either voluntary
or compulsory for the participant hospitals. Each year, a catalogue is developed with unified criteria by purchasing officers and by professionals, reaching today to 6,000-7,000 products. There is a unique supplier per product in 82%-83% of items. The tender consists of two phases: first, each hospital provides its needs and a tender is issued as the sum of needs with a maximum price (only technically correct suppliers will make it to the second phase); second, the ICS centralizes the tender and negotiates consumptions and prices with the suppliers. During the first years of the implementation, little hospitals were the most favoured by the system. Some of the main characteristics of this model are the following:

- If more representativity is given to the users that consume the product the most, they will choose their usual supplier.
- Professionals spend time evaluating products, not in their professional activity.
- Some professionals do not consult the catalogue.
- Another problem is the amount of time spent by professionals from different hospitals to decide what products are selected. This last problem will be solved in the future by creating a register system whereby for each product you have all the references from the product as of today available in the market, the supplier reference and its technical note. This new methodology makes sense for products with low differentiation relative to high-technological products.

In some cases, this unique catalogue model has been institutionalized through a group purchasing organization (GPO), an entity that helps health care providers - such as hospitals - realize savings by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors. In a more general sense, GPOs provide three essential functions for health care providers:

- Aggregate buying power in order to obtain discounts from manufacturers and distributors (strategic alliance, pool purchasing dollars to exert leverage over suppliers, concrete avenue for economies of scale, lower unit costs for members, negotiate & manage contracts).
- Facilitate and enhance comprehensive product comparison analysis, using clinician input (update pricing changes, disseminate information from vendors under contract, cost reduction tools for members, benchmarking data).
- Finally, they streamline and standardize the purchasing process, thereby reducing the inefficiencies inherent in today’s health care systems and offering valuable cost avoidance savings to providers (product standardization programs, product utilization programs, designate authorized distribution agents (ADAs), private label programs for smaller manufacturers).

In the future, the next step for GPOs would be to assume the logistic function of the hospitals it serves and to expand its services through Internet.
International benchmark of GPOs.

GPOs in the US.

Although provider group purchasing has existed since 1909 in the US, it was not until the 1970s and 1980s that national GPOs emerged, through the mergers of state and local GPOs. Severe financial pressures for health care providers increased demand for tools to reduce operational expense, such as GPOs (one third of US community hospitals had negative margins in 2000, 60% had negative Medicare, nearly two-thirds lost money on patient). By 2002, group purchasing sales volume was higher than ever, with the seven largest national GPOs maintaining contract portfolios representing purchases of nearly $43 billion annually.

Graph 2 – GPOs in the US

The GPO industry in the US is large and concentrated. There are 600-700 GPOs in healthcare industry; however, 7 national GPOs account for more than 85% of all hospital purchases nationwide made through GPO contracts. There are differences in terms of ownership (for-profit, nonprofit, public), geography covered and membership (hospitals vs. alternate site market). Up to 98% of hospitals nationally participate in GPO’s. On average, hospitals utilize the services of at least two, and as many as four, GPOs per facility, according to a report by SMG Marketing.

The two largest GPOs account for about 66% of total GPO purchasing volume for all medical products (including, among other things, medical-surgical products, pharmaceuticals, capital equipment, and food). These two GPOs also account for 70% of the seven GPOs’ total medical-surgical product volume. One of the two largest GPOs has as members 1,517 of the nation’s approximately 6,900 hospitals; the other has 1,469 hospital members. One of the two largest GPOs permits its members to belong to other national GPOs, whereas the other largest GPO does not.

Vendors pay GPOs administrative fees based on sales. Those fees finance operations, while surplus fees are distributed to owners or used to finance new ventures. GPOs argue that seller-based fees and buying cooperatives are widely accepted competitive business models in many industries (agriculture, real estate, insurance).

GPOs save hospitals and free standing nursing homes between 10 to 15 percent of their purchasing costs in the US. However, the practices of GPOs have been criticized and some industry analysts are seriously questioning the future of group purchasing:
Suppliers resent the ability of large GPOs to drive down the margins that the suppliers had enjoyed in years past, as well as the high administrative fees GPOs charge suppliers to fund their contracting services.

Providers also have become dissatisfied with GPOs, which have instigated high membership dues and required members to commit to purchasing a significant percentage of their supplies using GPO-negotiated contracts.

The contracts that GPOs negotiate with large, multi-product suppliers have the effect of blocking the introduction of highly cost-effective products to healthcare organizations.

Although suppliers clearly are interested in negotiating the enormous contracts that are possible with GPOs, they also are looking for practical alternatives to dealing with these sometimes unwieldy organizations, including opportunities to contract directly with regional hospital alliances and purchasing co-ops.

The sheer size of today's national GPOs also poses a serious problem for these organizations. Getting 500, 1,000, or even 1,500 hospitals to move in a common direction is difficult, if not impossible.

GPOs in Europe: France and UK.

France.

The French medical market is tightly regulated by the Health Ministry. Both public and private hospitals require authorisation prior to purchasing expensive high-technology equipment. In November 2001, the regional hospital agencies were made responsible for authorising most types of high-technology equipment, whilst equipment requiring authorisation at ministerial level was limited to open-heart surgery equipment, medical cyclotrons, and PET scanners. The government is now proposing to make the regional hospital agencies responsible for all high-technology equipment authorisations. Decisions will be taken on the basis of local population need and will no longer have to comply with arbitrary national limits on equipment numbers. It is hoped that decentralising the decision-making process to regional level will speed up the authorisation process, which normally takes several years.

Procurement by tender is the norm for public hospitals. Tenders are issued by the hospital boards and individual hospitals. In the past, smaller hospitals have often used a purchasing organisation known as Union des Groupements d'Achat Publique (UGAP). However, this organisation has recently been in financial difficulties prompting a major restructuring programme and an overhaul of its procurement procedures, and it is likely that fewer hospitals will purchase through UGAP in the future.

The Hospital 2007 reform programme includes proposals to overhaul public hospital purchasing procedures. The aim is to focus more closely on securing value for money as opposed to merely ensuring that purchasing procedures are in line with the current code of practice (equal access to public sector contracts, competitive bidding, transparency of procedures and decision-making). The move is in part a response to government findings that in some cases public hospitals are paying up to 20% more for costly drugs.

Private procurement is less structured. Most private hospitals buy direct or through a purchasing body. The leading private hospital operator, Générale de Santé, which has
annual purchases of some 275 million euros, has announced the establishment of a central purchasing unit designed to achieve economies of 10% within three years.

UK.

In the public sector, NHS trusts have primary responsibility for medical equipment management, including purchasing and maintenance. Trusts receive funding for equipment from the NHS Executive and are accountable for their expenditure. Purchasing procedures differ between trusts but procurement is generally either through the NHS Purchasing and Supply Authority, or put out to tender direct to suppliers and manufacturers.

In April 2000, the NHS Purchasing and Supply Agency was established as an executive agency, replacing the purchasing and strategy divisions of the NHS Supplies Authority. The NHS Purchasing and Supply Agency has recently formed a partnership with NICE (National Institute for Clinical Excellence) to provide NHS trusts with a central database of information on the performance of artificial hip joints. The agency has also worked on a number of projects in conjunction with the MDA (Medical Devices Agency) and the ABHI (Association of British Healthcare Industries).

Since 2001, the NHS Purchasing and Supply Agency has been assisting with the implementation of the NHS Plan. As part of the programme, the agency is already linked into a number of key priorities identified in the NHS plan and has made significant contributions including the procurement of IT systems and associated equipment, the purchase of specialist medical equipment for cancer treatment and the supply of single use instruments for tonsil surgery. With regard to the NHS plan, the Purchasing and Supply Agency has also continued to work closely with NICE to ensure that their appraisals and recommended guidelines are implemented.

GPOs in Spain

Evolution and background

In the past, public sector purchases under US$100,000 in value were generally handled by hospital administrators without recourse to tendering. Each hospital managed its own budget independently without considering potential economies of scale from belonging to a group of hospitals.

Later on, the government published a new tenders law which stipulated that all public purchases of medical equipment valued at more than Ptas. 2 million (US$16,000) had to be made by invitations to tender published in the official government journal, the Boletín Oficial del Estado, and two high-circulation national newspapers. Tenders for contracts valued at more than Ptas. 102.25 million (US$815,000) had also to be published in the EU Official Journal. In order to bid for tenders, foreign companies must have a Spanish subsidiary or appoint a recognised representative.

At the same time, there were moves to give hospitals greater autonomy in the field of purchasing. A number of medical technology evaluation agencies were set up. The first agency of this type was the Agencia d’Avaluacio de Tecnologia Medica (AATM) set up in Barcelona in 1991. The AATM is a non-profitmaking public company partly funded
by the Catalonian Health Service, which carries out assessment surveys for hospitals, health insurers and the medical industry.

In the mid-nineties, there was a revolution in the way hospitals manage their purchases. We saw innovation in logistics, greater education, centralized catalogues, group purchasing. The first model of advanced purchasing, unique supplier of several products, was implemented by Hospital Reina Sofía de Córdoba. The unique catalogue model was applied by the ICS since 1994 (also by Servei Valencia de Salut and Servicio Extremeño de Salud).

Nowadays, we have to differentiate those regions which have been managing their competencies for a long time from those that have just started in 2002. Obviously, we find that the former regions have much more advanced models of group purchasing organizations. Here, there should be incentives in place to share experiences and information from one region to another. In all, there will be 17 separate purchasing systems.

The typical purchasing model today is to have a unique catalogue for the needs of health-care providers of a region. A tender by product type is then organized on a yearly basis. This is the case for many regions such as Cataluña, Comunidad Valenciana and Andalucía.

In the future, we could envisage a system where regions share their catalogues, so that one region with a dominant position in one product line could translate the benefits to other regions. Alternatively, when a hospital needs a certain product, they call the supplier that won the tender for that product and ask for the product delivery. This process could be centralized in the future saving some transaction costs. This model could make sense for small hospitals because of their lack of scale.

*Example 1 of GPO: Banco de Productos del SAS*

The Servicio Andaluz de Salud (SAS) is the public organisation for the Andalucia region responsible for providing health-care services to citizens from the region.

The SAS has recently centralized all the purchasing process of products and materials from public health-care institutions. Basically, the products and materials that can be used by hospitals must first be screened and registered into a centralized database. Then, the SAS opens public tenders to secure the supply of specific products or materials. Once the public tender has been allocated to a supplier, the payment, stocking and distribution of the products are managed on a centralized basis.

This group purchasing initiative seeks reducing purchasing costs for products and materials, as well as improving efficiencies in supply and logistics management.

*Example 2 of GPO: Saniline*

Saniline is the leading company in Spain offering services of supply chain management activities for health-care providers and suppliers through its Internet platform. Saniline believes that connecting clients and suppliers through the Internet is a powerful efficiency driver of supply chain processes as well as a cost reduction tool.
Saniline is offering to its clients the following lists of services:
- Refined and actualized products catalogue connected with suppliers.
- Offers, orders, invoices in electronic format.
- Integration of Information systems within the hospital, connectivity and automatization of processes with suppliers.
- Management reports and benchmarking.
- Communication of public tenders to potential suppliers.

One of the success story from Saniline has been the project for “Servicio Extremeño de Salud (SES)” done in 2002. The objective was to create a unique catalogue for a group of eight hospitals.

Today, the unique catalogue and its platform enable the eight hospitals and the SES to speak a common language in supply management. This means having precise statistics, homogeneous information and better budgeting control.

Implications for health-care providers, suppliers and policy-makers

Implications for health-care providers

As an industry, GPOs save providers between 10 to 15 percent of what they would pay without the benefit of a GPO. Even when providers purchase directly from suppliers, they benefit from the GPO contracting process because suppliers have to price direct purchases to compete with annual GPO contracts. In an era when many hospitals have negative operating margins, reimbursements from private and public payers are falling, and overall expenditures are rising, this substantial cost saving is of critical importance. However, GPOs do not always get better prices and these savings depend on the size of the hospital (the smaller the hospital, the bigger the savings).

In addition to being able to get discounts in return for aggregating volume purchases, GPOs also reduce providers’ administrative overhead costs, and offer supply chain efficiencies for health care providers in the procurement, standardization, and contracting functions. This concept includes the volume discounts GPOs provide and also the benefits that result from taking out of the hospital much of the work that goes into identifying, tracking and performing due diligence on suppliers as well as negotiating, maintaining and updating contracts.

Apart from cost-savings that result from group purchasing, hospitals and other health care providers are increasingly relying on GPOs for sophisticated supply chain solutions to help manage and streamline the complex system of health care purchasing. Many GPOs offer providers e-commerce solutions that reduce widely recognized inefficiencies in the health care supply chain. The GPO community is also a leader in the effort to reduce medical errors, through such efforts as standardizing product use within a facility to reduce unnecessary variation, educating clinicians on best practices, and leading the drive to institute bar coding for medical products.
Fundamentally, GPOs are able to offer additional value to their provider-members because much of their operating revenue is generated through earning administrative fees paid by suppliers (at least in the US). It has been recognised that there is value in allowing such fees, given that the alternative would be for hospitals to take money away from patient care. However, some manufacturers have claimed that allowing GPOs to earn administrative fees creates a conflict of interest for GPOs and reduces their responsiveness to their provider members.

GPOs play a critical role in drawing upon and consolidating the clinical expertise of hospitals. What researchers have found is that, in working with GPOs, hospitals seek to make clinically informed, evidence-based decisions about which medical products will offer the highest quality of care to patients.

Another claim heard from some manufacturers is that specific contract structures create a situation where the best products are not available to providers. However, at the end of the day, it is up to individual providers whether to purchase products via a GPO contract, or whether to make purchases independent of a GPO. Additionally, in the long run, GPOs could create a monopoly or raise barriers to entry of new suppliers, indirectly rising prices.

Implications for suppliers

Group purchasing has several significant implications for suppliers:

1. Increasing competitive pressure.

Several factors associated with group purchasing and public tenders lead to an increase in price competition for suppliers. First, group purchasing implies buying more quantities of product, naturally leading to lower prices.

Second, when group purchases are done through a public tender process, suppliers compete at the same time for a specific contract which pressures them to lower the price to beat their respective competitors.

Third, sometimes group purchasing is done on a long-term basis meaning that the contract implies securing the supplies of a certain product for months and sometimes years. This increases even more the size of the purchase, which leads to greater price competition. For example, the public health-care organisation for Comunidad Valenciana (SERVASA) opened a public tender to buy a specific medical device for all the public hospitals of the region for the next three years. Say you are one of the suppliers and that you lose the tender. This would imply not being able to sell any volume of this medical device for three years in this region. Again, long-term group purchases pressure prices downwards.

Finally, group purchasing means more transparency in prices, leading to lower ability for suppliers to do price discrimination between hospitals. Given the enormous quantity of product references consumed by a hospital, suppliers manage to sell a specific product at a much higher price to some clients than to others. When both clients do their purchases of products together, they will have more price transparency on the product ending up paying the lowest of the two prices.
2. Focus the organisation towards selling to GPOs

If hospitals start to centralise purchases through a group purchasing organisation, suppliers need to build, maintain and sustain a business relationship with the new organisation. In the case of the “Banco de Productos del SAS”, the first step a supplier would need to do to sell any of his products to any hospital is to register the product into the centralized database.

Sales people need also to take care of the group purchasing organisations in order to influence the buying decision. This often implies educating the decision makers about the special benefits and characteristics of the product (non-financial factors).

3. Size and breadth matters

We know that public tenders are awarded based on a price factor but also on a quality and a service factor. For this, it will be crucial to have the right scale to offer competitive prices as well as to have the latest technology in your product and the capabilities to offer a good service to the client.

Implications for policy-makers

It is evident that GPOs generate savings for the system as a whole; however, it should be taken into account that pricing issues may drive (solely) GPOs performance leaving aside other relevant criteria for supplier selection such as quality and service. On this issue, policy-makers should foster the creation of a code of conduct for GPOs with the purpose of strengthening and improving the delivery of products and services to health care providers.

These codes of conducts should focus on several issues: eliminating the potential for conflicts of interests; ensuring open communications between members and vendors; establishing guidelines for the use of contracting tools and, establishing reporting and educating programs, including surveys to quantify the value of GPOs.

Perhaps, a regulatory body should be created to supervise the performance of GPOs and specifically issue regulations and standards. This organism should, for example, supervise that the GPO does not become too big which could cause rigidities and inefficiencies in the buying process.

Additionally, GPOs could raise barriers to entry for potential small suppliers with a very good product offering. For these reason, it would be good for the industry as whole to set a minimum percentage of purchases to be made to small players (provided that they comply with quality and service requirements) and/or to foster non-compulsory models of GPO.
Conclusions

- Due to high pressures on health-care cost reduction, Hospitals have developed several initiatives to reduce their purchasing budgets. GPOs have arisen as a solution for Hospitals, concentrating in the following issues:
  - Aggregate buying power in order to obtain discounts from manufacturers and distributors.
  - Facilitate and enhance comprehensive product comparison analysis, using clinician input.
  - Finally, they streamline and standardize the purchasing process, thereby reducing the inefficiencies inherent in today’s health care systems and offering valuable cost avoidance savings to providers.

- In the future, GPO models will create efficiencies in logistics and will use the internet in their advantage.

- GPO models have evolved differently depending on the country and the region considered.
  - The US has a very advanced model (with public and private initiatives competing in the market place), although the size of the GPOs (in some cases, national scope) has been contented for several reasons (drive down the margins; members required to commit to purchasing a significant percentage of their supplies using GPO-negotiated contracts; block the introduction of highly cost-effective products to healthcare organizations; getting 1,500 hospitals to move in a common direction is difficult, if not impossible).
  - In Europe, purchasing mechanisms have usually evolved inside the public healthcare system and are less developed than in the US. However, in recent times, big efforts have been made to keep on improving these systems.
  - In Spain, specifically, the Autonomias system has derived into 17 different purchasing systems (some more advanced than others). There should be incentives in place to share experiences and information from one region to another.

- In the risk side, regulators should keep an eye on the possibility of too much concentration (both in the Pharma industry –too long contracts could derive in monopolies- and in the GPO industry), which could be detrimental for the system in general.

- Policy-makers should foster the creation of a code of conduct for GPOs with the purpose of strengthening and improving the delivery of products and services to health care providers and to avoid an excessive focus on the price criterion.
Links and Bibliography


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