V.I.P.E.R. Group, Inc.

The Impact of Group Purchasing on the Financial Prospects of Health Systems:

Changing Value Perceptions and Unintended Consequences

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Introduction

Over the past year health care Group Purchasing Organizations have been the subject of a series of articles in The New York Times and the target of an inquiry by the Senate Judiciary Committee, an investigation by the U.S. Department of Justice, and a study by the General Accounting Office. In response to intense pressure a number of GPOs have put forth various versions of a Code of Conduct that would seek to create acceptable parameters for how GPOs govern themselves. However detailed and well intended the Codes of Conduct proposed thus far might be, they do nothing more than mask the more fundamental supply chain issue facing health systems and their leaders.

The real issue for hospitals is not so much how GPOs govern themselves (although that is very important) but rather how hospitals manage their supply chain relationships and govern their relationships with their GPOs, and how effectively they can capture the significant cost savings opportunities within their own supply chains.

While many in the health care industry seem to view the articles in The New York Times as an "indictment" of GPOs and their governance practices, it could be just as easily seen as questioning the ability of hospitals to manage their own affairs, including their GPO relationships. Hospital CEOs and CFOs have a fiduciary responsibility to effectively manage their business operations; and the supply chain, representing a third or more of their operating expense, is a key component of business operations. For that reason, and many others, hospitals cannot afford to be a silent observer of their supply chain activities. Rather they must be fully engaged in managing their total supply chain expense. If using the services of a GPO, the hospital must be able to identify what role that GPO will play in accomplishing its supply chain objectives and what GPO operating model is most in harmony with its own supply chain approach, and have the assurance that the selected GPO represents its interests and not the interests of a supplier or hospital with which it is in fierce local market competition. Hospitals must be willing to consider paying their GPOs a fair price for the services they provide or risk losing their status as the GPO's primary customer. Hospitals should understand the historic role of the Safe Harbor and determine if a Safe Harbor is truly in their best interests. Hospitals must be able to effectively evaluate the impact GPOs have on marketplace competition. The hospital must take full responsibility for operating in its own best interests. Failure to exercise proper due diligence in making these determinations places the hospital in jeopardy of failing to capitalize on its supply chain opportunities and calls into question senior management's ability to meet its fiduciary responsibilities.

The GPO marketplace is very complex and many hospitals have difficulty fully comprehending the breadth of the impact of a GPO relationship on their supply chain outcomes and their hospital's overall financial condition. This paper provides a critical look at GPOs, the market in which they operate, and the effects they have on health system financial performance.

Background

Since their inception, GPOs have created significant price decreases in a number of product areas, most of which can now be categorized as commodities. The aggregation of volume and pooling of buying power have provided large numbers of smaller hospitals with pricing that they likely would not have been able to achieve on their own. There can be no doubt that, in this respect, GPOs have delivered on their original mission and promise. Unfortunately for GPOs the laws of economics have produced predictable shrinking returns on investment. Simply stated, the pricing of most commodity items has been reduced to the point where other economic factors such as manufacturing efficiency and higher purchase volumes have little or no effect on pricing movement. While increased purchase volume contributes significantly to the ability to drive pricing down, eventually a manufacturer's production costs reach a point where they cannot go any lower. This is due to a number of factors including raw material costs, labor costs, and limits on how fast or how efficiently manufacturing equipment can function.

One "proof" of this may be the fact that for the past several years most contracting announcements by GPOs report extensions to existing contracts and not significant movements of market share to new or different suppliers. In fact, one might argue that the largest GPOs are almost incapable of moving significant market share in a number of product areas. A brief look at the I.V. Solutions commodity group would seem to illustrate this point. The two largest GPOs, Premier and Novation, would be hard pressed to pull off a successful move to a different supplier. Why? Such a move would produce two, almost insurmountable challenges for the manufacturers serving members of the two organizations. First, the company that lost the business would also lose a significant portion of its economies of scale, making it difficult to serve its remaining customers at its current pricing levels. At some point either the prices would have to go up to cover the loss or the company would lose even more customers and ultimately would go out of business. Second, the winning company would have an almost equally difficult challenge in being able to acquire the additional manufacturing capacity required to meet the needs of so many more customers. Of course, one option would be for the winning company to acquire the losing company and for a moment the problem would be solved, that is until the newly created monopoly decided to raise prices sharply because it could do so with little sustainable pushback from its customers.

While the GPOs have been successful in lowering pricing on certain product groups, many of their customers, hospitals and health systems, are increasingly coming to terms with their own financial mortality. As overall hospital operating margins continue to shrink amid new rounds of reimbursement cuts, a growing staffing shortage, the cost impact of HIPAA implementation, rising malpractice insurance, and likely increases in malpractice settlements, hospitals are increasingly desperate to find new ways to reduce their costs of doing business. For most hospitals, all of the easy answers have been used up. Essentially all that is left is the yet to be fulfilled promise of the supply chain. Up to this point in time the supply chain has been almost completely dominated by manufacturers, distributors, and GPOs who have planned and played to win while their hospital customers have opted to leave themselves largely unprepared to manage their supply chains, choosing instead to depend on the kindness of strangers and suppliers,

who often turn out to be one and the same. Hospitals complain that they are poor while their approach to their supply chain simply insures that they stay that way.

The supply chain provides two cost reduction opportunities. The first, product price reduction, has long been the domain of the GPO. The second, process cost reduction, has been all but ignored, save the endless cycle of empty savings claims made by desperate dot.coms. For hospitals to have any chance to control their own financial destinies, they must take the reins over both areas. However, while process cost reduction is of critical importance, it is not a main issue for this paper and will only be discussed as it relates to the larger issue of product price and the GPOs.

Some time ago a number of GPOs recognized that, once commodity prices were driven down to their lower limits, they would need to come up with new approaches that would create value for their members and justify their fees. A few of those approaches will also be discussed.

What Are GPOs and What Is Their Mission?

Group Purchasing Organizations were created to assist hospitals in lowering their supply costs by negotiating discounts based on aggregated volume. These discounts were often higher than a hospital could negotiate on its own. GPOs, much like hospitals, often depend on the maturation of products in the marketplace to create opportunities to move pricing down. As one-of-a-kind products lose their patent protection, additional suppliers enter the market and competition is created. Prices move down as a result of incremental market share gain attempts that engender staggered reductions in pricing offered to customers. As GPO members report price movements to their GPO, the GPO is then able to play its most favored nations card and obtain the new price for its members. This process continues until a product is "commoditized" and additional pricing movement is unlikely to happen. Once the price is "locked" at its commodity nadir, the GPO's remaining options are few. First, it can negotiate higher rebates on those products, thereby allowing committed members to benefit from the effects of a lower net price without forcing the manufacturer to lower its price across the board. These rebates are often not covered by the most favored nations clause and are a preferred method of gaining longer term commitments from GPOs and their members. Second, once it recognizes that the first option is exhausted, the GPO can then seek higher additional fees from the manufacturers. These are not administrative fees, as such fees are supposed to be capped at three percent. But the Safe Harbor (see page eight) enjoyed by GPOs does not appear to specifically place a cap on "other" fees. If a GPO crosses over into the collection of these "other" fees, it has reached the point where its members can begin to ask whom the GPO really serves.

Whom Do GPOs Serve?

Are GPOs contracting agents working for hospitals, are they pure brokers bringing buyers and sellers together, or are they sales agents serving as extensions of the selling organizations of the suppliers with whom they contract? Certainly, GPOs started out working as contracting agents for hospitals. And at first their services brought much needed pricing relief for their members. But hospitals were not the only beneficiaries of the work of GPOs. Manufacturers and distributors soon learned the market value of having a GPO contract. The contract provided them with easier entry into a larger number of hospitals for a lower cost and better return on investment than previous sales efforts had produced. This strengthened the position of GPOs with suppliers and provided an opportunity for GPOs to seek to charge manufacturers and distributors for that value. As time went on, suppliers began to understand the role of the GPO and the impact of the most favored nations clause on pricing competition in the market place. Suppliers had to like what they saw. As more and more products became "commoditized", the incremental value of GPO contracting activities for hospitals naturally began to wane, creating two situations. First, in order for GPOs to maintain their position with their members, they would need to develop some additional services to attract new members and retain old ones. As a result many new services such as consulting and benchmarking were developed. Holding hospital rebates on account and presenting them on an annual basis in a virtually all or nothing approach also strengthened the GPO's position with its members. GPOs recognized that even with their large volumes they could not control the rate at which new products could be placed on the fast track to "commoditization". Second, GPOs began to realize, on some level, that their real value to suppliers was beginning to surpass their real value to their members. These large blocks of contracting power surrounded by the most favored nations clause would provide suppliers with all of the cover they needed to hold their pricing steady across the market place without forcing them to engage in practices that traditionally would be viewed as anticompetitive. It is hard to imagine that GPOs would have actively engaged in divining or implementing such a strategy and it is fully plausible to believe that no such strategy even exists. But regardless of whether there is such a strategy, the results in the market place are exactly what they would have been if in fact such a strategy existed. It may be that no one planned any of this but the industry is still faced with working through the fact that this is what now exists.

The Role of the Safe Harbor: Who Really Pays For The Services of GPOs and Who Should Pay?

Investigative journalism usually is based on the notion that when things don't seem right, someone must be at fault. In the case of The New York Times investigation, the fault was placed squarely on the shoulders of the GPOs and they quickly became the villains in this whole story. But GPOs have members and owners who either empower them to do well or leave them on their own to perhaps fall into the trap of acting more in their own self interests.

While GPOs do collect some of their income from membership dues paid by hospital members, the bulk of their income is generated in the form of fees paid by the suppliers who are awarded contracts and sell their products to member hospitals. There is some debate over the type and size of fees paid but the most common and accepted fee is the administrative fee. The administrative fee is paid to the GPO by a supplier to help defray the GPO's cost of administering that contract. Each GPO has its own formula for how it distributes to its members and shareholders fee monies in excess of what it needs to operate. But since each GPO largely controls its own budgeting and expenses, it is essentially free to use up more of the money instead of sending it back to the hospitals. GPOs also receive additional fees from suppliers known as marketing fees and conversion fees. The marketing fee is a fee paid by a supplier to a GPO to assist the GPO in marketing the new contract to its members. Conversion fees are fees paid to the GPO and to individual hospitals to defray the cost of converting a hospital's product utilization from its former supplier's product to the new supplier's product.

There is another kind of fee that either no longer exists or no longer is talked about. It is known as the patronage fee or patronage dividend. The patronage fee was a one time fee paid by a supplier to the GPO as a reward for giving it the contract. These fees have been quite controversial because they have been rumored to be quite large, sometimes larger than the three percent administrative fee, sometimes much larger. It is these fees that have led many critics of GPOs to accuse GPOs of acting improperly.

Hospitals receive money back from the GPO in the form of rebates. A rebate is a payment that is based on the level of compliance by the hospital to a specific contract. Rebates are often paid by manufacturers to the GPO and the GPO in turn pools the rebates and issues the hospital an annual rebate check. For many hospitals the rebate check is a financial godsend, something they have been counting on and budgeting for the entire year. Regardless of whether the rebate process is a good deal for the hospital, those caught in a cash crunch have little time or interest in answering the question. However, the combined rebate check presents two significant challenges for the hospital. First, under Medicare guidelines the rebate, which is really a price discount, must be entered into the hospital's accounting system as a credit to cost of goods. Failing to do so would mean that the hospital over-reported its cost of goods, resulting in an incorrect but higher reimbursement from Medicare. Failing to do so is also considered Medicare fraud. Second, in a tight financial environment hospitals need to be able to assess the profit and loss of each procedure they perform in order to assess the appropriateness of

reimbursement which could lead to decisions about Medicare or Medicaid participation or the attempted renegotiation of a managed care reimbursement rate. The combined rebate makes it almost impossible for even the most sophisticated hospital cost accounting system to be able to correctly apply the appropriate supply costs to a given procedure. In many ways hospitals would be much better off it they could get their net supply costs clearly identified on an ongoing basis at the time of purchase.

The Safe Harbor was granted to health care GPOs by the federal government to allow them to collect administrative fees from suppliers without being subjected to charges of receiving kickbacks. Part of the justification for this stems from the belief that hospitals have no money to pay for GPO services and that even asking them to pay in their weakened financial condition simply would not be realistic or fair. The problem with this argument is that the hospital ultimately pays for all of the expense of the supply chain through the prices it pays for products. While everyone in the chain, up to the point at which the hospital take ownership of product, is paid for the product, the hospital is paid for the service it provides that makes use of the product. When a product acquisition cost goes up, hospitals are simply not able to pass that cost increase on to the payor (or patient) apart from a complete renegotiation of the reimbursement and would require a re-opener clause in a contract to do so. Hospitals complain that they have no money, yet they are wealthy enough to cover the profit of every player above them in the supply chain. This is not to say that suppliers do not deserve to make a profit. Certainly they do. But is it not ironic that suppliers are constantly being asked and are able to fund practically every organization, committee, group, or event and hospitals never seem to make the connection that the supplier is making the donation with what is essentially the hospital's own money?

Perhaps the most distressing aspect of the Safe Harbor is that it assumes that hospitals are so unsophisticated in their approach to their business dealings that they need the government to devise a legal system of kickbacks to provide financial incentives to GPOs to even get involved in the first place. One of the reasons the government should give serious consideration to the removal of the Safe Harbor is that hospitals must be given every incentive to operate as financially responsible businesses. The mission of caring can no longer be separated from the necessity of financial accountability. The looming Medicare crisis will not be solved in Washington, D.C. Well meaning legislators are no match for the challenges faced by hospitals. Until hospitals become fully engaged in the financial management of their organizations, there will simply not be enough money in the system to cover the costs of health care for America's rapidly growing senior population. It is not the government's responsibility to cover the costs of process inefficiencies, medical errors, and poor quality data. If the government were truly interested in protecting hospitals, it would abolish the Safe Harbor and allow real competition to come back into the market place, replacing the artificial competition that appears to exist at the present time. This single act would force hospitals to take responsibility for themselves, remove impediments for smaller suppliers, and allow hospitals to fully own their own contracting relationships and ultimately their own destiny. The Safe Harbor provides a benefit, not for hospitals, but for GPOs. Hospitals need to take control of their supply chains, not give that responsibility away to a third

party. Eliminating the Safe Harbor would also force GPOs to focus their efforts on meeting the needs of a single class of customers, the hospitals. Contrary to the belief in Washington, D.C., hospitals have the money to pay for GPO services. They already support the profit margins of manufacturers, distributors, and GPOs. But do GPOs have enough value to offer hospitals to make hospitals choose to pay them for their services? In the absence of the Safe Harbor, GPOs would have to clearly define whose side they were on and where their money was going to come from. It is difficult, if not impossible, for any GPO to equally serve hospitals and suppliers, yet many seem to believe they can easily serve both sides. At some point, one side will usually win out. Now, given the fact that suppliers are in a far better position to pay GPOs than hospitals, it is not a stretch to think that they would be more likely to win out. If the relationship between suppliers and GPOs becomes too close, that can have a devastating effect on competition, far worse than the good intent of multisource agreements could ever negate. If GPOs choose to serve as brokers, offering services to both suppliers and providers, they do not need to be protected by the government.

The Safe Harbor allows GPOs to collect fees from suppliers, hold those fees, and ultimately pass on a portion of them to hospitals. The collection of fees from suppliers places GPOs into the financial supply chain as an extra link. All the links in the chain add cost to the chain. The GPO was never intended to be a link in the chain but rather a third party arbiter of contract pricing. GPOs should not collect fees from suppliers and they should be funded on the basis of budgets agreed to by their members. Members would need to commit to their GPO for a specific period of time and could switch to another GPO during an "open season" not unlike how employees of companies can change their health insurance coverage. By removing the Safe Harbor the government could take cost out of the chain and allow GPOs to provide their services at a price consistent with the value they are able to identify for their members.

In the world of procurement outside of health care, the solicitation of donations from any supplier is viewed with great disdain. Why? Because procurement professionals know that such actions greatly reduce the leverage they have with their suppliers. They also know that in the end the supplier only has one place to go to make that money back. They would simply have to add the cost of the contributions into their total cost of doing business and price their products accordingly. There is no such thing as a free lunch. For some strange reason hospitals and the provider segment as a whole simply have not embraced this logical and historical truth.

The GPO claims to act simply as an agent of the hospital in its dealings with suppliers. Yet it is compensated by the suppliers with whom it does business. In any other part of the world, receiving compensation (administrative fees) on the basis of sales is called earning a sales commission. It is also ironic that while the GPO claims to act as an agent of the hospital, the people in materials management in the hospital often don't act as though they share that belief. Low contract compliance, multiple GPO affiliations, and using GPO pricing as a starting point in negotiating outside of the GPO are all symptoms of the fact that while hospital senior management may believe in the agency of the GPO, the people in materials management often do not. If the GPO were really the agent of the

hospital, would not the hospital senior management require that their materials management staff adhere to all of the contracts? Ironically, it is often the senior management of the hospital that orders the materials management staff to see if they can find a better price outside the GPO. If the GPOs are agents of the hospital, why do they put so much effort into marketing to their members? Should not hospitals be more committed to an organization that is supposedly acting in their best interests?

GPOs often argue that they take their direction from the shareholder or member hospitals who own or join them. Although this claim sounds good, there are several considerations that would call such a claim into question. First, although there are user groups or product review committees made up of representatives of member hospitals, these groups do not set policy. Rather they review products and recommendations of the GPO regarding a specific bid under consideration. Second, although hospitals' Chief Executive Officers may have the authority to commit their hospital to use a GPO, they lack the supply chain knowledge to fully evaluate the soundness of such a decision. While CEOs attend GPO conferences, they are there to take advantage of educational presentations and hear reports on how the GPO is performing but they are not there to establish policy or evaluate how the GPO carries out its business activities. Third, even if CEOs participated in policy setting, they are not equipped to make recommendations or identify practices that are problematic or fail to bring value to their hospital. CEOs are often business generalists, a role that, given their wide ranging responsibilities, is quite appropriate. But they simply lack the training and strategic understanding of the role of supply chain management to be able to effectively provide any kind of ongoing oversight over the activities of the GPO organizations they supposedly own. If they did, they would have recognized the value of supply chain management as a strategic competitive advantage and invested appropriately in their success in that area. In too many hospitals, the supply chain is an operational afterthought not worthy of consideration in the board room. This explains, at least in part, why so many hospitals are in financial peril. With limited resources, hospitals, individually or collectively, as GPO members, simply are not able to provide any kind of day to day oversight over their GPOs.

A few GPOs have created private label programs in which they contract with a supplier to make a product and put the GPO's name on the label. Since the GPO does not provide health care services and is not a manufacturer, what possible advantage would there be in putting the GPO's name on the label? Now it is possible that the GPO could contract with a supplier to sell a product to the GPO at a price well below market value and allow the GPO to sell the private label to its members at a profit without dropping the market price of the product. But unless the GPO's "profit" in the deal would find its way back into the bank accounts of its members, the arrangement would have little value for the GPO's members and shareholders. Such a practice would clearly move the GPO from acting as a contracting agent for its members to acting as a supplier itself, creating a serious conflict of interest. If the GPO is acting to protect the interests of its hospital members from the actions of suppliers, how can it perform its role and be a quasi supplier at the same time? This is another example of how the lack of oversight over GPOs can damage both GPOs and their owners.

The combination of the lack of day to day oversight by their hospital owners and the protection of a Safe Harbor presents serious potential for conflicts of interest for the GPO. First, the GPO is free to conduct its business as it sees fit, including the establishment of for-profit subsidiaries, focusing on its own gain instead of working in the hospitals' best interest, and creating opportunities for personal gain while many of its members struggle just to make payroll for their employees. Without some kind of diligent and ongoing oversight, a GPO is free to do whatever it wants, knowing that no one, neither its members nor the government, will be able to discover any practices that crossed the line. While it may sound like this paints the GPOs in a bad light, they may in fact also be victims of this arrangement. Would not questionable business practices on the part of a GPO really be an indictment of those who own and govern it and give license to operate in such a way? It would seem that those GPOs which are intent on doing what is right by their members would welcome a more formal, more accountable oversight, if only to protect them from being viewed as participating in wrongdoing. Perhaps, as an industry and as customers of the industry, we owe some thoughtful consideration to more formalized oversight over the GPOs.

In order for the Safe Harbor to stand, GPOs would need, at the least, to provide to their members and shareholders full disclosure of the accounting, finances, and tax status of all of their subsidiaries and holding companies.

What Is the Impact of GPOs on Marketplace Competition?

Since the Senate Judiciary Committee began its inquiry into the practices of GPOs, both sides, the GPOs and the forces opposing GPOs, have brought their legal scholars into the discussion. While each side makes some interesting arguments, both sides have approached the matter largely from an academic and legal perspective. Unfortunately, both sides err when they fail to appreciate the complex realities that exist in the health care supply chain. The health care supply chain does not, in fact, operate as supply chains in other industries and it would be difficult, at best, to apply legal and academic principles that are based on other industries to the health care supply chain. The real issues related to the competitive impact of GPOs that will need to be addressed by the industry include the maturation of the health care market for products, lifecycles of specific commodities, and the ability of various players in those markets to gain and utilize leverage to their own advantage.

Hospitals have historically focused on the results they produce in terms of clinical outcomes. Even as financial pressures increase, hospitals still tend to resist tying financial outcomes to clinical outcomes. Supply chain management, or materials management, has never been a focus for most hospitals. The acquisition of goods and services was considered a relatively unimportant clerical task often left to the lowest paid and least trained employees. It was the clinical expertise and billing and collections that were important. In those early days the specter of rapidly declining reimbursement was reserved only for the most surreal of a Chief Financial Officer's nightmares. While most hospitals never saw the supply chain opportunity, their suppliers, who hired the best, brightest, and most aggressive people to sell their wares to hospitals, flourished and came to dominate their customers. Suppliers continued to add to their advantage by providing ongoing training to their representatives. Meanwhile, back in the hospital basement, the status quo remained. Occasionally, a hard-nosed materials manager would secure a significant savings but even then it was likely the result of coercion and not the result of a well thought out strategy. Hospitals needed something that would seemingly turn the tide and improve their cost position vis-à-vis the prices they paid for product. The Group Purchasing Organization was just what the doctor ordered, so to speak.

The GPO aggregated the buying volume of multiple hospitals and leveraged it into lower prices from suppliers. In the early days of the GPO, everybody won. The hospitals had lower prices, the suppliers enjoyed the ability to win large blocks of business at a lower customer acquisition cost, and the GPO was able to support itself on the dues and fees it collected. Everyone seemed to live happily-ever-after---for a while. As more hospitals joined, each GPO gained more volume and thus more buying power and lower prices. However, as hospitals joined multiple GPOs or simply switched GPO affiliations for the promise of even lower prices, GPOs realized that this pattern was going to be too expensive for them to administer. At this point a number of enterprising GPOs began to implement the use of the Most Favored Nation (MFN) clause in their contracting language. This language would now provide protection for GPOs against losing members to the competition over pricing differences.

But the MFN also had an important, unintended consequence. In the past manufacturers could freely offer a lower price to a single customer without the fear of having to give every contract holder the same price, if the lower price were to come to light. The MFN now provided cover for manufacturers, if they decided that the price of a particular commodity was already as low as they could afford to go on a market wide basis. If, in fact, such a decision was grounded in the economic reality that the price could go no lower because there were no untapped economies of scale opportunities associated with manufacturing the commodity, then such a decision would seem normal and necessary. But if such a decision were made simply to maintain a commodity price at an artificially high level and protect that product or commodity from further price erosion in an open competitive market, then the MFN would have been used by the supplier, at the insistence of the GPO, in an anticompetitive manner. The MFN has the ability to take disparate GPOs and individual hospitals and turn them into a single marketplace entity based on a claim to have the lowest price, effectively eliminating any real competition for that product. In this sense, the MFN itself would seem to be anticompetitive.

GPO pricing has essentially become a class of trade issue. In the pharmaceutical industry manufacturers used to offer pricing to customers based on what class of trade they were in. Hospitals received the best pricing and pharmacies, home care companies, and nursing homes received higher prices based on their class of trade. The MFN has turned GPOs into their own class of trade, where pricing from one GPO to the next is the same or very close.

For all of the good that GPOs have seemingly done over the years, many of their hospital customers are still in financial peril and are underachieving in managing their supply chains. One must now ask if GPOs have gone as far as they can go in reducing product costs and if hospitals must now take over and take themselves the rest of the way. Are prices really as low as they can go or are they just as low as they can go with the GPOs occupying the middle ground between their suppliers and their members?

It has become clear that for most hospitals the supply chain offers the last, truly significant cost savings opportunity, yet many have simply waived their own ability to reap those benefits. Supply chain should also be a strategic competitive advantage for hospitals fighting for survival or dominance in their own geographic markets. Instead of gaining competitive advantage in the supply chain, many hospitals have chosen to give that advantage away by joining GPOs and buying at the same prices as their competitors. They trade the possibility of performing better for the certainty of performing no worse than the competition.

Bell South competes with other companies in the cellular phone service business. When it came time for it to decide which suppliers' cell phones it would sell, it did not seek to join a buying group. It did not negotiate a markup over an undefined cost. Instead, it utilized a fast growing procurement strategy known as strategic sourcing. In the end it did not negotiate a price, it renegotiated its supplier's profit margin (which no doubt was carefully defined). This is the attitude hospitals must bring to their contract negotiating environment but most have not done this. Years of dependency on GPOs have left many

hospitals facing the prospect of many more years of dependence unless they finally get serious about reaping the benefits of the supply chain by investing in the development and execution of a sound supply chain strategy.

For suppliers, winning or losing a GPO contract can be a future changing event. But with so much power concentrated in a limited number of GPOs, the future of any particular supplier can be determined by only a handful of isolated contracting events. This creates great challenges for some suppliers who, no matter how good their product is, may never be able to generate the critical mass of customers required to maximize their economies of scale and make themselves price competitive. GPOs essentially reduce the number of key decision makers in the supply chain and thereby effectively reduce the number of buyers. This puts too few people in charge of too much of the market and creates serious challenges, including conflicts of interest for those GPO employees charged with negotiating and managing contracts. For hospitals to maximize their own supply chain potential, they must maintain control over their own supply chain decision making. In a marketplace not dominated by GPOs, a single hospital or IDN acting independently could move pricing down by effectively committing its volume as a movement of market share to the supplier of its choice.

GPOs have often raised the argument that, if they went away, the cost of product for hospitals and the cost of health care as a whole would rise dramatically. The problem with that assumption is that once prices become known by hospitals (and they are already known thanks to GPO price books) manufacturers would be hard pressed to provide a good economic reason as to why they should suddenly go up. Manufacturers raising prices for no good economic reason would certainly be subject to inquiry in the press as well as from the federal government. Raising prices would also seem to open the door for foreign manufacturers, who now make many of the products sold under well known brand names, to directly enter the U.S. market and sell at prices far lower than the going rate.

What Does The Future Hold for GPOs?

In order for GPOs to continue their claim that they produce economic value for hospitals, they must overcome some serious challenges.

The first challenge is one of value for their members. While it is clear that GPOs have played a role in driving down commodity pricing, most of that work is done and they will need something else to convince members of their value. In some ways The New York Times articles and the Senate Judiciary Committee hearings simply underscored what is becoming a crisis of confidence among GPO members. The value of the GPO is becoming less and less accepted by hospitals and the desperation of financial reality is causing more than a handful of hospitals to question just what their GPO is doing for them. At a time when GPOs need the trust of their members more than ever, they appear to be having difficulty holding the attention of their members. If the value does not come from price, then from where will it come? Some GPOs have created enormous value added programs that offer services that use up some of the money that would otherwise go back to the hospitals in the form of rebates. While many of these programs have some merit, their value can never truly be known unless they are presented to hospitals as programs they can choose to pay for or not receive. The GPOs claim these programs have value but fear putting them to the real value test of customer willingness to pay. Because the hospitals never see the money these programs consume, they are less likely to miss the money. To survive, GPOs must refocus on their original mission and use that to identify value to their members.

The second major challenge lies in the GPO's questionable ability to assist their members in generating second dollar savings. First dollar savings are price based. If the price of a line item is reduced, the difference in price is a first dollar savings. Second dollar savings are more complicated. They are savings that are produced in the relationship with the supplier beyond the price point. For example, a relationship in which a supplier agrees to provide services at no extra cost to the hospital that the hospital formerly provided for itself and that service results in a savings to the hospital: that is a second dollar savings. Second dollar savings require a stronger relationship between the supplier and the hospital. It likely will also require a pricing relationship that is longer than one that would normally be desired by the GPO. When a supplier has that longer relationship, it provides a unique opportunity for supplier and hospital to become strategic partners, an arrangement that is much too rare in this industry. By controlling relationships between suppliers and hospitals, the GPO preempts real supply chain progress between a hospital and one of its key suppliers. The direct hospital-supplier relationship challenges the power of the GPO to arbitrarily set bid schedules according to its own need to assert its power and essentially makes it an outsider. Second dollar savings represent an enormous but largely untapped opportunity and it is doubtful that many hospitals can capitalize on them as long as GPOs stand between hospitals and their suppliers. Some GPOs might argue that they offer customized contracting but the real goal of such an approach seems to be to insure that fee opportunities are not lost. The reality is that it is enormously difficult for a hospital to extract second dollar savings from a supplier, if the hospital does not have full ownership of the contract relationship.

The third major challenge lies in the notion that GPOs believe that without their intercession prices would go up. The opposite, however, may be true. If earlier remarks related to market competition are accurate, the GPO contract may actually act as a dam that prevents the rushing waters of open competition from changing the landscape of the supply chain and would cause hospitals' financial fortunes to rise with those same waters. Certainly, the arrival of Pacific Rim based medical products into the market place would cause name brand manufacturers to rethink their pricing strategies in order to retain market share but, if the differences in price were large, significant amounts of business would likely be moved off shore even if it is just to punish the brand name manufacturers for keeping prices high for so long.

Most of the studies that suggest hospitals' cost of doing business would rise dramatically, if the role of GPOs is reduced, assume that hospitals would be forced to operate the same way a GPO does. However, if a hospital is able to act strategically, such an argument fails. Hospitals would, in fact, not have to suddenly add large numbers of staff because they would not have to immediately negotiate every contract. To protect their commodity pricing they would only need to solidify a distributor relationship or temporarily could opt to use any GPO to maintain that pricing. Neither the GPO nor the hospital can control pricing on new patented, sole source products so, rather than focus attention on negotiating a better price, the hospitals would focus their resources on controlling utilization through cooperative efforts with their clinical staff. The most significant area of opportunity for hospitals is in the middle product group that consists of products that were at one time sole source but now have multiple suppliers or whose patent protection is about to expire. The use of strategic sourcing techniques would effectively address this area. And since no hospital uses every GPO contract, each hospital would have a significant number of contracts that it would not have to even handle. The real issue here is not the quantity of resources, as the GPOs submit, but rather the quality of the resources. It is true that hospitals may need to spend more initially on moving to a self contracting model but over time the increase in cost would be minimal. The issue for hospitals is how they deal with the fact that they have so severely under funded their supply chain interests. This concept is not a pipe dream. Already a number of hospitals have successfully taken this approach. Among them are Virtua Health in New Jersey, LeeSar in Florida, and Iowa Health. The Orlando Regional Health System recently announced that it will be joining that number.

Major challenge number four consists of GPOs' historical reliance on exclusive agreements and their sudden willingness to back away from them. There is, in fact, nothing wrong with exclusive agreements. If an individual hospital is to succeed in managing its own contracting, exclusive agreements must play a major role. The challenge for GPOs is that when they control such a large block of business, and trade on higher purchase volumes, they actually shrink the market into a smaller number of large contracting blocks, creating the appearance of anticompetitive or monopolistic behavior. And although there may be hundreds of GPO type organizations, the vast majority of these serve as marketing organizations for the handful of GPOs that actually are in the contracting business. Backing away from exclusive agreements may solve the problem

for the ethicist but it can't possibly help the member hospitals from a pricing perspective. If a supplier yesterday enjoyed an exclusive agreement at a certain price and today must share that agreement with one or more other suppliers, would they not in fact be justified in increasing their pricing to accommodate the loss of volume? In a truly competitive market, this is exactly what one would expect to happen. If this is not what is happening in the cases where contracts are being opened to multiple suppliers, then one would be tempted to speculate on how open this market actually is. But if this is happening and hospitals are seeing their prices increased, one would logically expect some form of uproar over the increases. Yet so far such uproar has not surfaced.

The fifth major challenge lies in the notion of some GPOs that they are somehow involved in the promotion of safety and quality care. GPOs might want to give this notion a second thought. If a GPO is acting as contracting agent of the hospitals and is involved in making buying decisions regarding product, and selected one of those products over another, perhaps more suitable product, and a number of patients were severely injured as a result, would not the GPO be a legitimate target of a lawsuit by the injured patient along with the hospital, the physician, and the product's manufacturer? And should it not be subject to some kind of oversight and accreditation by JCAHO and other regulatory agencies? Clearly, hospitals and their medical staffs must be the ultimate bearers of the responsibility for quality and this raises a serious question about the joint ownership or control of a GPO. At what point, if any, can a hospital delegate any of its responsibility for quality to a purchasing agent that it may own on paper or control but cannot or does not effectively manage?

Number six: GPOs claim to streamline the purchasing process. Yet, by inserting themselves into the equation, would seem to complicate that process. Every hospital already has someone responsible for purchasing and contracting. And once a contract is signed by the GPO, each hospital still has to go through the process of getting a commitment letter signed, which is the same thing as signing a contract. The hospital is freed, true, from having to put out a bid, review the responses, negotiate, and select a winner. Although contract administration can be a time consuming process, a sound contracting strategy would reduce the number of supplier contracts to manage and reduce the frequency of contract management events.

The seventh major challenge for GPOs is that they have done little to endear themselves to hospital Directors of Materials Management. For years they have sought to exclude or marginalize the Director of Materials Management by bypassing the Director and going right for the CEO, who probably knows a lot less about the subject and is less qualified by experience to make a decision in this area than the Director of Materials Management. Of course, in order to get the CEO's ear, the GPO likely had to discredit the Director's contracting abilities and standing in the eyes of the CEO. The Director's responsibility is to manage supply cost and, if there is a lower cost available, many do not really care if there is a GPO contract. The CEO has become inundated with responsibility and if there is no real solid relationship between the GPO and the Director of Materials Management, the GPO could be in a lot of trouble in that hospital. So now where does the GPO go to sell its value to the hospital? The GPOs have only themselves to thank for this situation.

The eighth major challenge relates to what GPOs have left to offer as their ability to drive down prices moderates and their members still need more savings. If the GPO suggests that pricing can go down even more, the obvious question would be why now and not before? If pricing cannot go down more, how do GPOs explain the fact that a number of IDNs have pricing that is significantly below that offered through the GPO? This conundrum would suggest that the GPO's involvement creates some kind of a blockage in the supply chain as far as price is concerned.

Number nine: As hospitals evaluate their financial condition, they must demand more results from their supply chain activities and relationships. Pricing is extremely important but it is not as important as total cost. For most GPOs, their definition of supply chain management is limited to product management activities such as pricing, standardization, and contract compliance. Hospitals know the prices they get through their GPOs but have little or no idea of what the cost to the supply chain is of having GPOs in the picture. It could be argued that GPOs lower pricing by aggregating volume. It could also be argued that the total cost of the GPO is higher than the savings generated by the GPOs. Do we as an industry have any idea of the net effect of the existence of GPOs on total supply chain cost for hospitals? As long as the answer is no, GPOs are in danger of losing their position in the supply chain.

The tenth major challenge for GPOs relates to the hospital CEO's recognition of the competitive environment his hospital must operate in to be successful. Already he is competing with other hospitals in his area for patients, physicians, staffing, payer relationships, and community financial resources. At the same time he has few strategic competitive advantages to draw on for support. In a tight labor market he has little control over labor costs, a cost that typically represents fifty-five percent of his operating budget. His next largest cost area is the supply chain. Yet while thousands of companies across the globe have harnessed supply chain management as their strategic competitive advantage, hospitals seem all too willing to trade the possibility of performing better than the competition for the insurance of performing no worse than the competition. Once hospitals fully understand the absolute necessity of using their supply chains to generate strategic competitive advantage, they are more likely to consider a move to self-contracting and supply chain self-determination.

The eleventh major challenge for GPOs is related to the alignment of incentives. If a GPO is successful in reducing prices, its fees, which are based on percentages of volume pass through, also go down. The hospital benefits but the GPO does not. On the other hand, if prices go up, the GPO's net fees increase while the hospital's costs go up. Where is the incentive for GPOs to resist the attempts of manufacturers to raise prices? Do the GPOs really have a dog in this hunt? Without alignment of incentives, it is difficult to believe that GPOs work exclusively in the best interests of their members.

Number twelve, if a hospital is willing to pay a GPO, with little incentive to secure lower pricing, a percentage of its total volume for negotiating purchasing contracts, why is that same hospital determined to pay so comparatively little to its Director of Materials

Management for doing the same work when the Director of Materials Management has a vested interest in reducing product costs? Based on a three percent administrative fee, a hospital with a spend of thirty-five million dollars per year, spending about half its total volume through its GPO, will pay its GPO about one half of a million dollars a year for its services while its Director of Materials Management often averages less then one tenth of that amount for the same annual purchase volume. Moreover, this assumes that the GPO receives no more than the three percent in combined administrative and other fees or that all monies received in excess of the three percent are returned to the hospital.

The thirteenth major challenge for GPOs only affects a few of the GPOs. Private labeling of products has been a controversial topic for some time. The GPOs who have done it swear by the cost savings results they have presented to their members. But private labeling of commodity items, no matter how much money is saved, changes the identity of the GPO. A company that private labels product takes title (real or implied) to that product even if it sits in the manufacturer's warehouse and is never physically handled by GPO employees. If the GPO acts as a manufacturer or as a distributor, it has a conflict of interest because it cannot represent its members when doing business with itself. Private labeling also raises another question about pricing and competition. The GPOs who engage in private labeling state that they had to resort to that to save their members more money on commodity products. That could suggest that name brand commodity products have a generally accepted pricing floor and that the only way to get below the floor is to change the product by making a new part number and a new "manufacturer" identity, even if the same company makes both products, to remove it from the effects of a most favored nation contract clause. But if any product could be private labeled, could it not also be exempted from the effect of the most favored nation clause? It would seem that real and open competition in the marketplace would be a far superior approach to pricing reduction than private labeling.

Challenge number fourteen relates to the annual payments of rebates to hospitals by GPOs. If misapplied to the books by the hospital, the rebate amount will not be entered as a credit to cost of supplies, leaving the hospital in a precarious situation, where it could be accused of inflating its product costs to improve its Medicare reimbursement. The lump sum check also adds to the hospital's challenge of understanding its total cost of providing services to its patients, leaving it largely unable to make accurate business decisions about what it charges or what reimbursement it will accept. Most rebates are based on compliance, another way of saying volume. A requirements contract, on the other hand, would have pricing based on the hospital using the selected product for a certain percentage of its total needs, thus allowing for some needed flexibility in dealing with physician preferences. Perhaps if requirements contracts were used instead of volume-based contracts, rebates could be eliminated and net pricing at the time of purchase could become the rule of the day, allowing hospitals to be in compliance with Medicare rules and to protect their own interests by understanding their procedural costing. Rather than receiving a rebate, a hospital that met its requirements obligation could be moved to a new pricing tier for the next contract period, again eliminating the need for the costly and time consuming process of dealing with rebates.

The fifteenth and final, major challenge for GPOs is this: While most businesses maintain a firm grip on their critical decision making and outsource their process inefficiencies, hospitals seem all too willing to outsource their critical supply chain decision making and hold fast to their process inefficiencies. The supply chain represents one third of a typical hospital's operating budget. One must ask the question, Can any hospital afford to outsource the decision making for such a significant part of its operating budget? And if a hospital knowing this still chooses to be a GPO member, can it possibly believe it is doing its job of management, if it is not fully involved in how decisions are made within the GPO? Is there even one CEO outside of health care who would keep his job, if his board of directors knew he had outsourced the decision making of one third of his company's expense budget to an outside firm that was providing the same services for the competition?

Conclusion

GPOs have made a significant impact on hospital financial prospects over the last fifteen years. During that time many hospitals enjoyed product costs lower than they likely would have been able to generate on their own. But the last few years have brought tremendous financial challenges to health systems. Clearly, the supply chain offers more opportunity than what has been harvested to date. The future demands significant realization of supply chain opportunity by health systems and it remains to be seen whether that realization can be done in the context of GPO relationships or apart from them. Perhaps there is a third alternative that would allow a hospital to use only those GPO services that produce lasting and quantifiable value and depend more on itself and other business partners for the balance of its supply chain needs.

The challenges are many and the marketplace is complex but hopefully this paper will add to the understanding required by the health care supply chain to find its way into a prosperous future where value is the gold standard and only those companies who offer it will remain viable.

APPENDIX

Questions Health Systems Should Ask Themselves in Considering How to Restore Trust in Their GPOs and Improve the Financial Results of Their GPO Relationships

It is clear that for GPOs to remain viable they will need to garner additional commitment and oversight from their members or shareholders. The following recommendations would go far in restoring trust in the GPOs and allowing them to perform their mission without investigative articles in The New York Times and trips to the nation's capital to defend their practices. In order for this to happen, hospitals must take it upon themselves to establish their own GPO practice and performance requirements and hold the GPOs accountable as any supplier or service provider would be held accountable. These practice requirements will help protect the financial interests of health systems and their patients and allow hospitals to focus on their missions of caring.

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- Does my GPO provide me with full disclosure of all of its financial statements and financial holdings?
- Does my GPO subscribe to the Code of Ethics created by the Institute for Supply Management? Does this apply to each individual charged with performing contracting functions as well as to the corporate officers?
- Does my GPO use sound procurement practice standards for GPOs to follow?
- Does my GPO operate on a budget or collect fees from suppliers?
- Does my GPO have an active board of directors that provides oversight of practices? Who are they, how are they elected and compensated, and what are their affiliations?
- Does my GPO require its contracting employees to have a strong background in procurement and be working toward becoming Certified Purchasing Managers (C.P.M.)?
- Does my GPO fill the majority of its senior management positions with procurement professionals?
- Does my GPO collect marketing fees from suppliers?
- Does my GPO eschew private labeling of products?
- Does my GPO provide me with a realistic calculation of my return on my investment?
- Does my GPO seek to minimize expenditures on nonessential non value added services to maximize member return on investment?
- Does my GPO eschew bundling of contracts as well as bundling of specific products designed to qualify a hospital for a higher rebate?
- Does my GPO limit marketing expense to less than fifteen percent of its annual budget?
- Does my GPO resist the urge to acquire other business entities?

About the Author

Lynn James Everard is a Health Care Business Educator and Supply Chain Strategist and is the Executive Vice President of the Educational Resources Development Division of V.I.P.E.R. Group, Inc. He brings twenty-one years of progressive supply chain management knowledge and experience from several different links in the health care supply chain. His expertise includes operations improvement, business process reengineering, organizational redesign, e-commerce strategy, activity based management, and supply chain strategy development. His broad experience uniquely qualifies him to address the complexities of an ever-changing supply chain. Mr. Everard is also one of a small number of health care supply chain professionals to have earned the designation of Certified Purchasing Manager (C.P.M.) from the Institute for Supply Management (formerly known as the National Association of Purchasing Management). He is also a Certified Business Manager (CBM).

V.I.P.E.R. Group is a professional service organization dedicated to assisting health care and other organizations in identifying and resolving their process management challenges and providing them with the knowledge capital and employee empowerment to maintain their process improvements long after its professionals have completed their work. The firm can also assist its clients in developing fully executable strategic plans in each functional area. As V.I.P.E.R. Group's Executive Vice President of its Educational Resources Division, Mr. Everard is responsible for completing a number of education and training services designed to assist hospitals in developing their own future leaders instead of being forced to compete in a tight labor market for what often seems to be a shortage of talent. Programs include supply chain management, finance and business management, operations management, reimbursement management, and customer relationship management. As a supply chain strategist Mr. Everard also provides insight into the supply chain's activities, directions, and trends.

In his over twenty-year career, Mr. Everard has held a number of positions including Pharmacy Buyer for Buffalo General Hospital, Buffalo, NY, a tertiary care teaching medical center; Regional Director of Materials Management for Critical Care America in Fort Lauderdale, FL, a national home care company; National Materials Manager for HealthInfusion in Miami, FL, a national home care company; Purchasing Manager for National Health Care Affiliates, Buffalo, NY, a four state chain of long term care facilities; Senior Manager in the Healthcare Consulting Practice of PricewaterhouseCoopers in New York, NY; and most recently as Vice President of Supply Chain Education and Strategy for HealthCare Logistics Services. Everard also spent several years as an independent consultant.

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