

# Book review: Dissecting the healthcare supply chain

by William McFaul



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If you are the kind of supply chain executive who sees a glass as being half empty, then Lawton R. Burns' new book, *The Health Care Value Chain* (Jossey-Bass, 2002), might be difficult to read. But keep in mind that it could

prove more problematic for you *not* to read it.

By the time I finished the book, I couldn't help but wonder if Dr. Burns shared his insights and blunt opinions with the 15 integrated delivery networks that sponsored his research. If he had shared his opinions, I believe the information gained by the executives would have been startling. Plus, they would have a high probability of applying his ideas to offset rapidly intensifying cost pressure on providers.

Actually, sharing such information may have required Dr. Burns to use an M1A1 battle tank for his daily commute to the Wharton School. Furthermore, hundreds of executives upstream from providers might be calling Tony Soprano for consulting advice.

Does the book sound exciting? Have I piqued your interest in it? Don't get me wrong. Initially, I found it difficult to proceed beyond Chapter One. Admittedly, I was quite impressed by the five broad aims outlined by Dr. Burns, especially number four (appearing on page 4): "To assess future prospects for partnerships and improved efficiencies between value chain players." Afterwards, I became concerned when in the next paragraph, he wrote, "Our overall aim is to determine whether 'extended enterprise' models of supply chain collaboration found in other industries can develop in healthcare."

Could this book be another fiasco along the lines of the Efficient Healthcare Consumer Response? This is one of my pet peeves. EHCR stated, "Healthcare executives have the advantage of learning from those who have gone before them on this path, namely, grocery executives who embrace and benefited from Efficient Consumer Response."<sup>1</sup> EHCR promoted the point-of-use process and other activities in-

herent in the grocery industry as being ideal for healthcare. However, that notion ignores the fact that if point-of-use were implemented in the grocery industry as it is in healthcare, someone would be in my home stowing products away into my refrigerator, freezer or pantry.

After calming myself down a bit, I was further dismayed when on page 6 Burns said, "...brought together suppliers of component parts with large auto manufacturers to collaboratively improve quality, reduce costs and develop competitive advantages. Such strategic alliances have been held out as examples for the healthcare industry to follow."

Believing this book was another attempt at redesigning the healthcare supply chain to replicate another industry, my first impulse was to stop reading and just place the book on display. Fortunately, having been

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duly informed by numerous individuals that the Burns book is a must-read, I decided to give the book one last chance. So I skipped to Chapter 12, the conclusion, to form my own opinion about the value of the book. After reading that chapter, I was still left with many, many questions, so I decided it would be necessary to read the book in its entirety to find my answers.

As I started to read and before I got to Chapter Two, it became apparent that there were several different techniques to reading this book. The first is that it could be read from a perspective of 30,000 feet as an informational document. The second way would be to slow the pace of reading somewhat and read it at a mind set of 10,000 feet, and it would be considerably more educational. But I realized the book contained so much valuable information and insight it should be read at ground level as a practical "implementation possible" document. The cost of choosing the last approach was the commitment to slow down the reading to the point where a maximum of 4-7 pages could be effectively absorbed per hour.

I will not be refuting many of the opinions offered by Dr. Burns. Basically, the book offered neither hundreds of answers nor opinions about the many deficiencies and problems in the healthcare value chain, and I do not believe it was intended to do that.

I have, however, taken the time to rant about a few issues and comments that are among my list of pet peeves.

In nearly every chapter, Dr. Burns inserted numerous jewels worthy of considerable thought. A few examples:

- "... manufacturers claim the word partner does not exist in healthcare." (pg. 99)
- "... producers regard GPOs and wholesalers as influencers, order takers, and information channels, but not customers. For their part, providers are most interested in reducing costs to satisfy managed care reimbursement, constraints, improving quality to satisfy patients (for example, reduce medication errors) and attract physicians, and increasing utilization rates. Historically, there has been no clearly demonstrated path from supply chain management to the achievement of these goals. Materials managers within provider organizations have lacked the training and corporate-level position to make the case that such a path exists." (pg. 425)

• "... the cheapest product is the one not ordered and used." (pg. 409)

• "Manufacturers commonly express belief (actually hope) that GPOs will not survive as long as they focus on price. They would prefer to see GPOs provide more value-adding services to both their upstream trading partners and their downstream hospital members." (pg. 77)

The last comment piqued my interest because it along with one from page 402, "... the supposedly free products may not really be cost free," pinpoint a deep-rooted problem in healthcare. Adverse changes in reimbursement are continuing to diminish available funds for analyses and studies. Accordingly, over the past 10 to 15 years suppliers, including GPOs, continue to dramatically increase offers for value-added services. What makes this scenario unfortunate is that many providers still fail to realize that nothing is ever free. Furthermore,

whether you take advantage of such “free” offers or not, their cost is either indirectly added to the price you pay for other services or the refund from your GPO is diminished accordingly.

It is a simple fact that from time-to-time providers need expert, critical advice or assistance. Logically, one would assume that such advice should be unbiased and be solely in the best interest of the provider. Accordingly, it should follow that providers would use the same judgement as that used for the purchase of a critical product. Shouldn't “free” advice be screened carefully to ensure it is appropriate and of the level of quality that is really needed?

Like any other book, *The Health Care Value Chain* will have parts of particular interest to different readers. However, I think Chapters Four (Group Purchasing) and Ten (E-Commerce) will be of interest to nearly everyone. The latter chapter, which I like to refer to as “2B or not 2B,” presents an excellent overview of the Electronic Document Interchange (EDI)/B2B (Business to Business) controversy. Read the chapter carefully to gain insight into the wars between B2B companies, GPOs, GPO/B2B players, B2B/GPOs, distributors and their platforms, Broadlane's GPO/B2B model with Owens and Minor and the manufacturers (Global Healthcare Exchange). When history is written, you do not want to be known as someone who went in the wrong direction.

Chapter Four (The Role of Group Purchasing Organizations), while highly informative and extremely well written, left me with many questions.

- Have most, if not all GPOs, lost focus of their real objective – working solely for the best interest of their members?
- Where is the money? Show me the money. There are hundreds of millions of dollars swirling around with clumps dropping off to support various infrastructures and related activities.
- Shouldn't there be more disclosure?
- As not-for-profit enterprises, shouldn't GPOs tell all participants which organizations get which proceeds?
- Why are there such secrets?
- Is bigger really better or even necessary?
- Is volume the key or is it commitment?

If the answer is commitment, shouldn't GPOs deal with that reality and not waste valuable dollars offering value-added services or spending mega-dollars to fluff the numbers showing dollar participation, number of members and other trivial data? This chapter really got my attention, but it prob-

ably got the attention of a lot of IDN supply chain executives as well.

As you read the book or re-read it (which I highly recommend), be careful of information overload and do not get confused or misled by the many numbers presented. Keep in mind, Burns is reporting on his research and did an excellent job of remaining fair and balanced. I am certain, however, he did not pull his badge number 714 and in a Sergeant Joe Friday voice say, “Just the facts, Ma'am.” So, be careful of some of the

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data that was provided to him. Some of it, in my opinion, is erroneous, slanted or misrepresented, and some of the people providing the information were either partially informed or misinformed. Examples of such instances include:

- Private labeling is used so smaller manufacturers can promote their products using the GPO label (pg. 62). Forget all the sewage and other rationale: GPOs use private labeling to bypass Safe Harbor issues and dramatically increase revenue.

- Novation estimates that it saves an average of \$1,367 per contract, using its group purchasing approach over a hospital's self-contracting approach. “For a hospital with 340 GPO contracts, this translates into an annual savings of roughly \$465,000” (pg. 84). Really? That means if 100 Novation members split off to form their own group, they would spend in excess of \$4,650,000 to develop the contracts. It is interesting to note that a study conducted by The Levin Group (May 2003) for the Health Industry Group Purchasing Association (HIGPA) says “To replace the work performed by a GPO, the average supply chain executive would have to add staff costing approximately \$198,000 per year.”<sup>2</sup>

- “The number of hospital-focused GPOs may range from 200 to 400 or more” (pg. 63). It is interesting to note that the same HIGPA study says, “When last counted in May 2001, there were approximately 800 healthcare affiliated GPOs and 684 hospital GPOs nationwide.”<sup>3</sup> Which numbers are correct? Based on a definition that I believe a provider supply chain executive would consider as being a traditional GPO, both sets of numbers appear to be grossly exaggerated.

Why do such fluctuations in data and information exist? It is probably due to a problem translating “Fullofit.” This is a language that has roots back to the early days of consultancy in healthcare. “Fullofit” is now used so often by consultants and players in the supply chain upstream from the providers that many healthcare supply chain executives anticipate its use and are becoming well versed in its translation. It should be noted, however, despite the voluminous amount of information reviewed by Dr. Burns and his assistants, they were still able to keep the use of “Fullofit” to a minimum.

Of all the information provided by Dr. Burns, I found the use of demand planning to be a dangerous option for provider supply chain activity. Providers can and should use demand planning for work flow in the admitting department, in the ER, in the OR, etc. Trying to provide supplies for patients just as the auto industry provides parts for cars would be disastrously cost excessive. On the other hand, it would be a gold mine for distributors and consultants alike.

One of the highlights of the book appeared on page 409, “... hospitals will need to refocus their priorities to include partnership (not just price), long-term focus (not just short-term gains), and more comprehensive ways to reduce spending (not just lowering line-item prices).” This statement alone should prompt provider supply chain executives to recognize that the book offers a wealth of knowledge for readers willing to “mine” it.

If Dr. Burns writes a subsequent book, I hope he places more emphasis on the elements upstream from the provider supply chain executives and expands the scope to include “the whole enchilada” – the 45 cents of every hospital dollar that goes toward all non-labor expenses. Only then might CEOs, COOs and CFOs realize the full potential from a strategic initiative for overall non-labor, not just supply, expense reduction. **HPN**

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#### Footnotes

1 Efficient Healthcare Consumer Response, Chapter 6, page 85

2 Assessing the Value of Group Purchasing Organizations, The Levin Group, May 2003, page 2

3 iBID, page 3