

# Creating Value through Improved Supply-Chain Management



Lawton R. Burns, PhD

Lawton R. Burns, PhD, is professor of Health Care Systems and Management in the Wharton School at the University of Pennsylvania and director of the Wharton Center for Health Management and Economics. Dr. Burns has published extensively on healthcare management issues for the past 20 years and most recently is lead author of *The Health Care Value Chain: Producers, Purchasers, and Providers*. The book, an outgrowth of a research initiative underwritten by the industry/university consortium Center for Health Management Research, explores key ways the healthcare supply chain helps create value and competitive advantage.

**Q** What are some of the chief obstacles that providers face

when striving for effective supply-chain management?

**A** The biggest challenge is that not enough time or interest is devoted to supply-chain management as there should

be. As a result, supplies constitute an area for efficiencies, cost reductions, and strategic alliances that has not been fully addressed.

One reason this area hasn't received the attention it deserves, I suspect, is that the majority of hospital executives have not had adequate education in this area. Only within the past year or two has the ACHE offered a session on supply-chain issues at its annual congress, and it's a topic that you do not find taught in any school of health or public administration. Only occasionally is it a part of the required curriculum at a school of business administration.

As a result, because so many people at the corporate level don't know everything they should in this area,

there's not as much interest or passion toward it. Yet when you talk to CFOs that truly understand supply-chain management, they are among the first to identify it as a significant area for cost savings.

Another major challenge is that so many different departments are involved in supply-chain management—at least nine or 10 major departments in any given hospital. Sometimes the sheer number of people

**formal cost-benefit analysis or budgetary constraint. What advice can you offer financial managers who are looking to change this culture?**

**A** A key factor for success is whether clinicians are allowed to shape or influence this change. For example, consider the purchase of adhesive bandages. A typical medical staff will have a range of preferences for different

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involved can make it a priority that is more difficult for corporate leadership to manage. Also, forging new relationships with clinicians can be difficult. In a nutshell, it is a new frontier for studying physician-hospital relations and for how we partner.

**Q** In your book, you discuss the challenges associated with product demand based primarily on the clinical preference of physicians, rather than

vendors and different sizes of product. Yet if you can reduce the variability and get everyone to agree on using a smaller number of different products in standard sizes, you can drive greater volume. This creates a two-fold financial benefit: you can get a better price at a higher volume, and you can reduce inventory costs. Plus, you reduce the obvious noise and inaccuracy that results from having multiples names for the same product item.

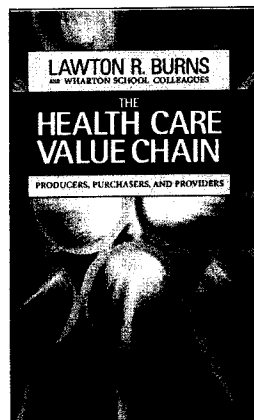
Physicians respond to information. Providing them with potential benefits to be gained, backing this up with data, and asking for their input on a solution can go a long way toward achieving necessary buy-in for change. The key is to identify physicians who are interested and willing to help lead this effort for you. You have to have people to help energize and motivate the others. Frankly, there's no magic bullet—obtaining buy-in is important, hard work.

**Q** What are some common best practices in obtaining physician buy-in for improved supply-chain management?

**A** One best practice is to promise to take some of the savings and efficiencies and reinvest them in whatever the medical staff is interested in. Another idea is including cost and quality initiatives in discussions of outcomes achievement. Whatever your approach, you need immediate payback to reduce variation and to make the idea attractive to them.

**Q** In terms of the future, what do you see as one of the next most significant supply-chain trends?

**A** One major change is that product manufacturers are investing



*"The formation of extended enterprises that span manufacturers and their suppliers... can achieve competitive advantage over other manufacturers that [lack such alliances] in terms of the speed of product development, product development costs, transaction costs in procurement, product costs, quality, market share, and profitability."*

—Lawton R. Burns, *The Healthcare Value Chain: Producers, Purchasers, and Providers*

in their hospital customers. There's a quid pro quo: hospitals get massive investment from outside in exchange for being a beta testing site, in which the vendor receives real-time information on how its equipment is being used and patient

outcomes. Even though a majority of hospitals will probably not be involved in these relationships, I see them as the future's primary win-win situation.

**Q** In your book, you also discuss the influence of technology. How do you see greater use of the Internet effecting supply-chain management?

**A** Briefly, in the near term, it can clean up a lot of dirty data now on the hospital end of the supply chain. In the long term, it may increase procurement efficiency and reduce the amount of dirty information that leads to rework.

**Q** What advice do you have for improving supply-chain management as a whole?

**A** If we're ever going to see value-adding partnerships within the chain of activity among the key players—manufacturers, wholesalers, GPOs, and hospitals/health systems—each must understand the other's needs. It's also important to better understand your own supply issues to make yourself a better trading partner. ■

**QUICK TIP**

**Are You Staffing for Greatest Success?**

Are you matching staffing to patient volume?

Doing so can lead to significant cost reductions, as one hospital is learning by implementing this practice in its emergency department (ED).

The graph below shows the average patient volume

in the ED on the average day over the course of one month.

Given that staffing levels are constant over 24 hours, notice that length of stay does not increase even at peak times. This constancy demonstrates the opportunity for reduced staffing during off-peak hours.

Even after allowing for higher volume days, reducing staffing during low volume times of day can amount to substantial savings for the hospital—topping \$800,000 annually.

Source: Chip Caldwell & Associates, Charlotte, N.C., [www.chipcaldwellassoc.com](http://www.chipcaldwellassoc.com)

