Helpful, or Harmful?

An interview with Lawton R. Burns, Ph.D., regarding his latest study on hospital purchasing alliances: utilization, services and performance.

A lot has been said about group purchasing organizations – in the Senate, in media outlets, among medical manufacturers and distributors. The problem, as Dr. Lawton R. Burns sees it, is that no one was asking the most important source – materials managers.

"I always felt that it was rather surprising that we're evaluating the GPOs based off of everyone else's perspective except that of the end customer – the hospital," Burns says. "So why don't we get the voice of the customer? If you look inside a hospital, there's one individual who is responsible for dealing with the GPO – that's the director of materials management."

Lawton Burns, Ph.D., professor at the Wharton School, University of Pennsylvania, and doctoral student J. Andrew Lee conducted a national survey of materials management executives in order to discover a number of things, including the level of their hospital's participation in GPO contracts, what value-added services (other than cost-savings) were offered by the GPOs, and how they would rate the performance of their GPO.

Among the key findings:

- Materials managers believe that their GPOs not only help them reduce prices and costs, but also increase hospital revenues.
- Materials managers believe GPOs behave in accordance with ethics laws.
- Materials managers believe that non-core services offered by the alliances aren't quite satisfying.

JHC recently spoke to Burns regarding the study.

The Journal of Healthcare Contracting: Your study showed how purchasing alliances such as Group Purchasing Organizations (GPOs) reduce healthcare costs by lowering product prices. How so?

Dr. Lawton Burns: They lowered the costs for the hospitals primarily by achieving lower prices on the products. They also increase hospital revenues through the rebated CAFs (contracted administration fees).

JHC: Which products work best?

Burns: If you look at the data, it's the commodities and pharmaceuticals, but also somewhat on the physician preference items. Primarily commodities and pharmaceuticals, secondarily on physician preference items.

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JHC: You use the term "hospital purchasing alliances" rather than "group purchasing organizations" in your study. Is there a difference between the two terms?

Burns: No. Usually academics talk about purchasing alliances or pooling alliances. That's a term that is generic across industries. You really don't find the term "group

purchasing organization" until you enter the healthcare industry. This was an attempt to tie this study, which was hospital specific, to a broader literature and strategy and management area called pooling alliances, or purchasing alliances, where hospitals pool all their purchases. It's just a branch of corporate strategy.

JHC: Do your findings apply to GPOs?
Burns: Directly. This is a study of GPOs. It's just that generically, they're called purchasing alliances.

JHC: Do you think hospitals would have to find other sources of funds if they weren't the beneficiaries of the savings and revenues derived from these alliances?
Burns: The study suggests that the GPOs help hospitals with their margins. If the GPOs didn't exist doing all of this contracting for them, the hospitals would have to do a lot more direct contracting by themselves to capture those same revenues and savings. They'd be spending more money on FTEs to get those, and then you get into the issue of in what areas will there be a bigger offset. In other words, if there are greater savings from localized contracting, will those swamp the costs of adding more FTEs to do it? In commodities, it's probably not worth the hospitals' while. It could be worth the hospitals' while in the PPI area, and I think hospitals do that. So it's kind of a mix. But the GPOs clearly help the hospitals with their margins.

JHC: Your study found that group purchasing improved efficiencies in the healthcare supply chain. How so?
Burns: The study shows a number of areas. One, the ability to share information and experience across hospitals. One of the recent contentious areas is GPOs helping hospitals with pricing for medical devices, and being able to share some aggregate information across hospitals. The study suggests that hospitals value the sharing of information generally that GPOs facilitate.

Other areas are the efficiencies of Web-based catalogs, efficiencies of lower prices and contracting convenience, the ability to bring multi-source contracting to the hospitals' attention where the hospital has some choice but still gets the lower price. Those are the major areas.

JHC: How would hospitals miss out if GPOs didn't play such a big part in the supply chain?
Burns: It'd be a bigger hassle for them. At the end of the day, you could ask is this a core competence of hospitals, to contract for thousands of supplies with hundreds or thousands of vendors? Or is it better for hospitals to outsource all of that and let hospitals focus on what they should be focusing on, and what they've had some difficulty on, which is improving and documenting quality of care.

I think it's a misplaced emphasis for hospitals to take on the GPOs' role. I think the GPOs actually serve a function, and we ought to let them serve that function. Only because hospitals would have to put more into that area, and it's not clear to me that contracting is a core competence of hospitals. Not that they shouldn't do some. Obviously, they already do so if they are negotiating local deals. But is that what we should have them do, or focus more of their attention on? I don't think so.

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JHC: You did your work with co-author J. Andrew Lee, also at Wharton. Who funded the study and why?
Burns: It was funded by the National Science Foundation in Washington. It was funded as part of an effort to look at improving supply chain management in healthcare and re-engineering healthcare processes.

JHC: Your study waded into some controversial territory. For example, Senators received testimony on Capitol Hill that purchasing alliances exclude new and innovative firms from the marketplace or restrict hospital access to desired products such as physician preference items. Was there a lot of evidence for these claims?

Burns: No. There was no great feeling among the survey respondents that the GPOs were blocking access to newer innovative technologies. That whole claim has basically been brought by a handful of small start-up companies who felt that, "The reason we're not able to sell our product in the hospital market is because of the restrictive GPO contracts struck with large dominant monopolists," like a Johnson & Johnson, or HillRom, Tyco, those kinds of companies. I've actually been studying that issue for some time. I believe that's a bunch of bunk.

One of the other criticisms that's been leveled at the GPOs has to do with the sole-source contracts and dual-source contracts and how those allegedly exclude new companies, as well as the issue of multi-product, multi-vendor bundling. Those practices are always at the center of these disputes. Critics of the GPOs complain these are anti-competitive practices. I don't believe that either. The study shows that materials managers actually find those practices that the GPOs utilize to be very helpful.

JHC: What would you tell the Senate?

Burns: I was actually interviewed by the attorneys who helped the Senators with the hearings. Once they found out what I had to say, I was not invited to testify. I would tell them now the same thing I told them when I was interviewed. I said there is a lot more smoke than fire here with regard to these GPO practices.

JHC: Speaking of which, you write that the results of your study suggest that there is "more smoke than fire" after examining some of the major public policy questions surrounding the ethical conduct of some purchasing alliances and how the Senate approved code of ethics is working. Can you elaborate?

Burns: We asked the directors of materials management if they looked at the Senate-approved Code of Ethics for how GPOs should behave. Three quarters of them have reviewed those Senate-approved Codes of Ethics, most think the Code of Ethics is strong enough, and most think that their GPO is compliant with them.

JHC: Did you find hospital executives supportive of their GPOs, or do you believe hospitals are "captives" of their GPOs as some advocates have suggested?

Burns: The hospitals will always tell you, this is a voluntary deal. They are free to join a GPO or not join a GPO, they're free to join more than one GPO, they're free to switch GPOs. In fact, the hospitals use these GPOs somewhat opportunistically. "If a GPO doesn't contract for this, well then I'll join a GPO who does." They'll play them off one another and have these bidding wars between them. They'll cherry-pick the contract. Everybody knows this. So they're clearly not captives. They're shareholders in the GPOs. Hospital or hospital systems are often the shareholder or outright owners of these GPOs. The GPOs are basically working for their hospital members. It's nonsense to call them captives.

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JHC: Do you have any additional studies planned for the future that would build upon the results you've presented?

Burns: I have several additional studies planned with the survey data. There's also an additional survey. I'm doing one more paper with this survey data. The paper just published was much more descriptive, the next one will be a little bit more of a predictive model. I also did a second survey of the same group of people, the hospital materials managers, about their views of new technology committees, value analysis committees, their relationships with distributors, things of that nature. JHC