

Group Purchasing: Forcing Compliance or Organizing the Talent?

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The article by Dr. Hill is timely and specifically addresses one of the most challenging areas of medicine and healthcare delivery. Namely, how do practitioners, hospitals and health systems approach the delicate issue of selection and purchase of physician preference items?

In a cost constrained environment, the purchase and use of costly items becomes a focal point of discussion with numerous constituencies. This is only enhanced by the fact that at the time of this writing, after years of relatively flat health insurance rates, employers are once again confronted by rising health premiums. During the past two years, average premium increases of 7-11% signal another round of cost containment efforts with supply costs and pharmaceutical costs likely targets of scrutiny.

Managed care and the Balanced Budget Act of 1997 have spurred efforts at redesigning the way care is delivered. Purchasing programs or programs influencing major purchasing decisions for medical devices, pharmaceuticals and other medical equipment have surged to the forefront of priorities. In the eye of the critics, technology has been a form of social mayhem, a conveyance for higher costs and an excuse for costly practice variation. Operating rooms and diagnostic labs are stocked with numerous devices (some used rarely) which require costly maintenance.

Nonetheless, technology and the advances of modern medicine have profoundly transformed our lives. Why are we, therefore, so beguiled by these devices and new pharmaceuticals, and what are the reasons that it is so difficult to control appropriate usage? The answer is really not that complex, and yet it is not simple. All people enjoy choice and clinicians are no different. Clinicians develop a comfort level with certain

technologies and therapeutic agents -- to the point that variation from that familiarity is often felt to jeopardize the efficiency of a procedure or a patient outcome. Additionally, there are a host of other issues such as the reputation of the company, product service, depth of products provided, costs, and relationships with vendors and salesmen, which have bearing on the selection of a particular medical device or pharmaceutical agent.

Unfortunately, development of group purchasing programs has often been undertaken by hospitals or health systems with little or no input from the clinical community. Even when the clinical community has been engaged, it has often been a task force composed of remote (though allegedly clinically astute) clinicians who may not understand the nuances of the particular community in which the clinical practice is occurring. Managed care via profound pronouncements about the necessity for cost constraints has often been a curiously powerful inducement to pontification, but in reality has often resulted in little acceptance of modification in device or equipment usage by clinicians engaged in the trenches of patient care.

What has been discovered in the recent backlash against restrictive health insurance programs, or perhaps reaffirmed, is that patients expect their clinicians to be making decisions for them based on their best professional judgment. Physicians bear the brunt of liability for adverse outcomes. Therefore, effective group purchasing compliance has been a moving target and an elusive target at best, unless the clinical community is actively engaged in the dialogue in a meaningful way. However, earlier failures of compliance with some of these group-purchasing programs should not be viewed as terminal. The following are put forth for consideration:

- The leaps in traditional materials management practice to common sense engagement of the clinical community are at first heroic. The dividends, however, are significant. Materials managers are often seen as the key control point or decision makers in a traditional group-purchasing

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program. Many receive information directly via managers of key departments, but in reality there is often little personal contact with clinicians directly involved in clinical care and in fact, many materials managers feel ill-equipped and uncomfortable dealing with physicians on these issues.

- Focusing on a few small successes is very important. It is better to highlight a few areas than immediately attempt broad-based, all-encompassing activities. What is expected should be clearly articulated and easily measurable.
- The clinical leadership and practitioners in a given community must be engaged and lead the process. This needs to include representatives of the local community.
- People work hard if there is an incentive to do so; hence, the importance of articulating the value for being a participant. These incentive programs need to be discussed carefully in light of recent OIG Advisory Announcements) prohibiting feedback of cost savings to individual practices. However, there are other ways that the clinical community can be convinced to participate. There needs to be appropriate value for time and services rendered.
- Selecting the right people to work with is absolutely critical. The clinicians who will lead the process need to be respected professionally and socially by their colleagues.
- Realize that issues of control and choice are essential ingredients of a medical professional career. The issues must frame the context of discussions and processes utilized.
- Attempting too little may also be the recipe for failure. Experience would suggest that just as trying to accomplish too much may be self-defeating, meaningful changes in performance rarely take place when too little is being attempted. A little change may verge on being no change at all.
- Start early and with the right process. Busy clinicians look upon meetings as a prelude to work - - not work. Therefore, when holding a meeting, do so with a tight agenda and start and end on time. My experience is that task force meetings should last no longer than an hour and occur early in the morning, before the chaos of daily routine sets in. Sometimes a knowledgeable, clinically credible, outside facilitator may be necessary to get the process moving.
- Maintain a connection between the top and bottom. Make sure appropriate representation of the senior management team is present and engaged in the dialogue to show the importance of the project.
- Remember that we are dealing with different businesses, which may not be willing to share what they perceive as a competitive advantage. Hospitals

and clinicians often are part of different businesses. Indeed, many of the practitioners who design group purchasing and physician preference programs are competitors. The types of products they use and the manner in which those products are utilized is perceived as providing strategic advantage to some practitioners and practices over others. These are items which need to be carefully discussed and dealt with when designing a clinically relevant and effective group-purchasing program.

- Leave room for innovation. Group purchasing programs that limit access to various forms of technology can frequently be construed as a deterrent to new innovative techniques and devices. The program needs to allow assessment of new techniques and devices as they become available.
- Respect the persistent tortoise and the naysayers. Progress is often torturous and slow, and there are some individuals and practices who will not engage in the process initially. Don't focus on them or expend valuable energy on this group. Start with those willing to engage in the process and reward appropriately. If you are successful, others will follow.

In general, the specifics of a program in any given locale, the incentives outlined, and the people willing to engage in the process will be the ingredients for a successful experience. A growing number of systems and clinicians are learning to navigate through the serious demands posed by a tough economic environment, an environment that dictates innovation and valuable collaborative working relationships. The tension that will inevitably exist in terms of deciding who leads the process of selecting physician preference products will have broad business implications. The successful group purchasing organizations, suppliers and health systems will actively engage the clinical community in the process, and the really innovative will allow the clinicians to lead the process. The clinical community will need to rise to the occasion to shoulder that responsibility.

*As many fresh streams meet in one salt sea;
As many lines close in the dial's (sundial's) centre;
So may a thousand actions, once afoot
End in one purpose*

-Henry V
(Act I Scene ii)
William Shakespeare

REFERENCE

1. OIG special Advisory Bulletin Regarding Gainsharing Arrangements, July 8, 1999.