



# **Future Procurement Arrangements in Victoria**

## **Consultation Paper**

Prepared by the Procurement Reference Group

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## 1 INTRODUCTION

The Procurement Reference Group (PRG) has been established by the Department of Human Services to consider the arrangements for supply for all Victorian Hospitals including Metropolitan Health Services and Rural Hospitals. The PRG is chaired by Jennifer Williams and there are representatives of all Metropolitan Health Services, Rural Hospitals, Department of Human Services and the Department of Treasury and Finance. A full membership list is included in the Attachment: PRG Membership at page 30.

The scope of activities considered by the PRG includes the contracting and purchase of all consumables, pharmaceuticals, services and equipment used in the provision of hospital services.

This paper has been prepared on behalf of the Procurement Reference Group (PRG) to assist in the process of consultation with hospitals and other stakeholders to the procurement process. The paper outlines the process that has been identified for the implementation of centralised purchasing arrangements and includes draft recommendations for the formation of a Health Procurement Council.

### 1.1 Definitions

The following definitions apply to this paper:

*Common Use Contracts* or *Common Use Arrangements* refer to Standing Offers.

*Contract* is an agreement between two or more authorised persons on behalf of their organisational entities to perform or not perform a specific act or acts, which is enforceable in law. A contract may be verbal or written. Acceptance may be in writing or performance.<sup>1</sup>

*E-commerce* is any type of business transaction or interaction in which the participants operate or transact business or conduct their trade electronically.<sup>2</sup>

*Lead agency* is the nominated and authorised agency that performs certain functions on behalf of other agencies. In the context of this paper it relates to requirements determination, data collection, product specification and evaluation, tendering, tender evaluation and tender recommendation. The lead agency would consult with relevant agencies and people in the conduct of these activities. The lead agency may also be responsible for ongoing contract management and re-tendering upon contract expiration.

*Pricing agreements* are offers from suppliers to provide goods at a certain price. There is no legal obligation on either party and the offer may be withdrawn at any time or may not be used by the customer.

*Procurement* or *Purchasing* is the process of satisfying a requirement by the sourcing and acquisition of goods or services, usually from external suppliers.

*Product evaluation* stems from the identification of a requirement and involves determination of criteria that will provide outcomes of that requirement, specification of the technical features and functions of that requirement, investigation of current standards, assessment of available products against the specification and criteria and preparation of a formal report on the findings of the assessment. This process involves representatives from clinical, financial, engineering and supply areas from more than one agency. The

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<sup>1</sup> *Glossary of Purchasing and Materials Management*, Central Queensland University

<sup>2</sup> NOIE, 1999

outcome of this process is a specification for use in the tendering process or a decision that no product meets the identified need.

*Standing Offer* is an agreement that does not incur an obligation upon the customer to purchase particular quantities. Essentially it is a continuing offer from a vendor to provide the nominated goods and services at an agreed price for an agreed period.<sup>3</sup> Standing offers are sometimes called Common Use Contracts, Common Use Arrangements or Forward Purchase Agreements and can be awarded to more than one supplier, becoming a panel standing offer.

*Prime Vendor* is the nominated agency (internal or external) that provides a supply service to one or more other agencies. The range of services may vary, but usually include procurement, storage, inventory management and distribution to end-users. In its mature state, inventory is managed and owned by the vendor up to consumption.

*Supply chain* is the network used to deliver products and services from manufacturer to customers through an engineered flow of information, physical distribution and cash.

*Supply chain management* oversees the enterprise relationships in order to get the necessary information, deliver the product to the customer and to facilitate payment that generates profits for the business. Supply chain management looks at the network as a whole. It includes not only relationships with other functions within the firm but also with all trading partner relationships outside the firm.<sup>4</sup> The supply chain comprises:

- Inbound Logistics – activities associated with receiving, storing and disseminating inputs to the product (materials handling, inventory control, scheduling and returns),
- Operations – activities associated with transforming inputs into the final product form (manufacturing, packing, maintenance and facility operation),
- Outbound Logistics – activities associated with collecting, storing and physically distributing the product to buyers (finished goods warehousing, materials handling, delivery operations, order processing and scheduling)
- Marketing and Sales – activities associated with providing a means by which buyers can purchase the product (advertising, promotion, sales, tendering, channel selection, channel relationship, pricing)
- Service – activities associated with providing service to enhance and maintain the value of the product (installation, repair, training, parts supply, product adjustment).<sup>5</sup>

## 1.2 Abbreviations

The following abbreviations are used throughout this paper:

AHP	Allied Health Professions, e.g., occupational therapy, physiotherapy
CEO	Chief Executive Officer
CHA	Catholic Health Alliance, the umbrella organization for all Catholic health services in Australia
CSSD	Central Sterile Supply Department, where goods are pre-packed and sterilised for use in operating suites and wards
DHS	Department of Human Services
DTF	Department of Treasury and Finance
EAN	European Article Numbering system, an open and global barcode numbering system allied to the Universal Product Code in the USA
GST	Goods and Services Tax

<sup>3</sup> VGPB Panel Common Use Arrangements

<sup>4</sup> *Understanding Supply Chain Management*, Walker & Abler, <http://www.apics.org.au/magazine/jan99/walker.htm>

<sup>5</sup> Adapted from *Competitive Advantage: Gaining and Maintaining Superior Performance*, Porter, 1987

HSA	Hospital Supplies of Australia Pty Ltd, trading arm of the Victorian Healthcare Association Ltd
IT	Information technology
MHS	Metropolitan Health Services
PPC	NSW Health Peak Purchasing Council
PRG	Procurement Reference Group
SME	Small to medium enterprises, including micro-enterprises (those which employ 1-3 people), small enterprises (those which employ up to 20 people in the services industry or up to 100 people in manufacturing industry) and medium enterprises (those which employ (those which employ up to 500 people) <sup>6</sup>
VGPB	Victorian Government Purchasing Board, also known as the Procurement Branch, Department of Treasury and Finance

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<sup>6</sup> *Where to Go, How to Get There*, DOCITA 1998

## **2 BACKGROUND**

### **2.1 Ministerial Review**

The Ministerial Review of Health Care Networks commissioned a review of supply arrangements and determined that there were significant opportunities open to obtain better pricing through hospitals purchasing from 'approved' (central) contracts. The Review made four recommendations regarding centralised purchasing and supply chain management, these were:

#### **Recommendation 29**

*That the Government should mandate that all hospitals will purchase a specified range of pharmaceuticals and general medical supplies according to approved contracts from 1 July 2001. This should be predicated on the establishment of mechanisms to ensure that the purchasing contracts reflect the needs of the field and that the purchasing agency/agencies meet agreed performance standards with respect to price and responsiveness.*

#### **Recommendation 30**

*That the Department of Human Services should establish a Task Force with the industry to examine the best possible model for establishing centralised purchasing for the health sector and to make implementation recommendations to achieve the 1 July 2001 start-up date.*

#### **Recommendation 31**

*That the Department of Human Services should review the opportunities available to build on existing structures and centres of proven performance in developing the Victorian centralised purchasing framework.*

#### **Recommendation 32**

*That section 42 of the Health Services Act 1988 should be amended to authorize the making of statutory directions with respect to centralised purchasing arrangements.*

The Government accepted these recommendations and expanded the scope of the project to include equipment.

### 3 CONTEXT

#### 3.1 Purchasing in Victoria

Hospitals and health services in Victoria purchase equipment, services and goods in excess of \$750m<sup>7</sup> per year. These items are supplied by more than 2000 individual vendors and cover in excess of 30,000 items<sup>8</sup>. Most hospitals tender, contract and purchase items independently, although most metropolitan health services have rationalised these arrangements to some extent and there are also some regional supply arrangements in a number of rural areas.

#### 3.2 Different types of hospital purchases

When examining the process for centralised procurement it is appropriate to consider the range of supplies that may be purchased via central common use contracts or pricing agreements. Clearly, it is not appropriate to purchase all hospital products via one central purchasing arrangement. Set out in the table below is one way of splitting the types of purchases into germane categories that can be borne in mind when considering the various organisational models.

Category	Characteristics	Method of purchasing	Notes
Hospital Specific	These items include non-standard, and often complex, items that are critical to the operation of a particular function within a hospital or a small number of hospitals eg cardiac stents, specialised drugs for transplant surgery	Case by case decisions on whether purchasing can be combined with other sites, often a hospital acting as a 'lead agency' will manage purchasing arrangements and make items available to other sites <sup>9</sup>	In some cases there may be opportunities to drive costs down when purchasing specialised high cost equipment if purchasing is coordinated between several sites e.g. radiology equipment purchases
	One-off irregular purchases of low cost equipment or services and regular purchases of food items etc in rural areas.	Usually best dealt with at local level.	
Common Use	These items include 'standard' items that are widely used in hospitals eg syringes, wound dressings, etc.	Common use Health contracts will usually offer the best value for these products <sup>10</sup>	Many of these items are found on the NSW Government health contracts
Non Health categories	These items are often widely used across a number of areas/industries eg stationery, fuel, vehicles, legal services, temporary staff, etc.	Usually a State contract via VGPB or groups of purchasing agencies will offer best value.	Many of these items may already be the subject of common use contracts across Government

The NSW PPC purchases approximately 20% (or \$220m) of hospital products centrally; the remainder are purchased by hospitals individually or through Area Health Service (AHS) arrangements. There are also some one-off collaborative purchasing arrangements or alliances between individual hospitals, AHS's and other organizations in place for specialised products such as prosthetic implants. Using the NSW figure as a benchmark, it is expected that 15-20% percentage of goods would be centrally purchased in Victoria; however, it is likely that as systems are improved and data becomes readily available that this percentage will rise.

<sup>7</sup> Estimated based on total hospital expenditure in FY 99/00.

<sup>8</sup> This is an estimated figure, it should be noted that Qld currently has 54,000 items in their catalogue although there is still some duplication of items, which, if removed, would result in a lower figure.

<sup>9</sup> It is expected that where central contracts are arranged and their use is mandated, an exemption process would be established to ensure that a particular need could be met or a specialised product obtained.

<sup>10</sup> As above.

### 3.3 Arrangements in other States

Most other States have some form of centralised purchasing arrangement in place for hospital supplies. Set out on the following table is a brief description of the arrangements in place in NSW and Qld. Arrangements in the other States fit broadly within the range of operations between those outlined in the NSW and Qld models. A comparison with the current Victorian system is also included in the table.

	NSW	Qld	Vic
<b>Organisational Structure</b>	<ul style="list-style-type: none"> <li>Peak Purchasing Council</li> <li>Senior Executive Forum (currently 7 AHS CEO, Ambulance, Health Dept &amp; NSW Supply)</li> <li>Strategic Operations Reform Group</li> <li>E-Commerce/Supply Chain Mgt</li> <li>Procurement Reform/Contract Mgt</li> <li>Working Groups eg, Forms, Tenders &amp; Contracts Networking, Logistics Reform, Renal Consumables, etc</li> <li>Contract Management Committees</li> </ul>	<ul style="list-style-type: none"> <li>Health Department (through Purchasing &amp; Logistics group)</li> <li>Queensland Purchasing Government Marketplace regulates procurement policy</li> </ul>	<ul style="list-style-type: none"> <li>MHS/Rural Hospitals</li> <li>Local supply departments</li> <li>VGPB – undertakes tenders for goods/services/equipment that are commonly used in Government departments</li> <li>HSA is a company wholly owned by the Victorian Healthcare Association, which is 'owned' by Victorian Hospitals.</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>Managed by Senior Executive Forum</li> <li>Contracts authorised by State Contract Control Board</li> </ul>	<ul style="list-style-type: none"> <li>Central departmental governance</li> </ul>	<ul style="list-style-type: none"> <li>Locally managed by each hospital or health service; some vendoring (e.g. Hume Alliance)</li> </ul>
<b>Tender Process</b>	<ul style="list-style-type: none"> <li>Managed by Contract Management Committee</li> <li>Public tenders called by Health Supply</li> <li>Often panel arrangements (e.g. standing offers) rather than central volume based contracts</li> </ul>	<ul style="list-style-type: none"> <li>Central tendering process (eg, pharmaceuticals managed by Royal Brisbane Hospital)</li> <li>Standing Offers</li> </ul>	<ul style="list-style-type: none"> <li>Public tenders, note that HSA tenders for a number of goods used in hospitals particularly pharmaceuticals.</li> <li>Usually sole preferred tenderer on a hospital by hospital basis</li> <li>Minimal contracting, usually pricing agreements/standing offers</li> </ul>
<b>Product Evaluation Process</b>	<ul style="list-style-type: none"> <li>Working Groups arranged by PPC</li> <li>Comprise reps from AHS</li> <li>Reports held in central database</li> </ul>	<ul style="list-style-type: none"> <li>Centralised product evaluation process, with local specialist representation</li> </ul>	<ul style="list-style-type: none"> <li>Some MHS-based, but not universal. Often hospital based evaluations.</li> <li>Tend to be brand focussed instead of outcome specification</li> </ul>

Whilst there are significant differences in the organisational arrangements in place, both the NSW and Qld models have centralised contracting as a key element of their procurement strategies. Information provided by the Directors of the NSW PPC and the Qld Department of Health suggest that very significant efficiencies and savings have been harvested in their States through co-ordinated (centralised) purchasing arrangements. NSW have estimated that approximately 5% (\$9.5m pa) has been saved through central purchasing arrangements.

Victoria is in an ideal position to use the experience of both NSW and Qld in rationalising its purchasing arrangements. There is one obvious lesson that should be considered in establishing the new Victorian organization and that is the benefit of linking volumes/market share with price in order to obtain the greatest leverage in negotiations with suppliers.

To date the savings in NSW have largely been achieved without linking volumes to contracts. The experience in Victoria, and other states, is that where volume is linked with long-term contracts, better pricing results. That is, where a supplier is guaranteed volume over a set time period, a better price is derived compared with a panel contract arrangement. It is also worth noting that NSW have built in clinician involvement in areas such as specification and product evaluation through their contract management committees, as a primary element in their processes to ensure 'buy in' of the clinicians.

### 3.4 Stakeholders

Any centralized procurement system or organization will need to manage a fairly diverse group of stakeholders on a day-to-day basis. The following people and organizations have been identified as significant stakeholders in a centralised procurement environment.

Stakeholder	Nature of Interest	Effect
Manufacturers/Importers/ Agents/Suppliers/Wholesalers	<ul style="list-style-type: none"> <li>✓ Suppliers of goods – interest in maintaining/increasing market share</li> <li>✓ Competitive advantage</li> </ul>	<ul style="list-style-type: none"> <li>▪ Control costs and pricing</li> <li>▪ Market presence</li> </ul>
Prime Vendors and management service providers e.g. Fauldings, Spotless/Clifford Hallam, Sigma, HSA, API	<ul style="list-style-type: none"> <li>✓ Interest in changing the traditional internal system to outsourced logistics and warehousing</li> <li>✓ Commercial opportunities</li> <li>✓ HSA provide a substantial quantity of medical consumables and pharmaceuticals to Vic Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ability to reduce logistics and administration costs</li> </ul>
Victorian Healthcare Association	<ul style="list-style-type: none"> <li>✓ 'Owner' of HSA</li> <li>✓ Peak organization – represents interests of metro and rural hospitals</li> </ul>	<ul style="list-style-type: none"> <li>▪ Need to be aware of and manage any actual, <u>or</u> perceived, conflict of interest in relations to VHA's interest in HSA and their role as the hospital peak organization.</li> </ul>
Supply Departments and other areas involved in purchasing e.g. Theatres, CSSD, etc. Also includes Association of Hospital Supply and Purchasing Officers and the Society of Hospital Pharmacists.	<ul style="list-style-type: none"> <li>✓ "What happens to me?" Future role in purchasing and control of purchasing decisions</li> <li>✓ Costs of goods</li> <li>✓ Job design</li> </ul>	<ul style="list-style-type: none"> <li>▪ May act as blockers if change is not managed well and they are not involved in the process</li> </ul>
Unions	<ul style="list-style-type: none"> <li>✓ Staffing issues</li> <li>✓ Job design</li> </ul>	<ul style="list-style-type: none"> <li>▪ Need to involve and consult with unions to ensure any changes are implemented</li> </ul>
Clinicians - Medical, Nursing, AHPs and their professional organizations	<ul style="list-style-type: none"> <li>✓ Quality issues</li> <li>✓ Personal preferences</li> <li>✓ Funding from companies for conferences, teaching research etc</li> </ul>	<ul style="list-style-type: none"> <li>▪ May exert political clout</li> <li>▪ Risk of media involvement</li> </ul>
Minister/Government	<ul style="list-style-type: none"> <li>✓ Cost at system level</li> <li>✓ Network Review Savings have to be achieved</li> <li>✓ Probity/transparency</li> <li>✓ Election commitments</li> </ul>	<ul style="list-style-type: none"> <li>▪ Approval of new arrangements</li> </ul>
DHS	<ul style="list-style-type: none"> <li>✓ Co-sponsors of change</li> <li>✓ Cost at MHS and system level</li> <li>✓ Supply chain efficiency</li> <li>✓ Legislative change</li> </ul>	<ul style="list-style-type: none"> <li>▪ Establishment of new organization</li> <li>▪ Sponsor legislative change</li> </ul>
DTF inc VGPB	<ul style="list-style-type: none"> <li>✓ Cost at system level</li> <li>✓ Role of VGPB</li> <li>✓ Submission for funding, legislation, etc</li> </ul>	<ul style="list-style-type: none"> <li>▪ Role in approval of new arrangements</li> </ul>
Boards, CEOs and other Hospital Executives including Chief Finance Officers	<ul style="list-style-type: none"> <li>✓ Co-sponsors of change</li> <li>✓ Cost at local level</li> <li>✓ Locus of Control</li> <li>✓ Local purchasing decisions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Support and endorsement is required for successful implementation of changes.</li> <li>▪ Note that special care needs to be taken to ensure rural hospitals have the opportunity to influence decision-making processes.</li> </ul>
IT and Systems departments	<ul style="list-style-type: none"> <li>✓ Control IT systems</li> <li>✓ Cost of, and time to implement, new systems</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ability to get data</li> <li>▪ Ability to implement e-commerce solutions</li> </ul>
Patients	<ul style="list-style-type: none"> <li>✓ Right product at right time</li> </ul>	<ul style="list-style-type: none"> <li>▪ Any special clinical requirements need to be considered and accommodated</li> </ul>
Other Agencies e.g. Nursing Homes, Hostels, Ambulance, etc	<ul style="list-style-type: none"> <li>✓ Access to hospital purchasing power</li> </ul>	<ul style="list-style-type: none"> <li>▪ Unknown</li> </ul>
Private not for profit providers	<ul style="list-style-type: none"> <li>✓ Access to contracts</li> <li>✓ Maintenance of national arrangements e.g. CHA</li> </ul>	<ul style="list-style-type: none"> <li>▪ May be able to contribute to buying power</li> </ul>
Other state purchasing organizations e.g. NSW Peak	<ul style="list-style-type: none"> <li>✓ Collaboration and cost sharing</li> <li>✓ Possibility of multi-state tenders</li> </ul>	<ul style="list-style-type: none"> <li>▪ May offer volume opportunities</li> <li>▪ Ability to share development costs</li> </ul>

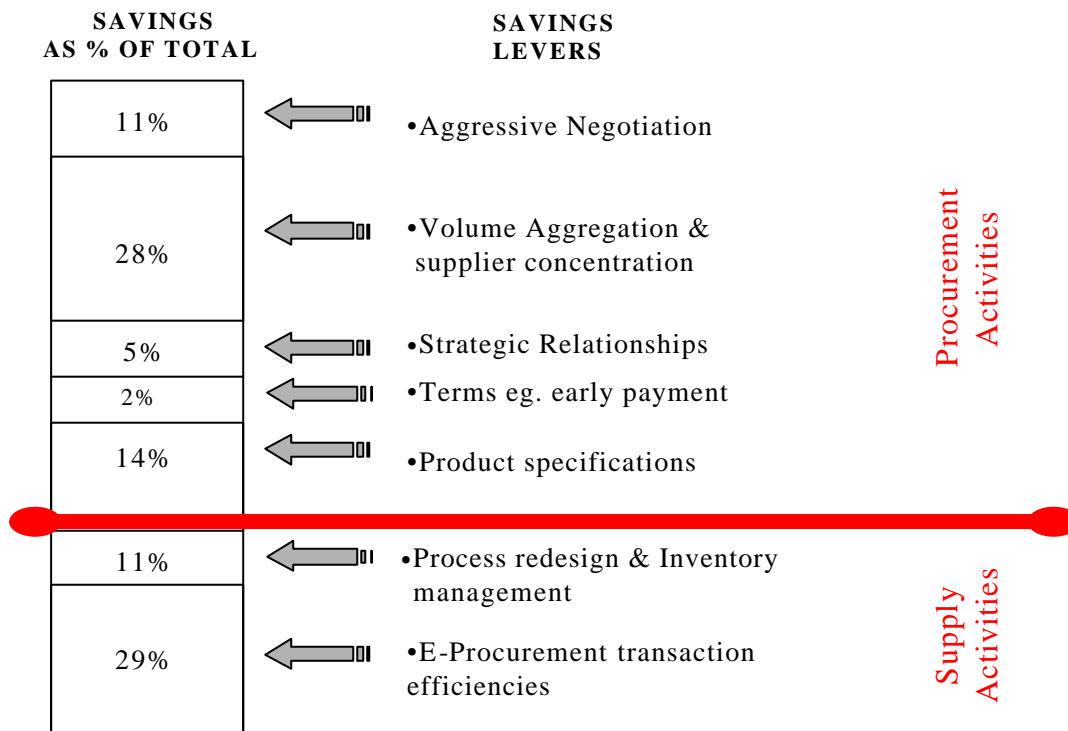
Stakeholder	Nature of Interest	Effect
Purchasing Council, Queensland Health etc	<ul style="list-style-type: none"> <li>✓ Standards issues e.g. EAN etc</li> <li>✓ Catalog issues</li> </ul>	for projects such as catalog and e-commerce systems

### 3.5 Supply Reform activities

There are broadly speaking two areas where reform can take place, these are:

- Procurement activities that are related to the specification, tendering, selection/evaluation and contracting of the product – these activities control product selection and product price.
- Distribution activities related to the movement of the product from the supplier to the area of use including requisition/ordering, transport/distribution, storage/warehousing, payment, etc – these activities control how the product is provided to the end user and the cost of the supply process

Whilst the Ministerial Review concentrated on the efficiencies that can accrue through rationalising tendering and contracting these are only two components of broader supply chain management, and will only realise a portion of the potential savings. The following diagram gives an indication of the dissection of savings and savings levers.



Source: Adapted from marchFIRST Consulting

The above diagram indicates that there are opportunities to leverage further savings through improvements and redesign throughout the supply chain. Those savings that fall above the line essentially relate to better purchasing through combining volumes, better specification, rationalising products, etc. Those savings that fall below the line relate to process redesign and the introduction of new technologies into the supply chain management process. The focus of centralised procurement strategies is principally on the activities above the line.

Whilst the consultants that have provided this diagram estimate those savings to be of a slightly smaller quantum to those available through central purchasing, other reviews have estimated that substantially more savings are available through broad supply chain reform

and in particular the implementation of e-commerce. Regardless of this, supply chain management is moving into a dynamic phase where there are going to be considerable challenges that will need to be addressed.

It is highly likely that the current system does not have the flexibility to maximise the opportunities that will be available through changes in procurement arrangements and supply chain initiatives, such as e-commerce, that will emerge over the next 5-10 years. It is also apparent that large scale collaboration with purchasing authorities in other States to obtain best pricing on a range of goods and share the expense of new developments such as catalogues and common numbering systems, is almost impossible with the current Victorian arrangements and culture.

The changes that will result from supply chain reform along with the introduction of e-commerce, will be dramatic and it is likely that the supply department of the future will bear little resemblance to that in place today. Whatever system/organization is put in place, it should be able to identify which areas of reform will provide the most benefit to hospitals, be flexible enough to respond to changes in supply chain management and provide the infrastructure (e.g. standards, systems, management arrangements, etc) to harness the efficiencies that are expected to flow from the introduction of new technologies.

## 4 OPTIONS FOR CENTRAL PROCUREMENT

The PRG conducted a workshop in early September with the following objectives:

1. Identify and confirm the process options that can be used to achieve the Government's procurement objectives;
2. Establish criteria to be used to prioritise the potential process options; and
3. Having agreed on the set of options and the evaluation criteria, prioritise the process options as a basis for further discussion.

### 4.1 Workshop Outcomes

The outcomes of the workshop are briefly summarised below:

#### 4.1.1 Process Options

It was agreed that the three options presented to the workshop (summarised under the heading 'Purchasing Models/Options' on page 13) represented the range of options available to implement centralised purchasing. It was noted that the models represented points on a continuum and that it would be possible to 'move' or adjust how the processes are undertaken by moving the models on that continuum. For example some in-house tendering could be undertaken within the co-ordinating model or some purchasing outsourced with the centralised model.

#### 4.1.2 Criteria

The criteria that should be used for selecting a purchasing model were discussed. It was agreed that the criteria should concentrate on the selection of the preferred model rather than implementation issues. The criteria were condensed into the following categories:

- **Timeframe** – the model must deliver within the timeframes determined by the Government
- **Savings** – the model must deliver the savings in both the short/medium timeframes (1 to 3 years) and the longer term (5+years)
- **Buy-in of Stakeholders** – the model must be able to manage the stakeholders to the process and, in particular, get the 'buy-in' of the clinicians.
- **Implement Supply Chain Reform** – the model should be able to foster improvements in supply chain management
- **Probity and Transparency** - the model must maintain the highest levels of probity and ensure as far as practicable purchasing decisions are 'transparent' to stakeholders
- **Maximise Volumes contracted** – It was accepted that, where appropriate given the clinical and other requirements, to get the best pricing the model should be able to maximise the volumes/market share committed to contract.
- **Leveraging off Current Systems** – the model should not have to "reinvent the wheel". Where it is possible to tap into current arrangements that are working well this should be achievable within the model.

There was also agreement that initially we were looking at how the purchasing should be done and that this should not be confused with how this function would be supported, that is the organization(s) that would undertake the work would be determined after the process was agreed (i.e. form follows function).

### 4.1.3 Purchasing Models/Options

Three models of centralised contracting were identified and agreed by the workshop. These are briefly described below (also see Attachment: Diagrammatic Representations of Purchasing Models at page 28).

#### 4.1.3.a Virtual Model

This model was defined as:

*Loose affiliation and collaboration among a number of organizations. Best described as an information sharing arrangement.*

There was general agreement that the 'Virtual Model' did not represent a significant change from the arrangements currently in place, except that some technology may be applied to facilitate the communication and information sharing processes. There was agreement that this model would not produce the level of savings required or facilitate centralised purchasing as recommended by the Ministerial Review. Given this, there was no support for this model as a preferred model.

#### 4.1.3.b Co-ordinated Model

This model was defined as:

*Participant organizations establish a structure to co-ordinate and manage the procurement process. Tenders and contract management will generally be undertaken by third parties.*

It was assumed that some form of governance structure would be put in place for this model that would incorporate representation from the major 'customers' and stakeholders such as the hospitals (metro and rural), DHS, DTF and clinicians.

The question was raised of who the 'third parties' are. It was agreed that a high degree of flexibility should be applied when tasking organizations to undertake the tenders. The sorts of organizations could include hospitals or groups of hospitals, HSA, consultants, VGPB, other government tendering bodies including those in other States, e.g. NSW PPC.

#### 4.1.3.c Centralised Model

This model was defined as:

*Structure is established that provides for all tenders and manages all contracts. All processes are centralised in one structure.*

It was noted that the main point of differentiation between the centralised model and the co-ordinated model was where tendering was undertaken. It was also noted that in a centralised model a participative structure such as a board representing hospitals, DHS, etc was not a prerequisite for the model, e.g. Queensland purchasing is controlled entirely by the Health Department.

## 4.2 Comparison of models against criteria

The following table provides some analysis of the models against the criteria that were developed at the workshop. No comparison has been made of the virtual model as it was agreed by the workshop participants that this model is, in effect, the current system and

would not be effective in a centralised purchasing environment as required by the Ministerial Review.

Criteria	Co-ordinated Model	Centralised Model
<b>Achievable in timeframe</b>	<p>Small size means a structure can be developed and implemented before 1 July 2001. This will ensure that the new organization will be able to "hit the ground running" and will have in place a tender program on 1 July.</p> <p>Legislative timeframe (Autumn Sitting) is achievable.</p>	<p>More complex structure requiring extensive transition planning &amp; implementation; requires transfer of some current local tendering and contracting functions to a central body<sup>11</sup>. Industrial issues relating to transfer/relocation of staff may also slow the process. However, this model could probably be largely implemented by 1 July 2000 although some transition tasks would remain after that date.</p> <p>Time taken to implement will also be largely dependent on the percentage of hospital tenders that will be undertaken centrally. It may be assumed that the percentage would be greater than for the co-ordinating model and therefore the time taken to fully implement the centralised model will be correspondingly longer.</p> <p>Legislative timeframe (Autumn Sitting) is achievable.</p>
<b>Savings</b>	<p>Short-term savings achievable. Given that this type of model will be utilising current infrastructure for tenders, it is possible to commission tenders prior to 1 July 2001 and for contracts put in place very early in the new financial year.</p> <p>Long-term savings can be generated from flexible procurement strategies that utilise current systems/staff for tenders and provide benchmarks for further savings.</p> <p>Relatively low overheads associated with this model; minimal duplication as tendering would be done by current supply departments.</p>	<p>Short-term savings at risk as effort is concentrated on structural issues. Long term savings dependent on developing internal skills base.</p> <p>Higher overhead costs and duplication of functions in hospitals and central body will reduce savings to some extent.</p>
	Overall savings achieved under both models would probably be very similar.	
<b>Buy in</b>	<p>Principle Stakeholders (MHS's, rural hospitals and DHS) would also be represented on the Board.</p> <p>Clinical stakeholder ownership via involvement in tender specifications, evaluations &amp; recommendations and tender activity tasking.</p>	<p>Significant political issues from introduction of a perceived bureaucracy.</p> <p>There is a risk that the stakeholders would perceive that they are remote from decision processes.</p> <p>There are more sensitivities involved in the introduction of a fully centralised model particularly with rural stakeholders.</p>
	Both models could facilitate some clinical involvement in decision making and ongoing contract management through the use of clinical/product committees	
<b>Implement Supply Chain Reform</b>	<p>Long-term goal via cooperation with MHS/Rural Hospitals. May be accelerated in a collaborative environment where hospitals are able to both work together and implement local initiatives.</p>	<p>Possible early gains (eg, removal of local supply practices and introduction of common systems) but longer-term impetus may wane due to remoteness of the administration from the 'coalface'.</p>
<b>Probity and transparency</b>	<p>If it is assumed that with a Board structure in place, it should be easier to maintain high levels of transparency with stakeholders and customers. In addition, as tenders and evaluations would be undertaken by agents</p>	<p>In theory it should be possible to have a high level of conformity with 'standard' probity guidelines/principles with a centralised model. As the Board effectively undertakes the tenders, evaluation and decision making then</p>

<sup>11</sup> Note that there would remain the need to retain local staff for hospital specific contracting activities.

Criteria	Co-ordinated Model	Centralised Model
	external to the Board then a high level of scrutiny of the process can be exercised by the Board.	it is harder to have independent scrutiny of the contracting processes.  Removal of local supply activity removes a check on central activity (and vice versa).
	In practice, there would probably be little difference in the levels of transparency and probity between both models.	
<b>Maximise Volumes</b>	Commitment to contract requires local data. Initial strategies will need to account for diverse product range & usage patterns.  This model would require a high level of co-operation from the individual MHS's/Hospitals in order to identify and contract for volumes.	As for coordinated model. However, it may be easier to 'enforce' volume contracting, as hospitals would have less capacity/resources to contract locally.
	In both models the ability to mandate contracts would be available through statutory direction.	
<b>Leverage off current systems</b>	Greater flexibility in this model would allow the use of current systems such as Hospital Supply Departments, HSA and other States tendering/contracting systems.  Given that this model utilises resources in place in hospitals and other agencies there is an additional degree of complexity in managing those relationships compared with the centralised model. One of the key roles of the Council will be to ensure that available resources (systems) are fully utilised and the tendering process is coordinated.	More difficult to leverage off current systems due to less flexibility being built into the model.

**There was a general preference for the co-ordinated model amongst members of the PRG.**

## 5 DESCRIPTION OF THE PROPOSED (CO-ORDINATED) MODEL

It is proposed that the organization be called the Health Procurement Council (“the Council”).

The proposed model would act as a point of co-ordination for all supply chain, central tendering and contracting activities. It would build on and utilise current infrastructure in place in hospitals, health services and other organizations such as HSA and the NSW PPC.

Lead agencies, including hospital supply departments and other agents, would undertake all, or much of, the actual work of tendering and contracting so that current infrastructure is utilised and unnecessary duplication avoided. It is expected that agreements would be negotiated with hospitals where it is appropriate that they act as a lead agency and that the costs of undertaking the lead agency role would be minimal compared to the benefits derived.

At least initially, the main work undertaken by the Council would revolve around the identification of tendering opportunities, the authorisation of agents to undertake tenders and the approval of tender evaluations. The Ministerial Review identified that much of the benefit that can be gained is through the aggregation of volumes across the State and the linking of marketshare to contract pricing, this would be a key outcome of the Council's operations.

### 5.1 Significant Issues

It is not appropriate to prejudge what decisions will be made by the Council; however, there will be a number of important issues that will need to be considered by the Council, some of these include:

- The priorities that will be attached to various areas of operation i.e. which product lines should be targeted, how supply chain reform issues are addressed, etc.
- What process should be in place for mandating use of contract and whether this should apply to all contracts?
- What happens where a net saving accrues across the State but one or more hospitals suffers some disadvantage?
- Should goods be ‘free in store’ (price inclusive of freight) or ‘free on board’ (price at the suppliers door) and how this will affect the rural sector?
- The role that HSA will play in future tendering activity.
- Should lead agencies be reimbursed the cost of running state tender processes?
- How should e-commerce e.g. electronic catalogue, product numbering, data standards etc and supply chain reform issues be addressed?
- What are the advantages of further co-operation with other states/organizations and how can it best be achieved?

#### 5.1.1 HSA Role

Given the historic role of HSA in providing tendering services to some hospitals, the ownership of HSA by VHA, (ownership indirectly by the hospitals), HSA's role in the provision of tendering activities would also need to be carefully considered by the Council. There are a number of strategic and probity issues that need to be examined before determining what, if any role, HSA should continue to have in the tendering of hospital supplies. A number of hospitals and suppliers have also raised the issue of HSA

performance and customer service levels, these issues would need to be addressed in the context of any decision being made to utilise HSA to undertake any work for the Council.

The Council would need to consider whether it is appropriate to undertake a competitive process<sup>12</sup> to determine whether HSA has an ongoing role in tendering. If HSA were involved undertaking tenders, in any capacity, they would not be able to bid in any tender were they act as an agent for any products or product groups that were the subject of the tender.

There are also a number of sensitivities involving companies, who in some circumstances may compete in other States or in Victoria with HSA, providing commercially sensitive information to HSA. This would also need to be resolved to ensure that Victorian hospitals obtained best pricing on goods.

## 5.2 Scope of operations

There has been some debate on how wide a scope of operation the Council should have and, in particular, what role the Council should play in reform of the supply chain. It appears to be generally agreed that there are very substantial savings to be achieved through total supply chain reform and that to achieve the full potential to reduce costs and improve effectiveness, you need to reform all aspects of the chain from goods production through to consumption. Notwithstanding this, it is also agreed that the operations of the Council should have as its principal focus the achievement of best pricing for medical consumables and pharmaceuticals.

The inclusion of services within the scope of the project should also be considered. Whilst services<sup>13</sup> make up a fairly small component of expenditure there may be savings that can be achieved through collaborative purchasing.

Given the opportunities and potential savings that are achievable with supply chain reform and the synergies between purchasing reform and supply chain reform it is suggested that the Council should have the following scope of operations:

- The development and implementation of best value purchasing arrangements in the areas of medical and other consumables, pharmaceuticals, equipment and services purchased by public hospitals and health services.
- The identification and the implementation of best practice supply chain management and procurement practices including the appropriate implementation of 'e-commerce' initiatives.

## 5.3 Role and Focus

The Council would undertake the following types of activities:

Research and Analysis	<ul style="list-style-type: none"> <li>▪ Collection of data on current purchasing arrangements e.g. volumes, products, pricing, product evaluations etc. This data would be used in developing a tendering program and identifying priorities as set out below.</li> <li>▪ Development of ongoing data collection and forecasting systems for product usage</li> <li>▪ Development of a product evaluation database and product evaluation program.</li> </ul>
Priority setting	<ul style="list-style-type: none"> <li>▪ The Council would, with DHS and the hospitals as appropriate, be required to identify opportunities for improved purchasing and supply management practices and assign appropriate priorities and resources to those activities.</li> </ul>
Tendering and Contracting	<ul style="list-style-type: none"> <li>▪ Identification of products, or classes of product, that should be tendered centrally.</li> </ul>

<sup>12</sup> A competitive tender or expressions of interest

<sup>13</sup> such as legal services, some equipment maintenance services etc, but excluding mainstream support services such as cleaning, food etc.

	<ul style="list-style-type: none"> <li>▪ Determination of the most appropriate method of tendering including whether volumes should be contracted (100% or a lesser percentage of volume), whether a panel or a preferred supplier(s) should be contracted, standing offer or contract arrangement, contract period, etc.</li> <li>▪ Determine who should undertake the tender as an agent of the Council</li> <li>▪ Management of an exception process so that hospital may be excepted from using contracted products under certain circumstances</li> </ul>
Policy and Guidelines	<ul style="list-style-type: none"> <li>▪ Development of policy and guidelines for purchasing in the health care sector (note that this would be based on current VGPB guidelines)</li> <li>▪ Development of common evaluation processes and documentation</li> <li>▪ Development of common wording (templates) for contract documents (e.g. Conditions of Tender, Contracts, Expressions of Interest, etc)</li> </ul>
Supply Chain Management	<ul style="list-style-type: none"> <li>▪ Identification and implementation (in conjunction with hospitals) of best practice supply chain management practices including the co-ordination of e-commerce initiatives in hospitals<sup>14</sup></li> <li>▪ Sponsoring education and training activities.</li> </ul>

More detail on the types of strategies that could be endorsed by the Council are outlined under the heading 'Attachment: Purchasing Strategy' on page 26.

#### 5.4 Council and Support Structures

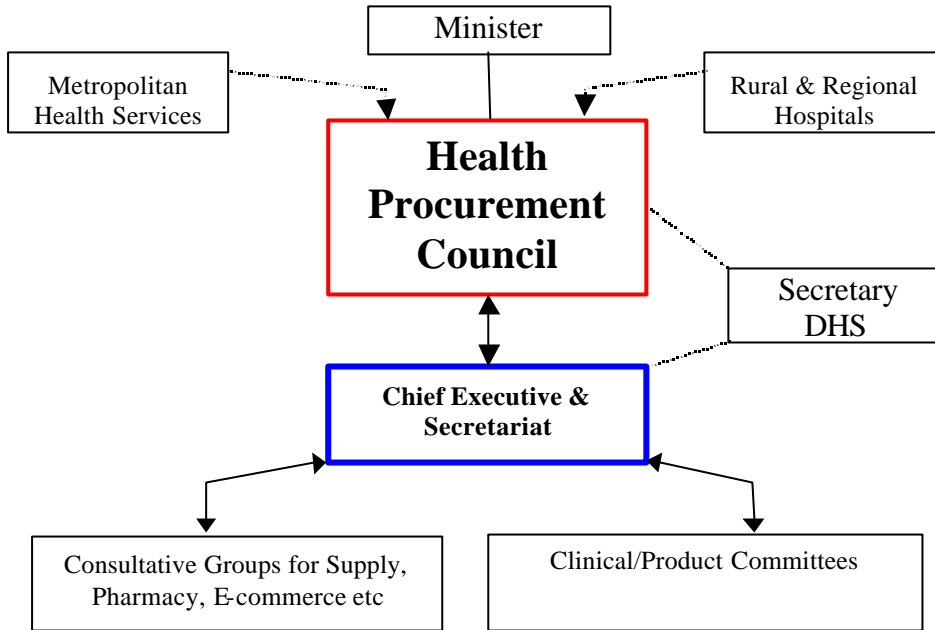
It is expected that the Council would have the following structure:

- A Council made up of eight or nine directors who would be appointed for terms of up to three years by the Minister or the Governor in Council. Hospitals (metro and rural), DTF (VGPB), DHS should all be represented on the Council.
- A Secretariat that would comprise:
  - A Chief Executive who would also be a member of the Council and would be responsible to the Council for the operations of the Secretariat.
  - Three project managers who would cover the areas of tendering/contracting, administration & technology e.g. web site development etc, and clinical coordination<sup>15</sup>.
  - Clinical/Product Committees that would be either standing committees or formed as required who would be responsible for clinical issues, including product evaluation arrangements and contract management issues before, during and after contracts are put in place. These committees would be chaired by one of the project managers and membership drawn from appropriate staff in the hospitals.
  - Consultative groups would be formed with supply managers and pharmacists to facilitate communication and co-operation between hospitals. Additional groups could be constituted as required (eg, e-commerce).
  - An administrative officer who would support to the Council/secretariat.
  - 1-2 Data Analysts who would be responsible for extracting information on volumes, pricing etc for use in tendering and to determine priority areas for tendering programs.
  - Other staff may be seconded from hospitals for special projects, etc.

<sup>14</sup> Note that DHS would continue to manage statewide policy initiatives relating to e-commerce and represent Victoria on national bodies

<sup>15</sup> Whilst each project manager would have defined areas of accountability and expertise they would work seamlessly across all areas of Council operations

The diagram below provides a diagrammatic representation of the Council structure:



## 6 COST AND FUNDING ISSUES

### 6.1 Budget

A draft Budget has been prepared on the basis that the Council would be accommodated on leased premises and that a full office fit out would be required. If the Council were accommodated on hospital premises this figure could be reduced by up to \$30-60,000<sup>16</sup> in year one and \$10-20,000 thereafter.

#### 6.1.1 Summary of Estimated Budget Costs

Operating costs	\$932,000
One-off establishment costs	\$75,000

### 6.2 Savings

At this point in time, given the volatility of the Australian dollar, the changes in the taxation system that are still flowing through the system and the introduction of new clinical and e-commerce technologies, it is very difficult to accurately forecast the level of savings that will be achieved through co-ordinated purchasing arrangements. However, using the savings quoted by NSW PPC and the Ministerial Review as a guide a conservative estimate of savings of the order of \$5-10m pa (0.7-1.3%) can be generated through co-ordinated purchasing.

There would also be additional savings generated through the introduction of e-commerce initiatives and rationalisation/standardisation of product lines. These initiatives could generate further savings of between 5-10% (\$35-70m) of total supply expenditure if the predictions made by the recent reports on e-commerce are accepted<sup>17</sup>. It should be noted that a significant upfront investment is required in systems infrastructure and major process redesign to enable these savings to be achieved.

Given the information available on savings achieved in other States, the Council would generate savings well beyond the operational costs. However, it is essential that there be regular reviews of the Council's performance to ensure that it is achieving savings and meeting its objectives. This review program could be undertaken on a bi or triennial basis.

### 6.3 Funding

Essentially there are two methods for funding the Council. These are through:

- a direct budget allocation from DHS<sup>18</sup>; or,
- direct or indirect funding from the hospitals via a levy on the hospitals or a suppliers rebate, or levy on purchases.

The direct budget allocation is the simplest and easiest method of funding; however there are no inbuilt accountability mechanisms in this method of funding.

Funding via the hospitals or suppliers would be directly related to the level of purchases made via Council contracts and could be structured in such a way so that funding was directed linked to activity providing some additional degree of accountability. Whilst this type of funding may be attractive because of the perceived additional accountability there

<sup>16</sup> Dependant on the facilities, cabling, phone systems in place

<sup>17</sup> Note some of the reports predict savings of up to 20% in this area.

<sup>18</sup> Additional funding would not be sought from DTF

is a greater degree of complexity, and additional cost, of managing it. There are also GST implications with this type of arrangement that do not exist to the same extent with a direct funding arrangement.

The advice from VGPB is that a funding arrangement from hospitals or suppliers should be avoided because of the additional administrative and management overheads. It is estimated that the additional costs of administering a levy arrangement would be one additional staff member for the Council plus some increased costs for suppliers or hospitals.

Initially, seed funding by a direct allocation could be provided from the Health budget with an examination by the Council, after the first two years of operation, to determine the most appropriate ongoing funding mechanism. This examination could be carried out in the context of a broad review of the performance of the Council in providing the hospitals with savings and improved supply chain efficiencies.

#### **6.4 Savings Requirements**

Based on the findings of the Ministerial Review, the State Government has tasked DHS with putting in place strategies to save \$6m from the hospital budgets through collaboration and co-ordination of purchasing. In addition, as a result of the Federal Government's introduction of 'A New Tax System', the hospitals are required to save a further \$14m in the 2000/2001 financial year and \$24m in the 2001/2002 financial year through reductions in prices as a result of the removal of embedded taxes.

Whilst no mechanism is yet in place to facilitate central tenders/contracting, DHS has been working with hospitals' supply and pharmacy areas to identify opportunities for savings. One of strategies used is the development of a 'basket of goods' that is used to compare pricing between Victorian hospitals (metro and rural) and with interstate purchasing arrangements. The outcome of this comparison is that there are opportunities where savings can be achieved through the 'leveraging' of best pricing achieved in Victorian hospitals. It was also found that in the majority of items costed, that the best Victorian pricing was better than that achieved in NSW. Work will continue on expanding the basket of goods and identifying opportunities where better pricing can be achieved through joint tenders, negotiations with suppliers and collaboration with the NSW PPC.

Given the devaluation of the Australian dollar against other major currencies and increases in costs of labour and materials, it is anticipated that many suppliers will be increasing pricing over the next 2-6 months, this is especially true of those 85% of supplies that are imported. Given this, it is expected that many of the Council initiatives will be focused on strategies to minimise or offset prices increases. It should also be noted that the Council should also work with suppliers to identify where current hospital practices increase costs so that efficiencies can be identified and cost overheads reduced.

It is assumed that, with the exception of the savings already harvested, future savings would be retained by the hospitals. This is essential to provide an incentive for the hospitals to work with the Council in achieving savings and to get the buy in of the clinicians who will have a major influence in what savings can be achieved. Hospitals could use the savings to invest in further opportunities, such as system upgrades for e-commerce, and offset unfunded cost increases that have resulted through the dollar devaluation and introduction of new medical technologies and pharmaceuticals.

## **7 GOVERNANCE ISSUES**

There are two issues that need to be resolved in relation to governance, these are:

- The authority under which a central purchasing organization operates and, in particular, the ability of the organization to enter into binding agreements with suppliers and other parties
- The structure that will be in place to govern the organization.

### **7.1 Authority to Operate**

Authority to operate and enter into agreements can be gained from two sources, these are:

- Under the authority of legislation e.g. an amendment to the Health Services Act
- Delegation from the Minister

There are significant operational advantages in operating under legislation where the organization has clear responsibilities and powers to operate. The organization would be able to enter into binding contracts directly with suppliers to provide supplies to hospitals and other health organizations. The ability to mandate use of certain contracts would also be covered by legislative provisions.

Alternatively, the organization could operate under delegated authority of the Minister and utilise the ability of the Secretary of the Department of Human Services to make directions to the Metropolitan Health Services. This would be an administratively complex arrangement with duplication of contracting at each MHS/hospital and could potentially lead to conflict with hospital management and Boards, as it would be the Board that would contract individually with suppliers rather than a central body on behalf of hospitals. If this approach was taken it could be expected that savings may be lower, or at least more difficult to achieve, compared to an organization operating with statutory powers and the ability to directly contract on behalf of all hospitals.

### **7.2 Governance structure**

Separate from the organization that undertakes the 'work' there is a need to have some form of governance structure in place. This structure could take a number of forms ranging from a small Council, with no legal standing, nominated by CEOs and other stakeholders through to a corporate board that would have responsibilities similar to the Boards of commercial corporations. To some extent the appropriate arrangements are dictated by how the organization gains its authority to operate; if the authority comes from legislation then it is probably most appropriate that a Board or Council appointed by the Minister be put in place. Nominations for the Board could be received from Hospitals and other health service providers and provision could be made in the legislation to ensure that stakeholders such as rural hospitals, and clinicians were adequately represented. One example of a Board structure is set out below

Possible Board Structure

- 1 Chair appointed by the Minister from the hospital sector
- 3 MHS Representatives
- 1 DHS Representative
- 1 DTF Representative
- 2 Rural Hospital Representatives

## 8 IMPLEMENTATION OF THE PREFERRED MODEL

### Key Implementation Tasks and timelines

Task	Timeframe	Issues
Enabling legislation <ul style="list-style-type: none"> <li>▪ Instructions to draftsman</li> <li>▪ Introduce</li> <li>▪ Enact</li> </ul>	Autumn sitting December 00 April 01 June 01	Minister would need to sign of recommendation in November so that drafting could be completed for Autumn sitting.
Staffing <ul style="list-style-type: none"> <li>▪ Appoint Temporary Staff</li> <li>▪ Commence Permanent recruitment</li> <li>▪ Complete Permanent appointments</li> </ul>	February 01 June 01 August 01	
Accommodation <ul style="list-style-type: none"> <li>▪ Temporary accommodation (if necessary)</li> <li>▪ Permanent accommodation</li> </ul>	February 01 June 01	It would be expected the Council would be accommodated on a suitable hospital site.
<ul style="list-style-type: none"> <li>▪ Administrative Systems (Accounting, etc)</li> </ul>		It is expected that a hospital will provide the administrative support for the Board e.g. accounts, systems support, etc. DHS could also provide some support.
Data Systems	November 00 – December 01	Given the large number of product lines > 30,000 and the number of suppliers >2000 there is a significant task involved in determining what data should be collected and how it should be collected.
IT <ul style="list-style-type: none"> <li>▪ Website Stage One – information</li> <li>▪ Website Stage Two – contract data</li> <li>▪ Website Stage Three – Tendering system</li> <li>▪ List server</li> <li>▪ E-commerce systems</li> </ul>	December 00/January 01 June 01 December 01 <sup>19</sup> May 01 *	This task also relates to data collection  Subject to separate budget processes, likely to implemented over a number of years.
Board <ul style="list-style-type: none"> <li>▪ Call for nominations</li> <li>▪ Appoint Chairperson</li> <li>▪ Appoint members</li> </ul>	April 01 May-June 01 June 01	Dependant on the timing of the legislation
Budget and Funding Processes <ul style="list-style-type: none"> <li>▪ Finalise Budget</li> <li>▪ Seek DTF/Cabinet approval for funding mechanism</li> </ul>	December 00 Early 01	

<sup>19</sup> Note that it may be possible to co-operate with another State in implementing this system

## 9 DRAFT RECOMMENDATIONS

The following draft recommendations have been developed to assist in the consultation process and indicate the direction that has been endorsed by the PRG. Following the consultation process the PRG will review comments that have been received from the sector and determine the final recommendations that will be made to Government with respect to central purchasing in Victoria.

1. That a Health Procurement Council (the Council) be established to develop and implement centralised purchasing arrangements and other strategies to ensure that best value is obtained in the purchasing of services, equipment and goods in Victorian Hospitals and Health Services. In determining best value the Council shall consider issues relating to clinical need, price and quality of the services, equipment or goods.
2. That the strategies put in place by the Council initially focus on obtaining best pricing for medical consumables and pharmaceuticals and build on existing arrangements in Victorian Hospitals or in other States. These arrangements include but are not limited to current Hospital Supply Departments, Victorian Government Purchasing Board, Hospital Supplies of Australia, Purchasing/Supply Alliances already established by hospitals and co-operative arrangements in place with NSW Peak Purchasing Council and other States purchasing organizations.
3. That an amendment be made to the *Health Services Act 1988* to:
  - a. Authorise and facilitate the operation of the Council including the formation of the Council and Product Reference Groups
  - b. Enable tendering and contracting by the Council on behalf of Victorian Public Hospitals and Health Services
  - c. Provide the power for the Council to make statutory directions with respect to purchasing and supply arrangements, including compulsory/mandated contracts, in Hospitals and Health Services. Note that an exception process would also be required to enable hospitals to get exemptions from certain contracts where appropriate clinical and other circumstances exist.
4. That the Council comprise of eight to nine members appointed by the Minister (or Governor in Council on Minister's recommendation?). Terms of appointment should be for a maximum of three years. With the exception of the Chief Executive, Directors should be eligible for reappointment but should not be able to serve more than three consecutive terms. The Chief Executive should be appointed for the term of their employment.
5. That the Council include:
  - Three people who are able to represent the views of the Metropolitan Health Services
  - Two people who are able to represent the views of rural hospitals
  - One person nominated by the Department of Treasury and Finance/VGPB
  - One person nominated by the Department of Human Services
  - The Chief Executive of the Council
  - A chairperson appointed by the Minister from nominations received from the Health Industry.

6. That the Council assume the following responsibilities:
  - a. The identification of items or categories of items where it is appropriate to centrally tender and/or contract, and that in undertaking this task that the Council have regard to:
    - i. Clinical needs of patients
    - ii. Ability of the suppliers to supply the goods as required by the hospitals
    - iii. Market and competition issues including the effect of tenders/contracts on the viability of SMEs.
    - iv. Local hospital conditions and requirements
    - v. Regional and industry development issues
  - b. Ensuring that probity is maintained in any tendering or contracting activities and that tender processes are as transparent as possible.
  - c. Promoting and, where appropriate, implementing best practice supply chain management including e-commerce initiatives.
  - d. In partnership with the VGPB promote the use of VGPB common use contracts and develop purchasing principles, policies and guidelines for use in hospitals and health services.
  - e. Reporting on activities on an agreed basis to all hospitals and Health services.
7. That a secretariat be established to support the Council, comprising a Chief Executive, three project managers, two data analysts and an administrative officer.
8. That funding for the Council is via a direct allocation from DHS for the first three years of operation.
9. That after two years of operation and in conjunction with a full review of the Council's operation and performance, the funding mechanism be reviewed to determine if direct budget allocation is the most appropriate method of Council funding.
10. That the Procurement Reference Group (PRG), established by the Department, be maintained, pending the appointment of the Council, to act as a steering committee for the secretariat.

## 10 ATTACHMENT: PURCHASING STRATEGY

Area	Strategy	Timeframe	Comments
Product Information	• Identification of pricing opportunities and best prices through pricing a 'basket of goods'	S-M	
	• Volume information for use in tendering	S-M	
	• Forecasting demand for use in tendering	M	
	• Shared information on contracts and pricing via Internet based database	S-M	
	• Identification types of opportunities in addition to medical consumables and pharmaceuticals i.e. services, utilities, equipment, etc	M	
Process Benchmarking	• Process mapping, definition and costing of all parts of the supply chain	M	
	• Identification of best practice inventory management through internal benchmarking e.g. stock holding, stock turns, shrinkage etc	M	
	• Benchmarking with other hospitals/states/internationally	M	
Tendering Program	• Identification of common tendering opportunities and implementation of a comprehensive tendering program	M	
	• Aggressive price negotiation	S-M	
	• Contracts with guaranteed volumes/market share i.e. volume aggregation	S-M	
	• Mandated state contracts for agreed/selected products/categories	S-M	
	• Negotiation of State wide Standing offers	S-M	
	• Development of most appropriate tender management arrangements e.g. - "Lead purchasing units", consultant managed tenders, VGPB, NSW Supply etc	M	
Partnerships and collaborative arrangements	• Development of collaborative arrangements with and between Suppliers e.g. shared distribution arrangements,	L	
	• Other purchasers eg NSW PPC, Queensland Health, CHA etc	S-M	
E-commerce initiatives	• Development of business case for e-commerce	S_M	
	• Implementation of On line ordering, automated invoice matching and EFT	M-L	
	• Access to product information online	M	
	• Automated medical/pharmaceutical supply systems	S-M	
	• Financials – linking of financial modules to materials management systems, common data/messaging standards, GL structures, etc	M-L	
Cost reduction strategies	• Identify unnecessary supplier costs	S-M	
	• Common:		
	o Conditions of tenders	S	
	o Contract terms and conditions	S	
	o Evaluation criteria	S	
	o Product specifications	S-M	
	• Longer contracts	S-M	
• Reductions in number of tenders	S-M		
• Rationalised ordering arrangements	M		

Area	Strategy	Timeframe	Comments
	• Product standardisation where appropriate	M-L	
	• Better forecasting of demand	M	
	• Better inventory management, reduced holdings	M	
	• Common numbering standards and bar-coding	M-L	
	• Standard State/National Catalogue	M-L	
	• Payment terms – discounts for shorter terms	S-M	
	• Sharing of product evaluation information – reductions in number of evaluations	S-M	
	• Rationalise contract management arrangements	M	
Supply chain management	• Internal and external prime vendor strategies	S-M	
	• Supplier managed inventory, consignment etc	M	
	• Warehouse rationalisation, regional/MHS supply services	M-L	
	• Education, training and consultancy in supply chain management	S-M	
	• Communication and Awareness processes	S	

Timeframe

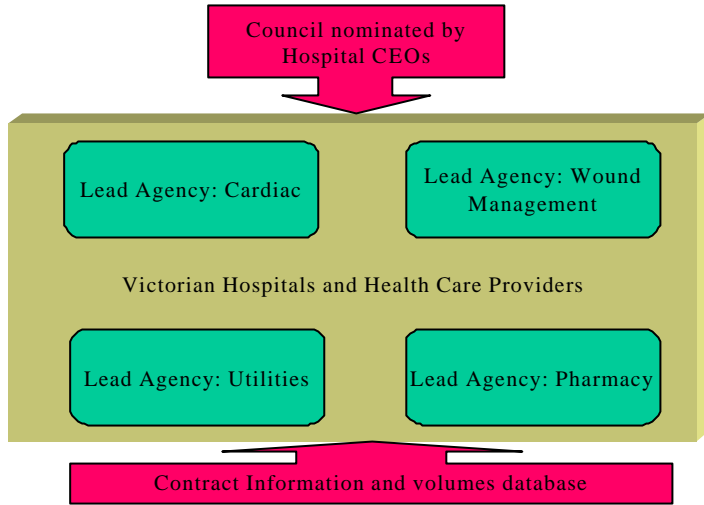
S = short term 12 months

M= medium term up to 3 years

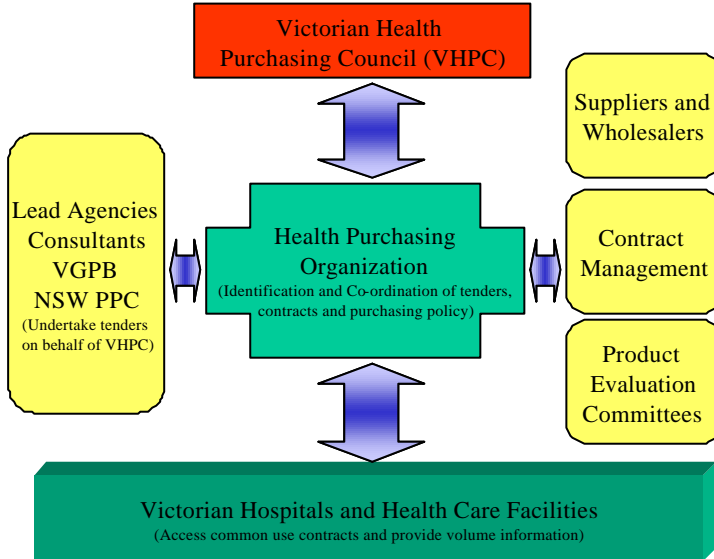
L= long term 3-5 years

**11 ATTACHMENT: DIAGRAMMATIC REPRESENTATIONS OF PURCHASING MODELS**

**11.1 'Virtual' Model**



**11.2 Co-ordination Model**



**11.3 Central Purchasing Board**





## **12 ATTACHMENT: PRG MEMBERSHIP**

Jennifer Williams, Chief Executive Officer (Chairperson) ARMC  
John Mulder, General Manager, Acute Health, Barwon Health  
Bruce Levy, General Manager, The Alfred  
Peter Sandys, Director, Finance and Administration, Dental Health Service Victoria  
Silvio Tiziani, Corporate & Support Services Manager, Eastern Health  
Kerryn Healy, Director Finance and Information, Goulbourn Valley  
Sue Ralph, Chief of Infrastructure, North Western Shared Services  
Peter Turner, Director Corporate Services, Peninsula Health  
Mark Sullivan, Director of Hotel Services, Peter MacCallum Cancer Institute  
Joe Carbone, Chief Executive Officer, Royal Victorian Eye and Ear Hospital  
Kim Wheeler, Contracts Manager, Royal Victorian Eye and Ear Hospital (alternate)  
John Stanway, Executive Director, Corporate Services, Southern Health  
Greg Spring, Executive Director, Women's and Children's Hospital  
John Peoples, Assistant Director, Business Support & Project Management Branch DHS  
Steve Sant, Manager, Procurement Strategy Unit, DHS  
Susan Medlin, Manager, Business Support & Development Group, DHS  
Peter Cubit, Project Manager, Procurement Strategy Unit, DHS (Secretary)  
John Rickard, Director Procurement, Procurement Branch, DTF  
Professor Graeme Ryan, Chair, Royal Victorian Eye and Ear Hospital Board  
Nicholas Tong, Director of Pharmacy, Bayside Health  
Brian Dillon, Director of Pharmacy, South West Healthcare