



Future Procurement Arrangements in Victoria

Report of the Hospitals Procurement Reference Group

February 2001

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1 Executive Summary

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 centralised purchasing of goods. In their final report released in May 2000, the Review recommended that a taskforce be established to examine the best model for centralised purchasing.

In August 2000, the Department of Human Services established a Hospitals Procurement Reference Group (PRG) to examine the Review recommendations and to determine the most appropriate means of putting centralised purchasing arrangements in place. The PRG included representation from all Metropolitan Health Services, Rural Hospitals, the Society of Hospital Pharmacists, the Department of Treasury and Finance (Victorian Government Purchasing Board) and the Department of Human Services.

The PRG held a series of meetings and workshops to consider the options open to the Government to implement centralised purchasing. The PRG considered that the most appropriate method of undertaking centralised purchasing was by establishing a structure to co-ordinate and manage the procurement process with tenders and contract management being undertaken by third parties such as hospitals, other State purchasing organizations (e.g. NSW Peak Purchasing Council), consultants or other organizations such as the Victorian Healthcare Association (Co-ordinated Model).

The PRG released a consultation paper in November 2000 to all public hospitals and the hospital supply industry recommending that a Health Purchasing Council be established to co-ordinate centralised purchasing. It was expected that the Health Purchasing Council would also have a role in the development and implementation of procurement policy, standards and the implementation of e-business initiatives.

Following the consultation phase, and as a result of representations made by the Victorian Healthcare Association (VHA), the PRG set up a joint PRG/VHA working group to explore an alternative purchasing model where VHA would undertake the role of the purchasing authority on behalf of all hospitals and Government. The outcome of that process was that whilst it was possible for the VHA to undertake tenders there were very significant problems with:

- The appropriateness of VHA exercising statutory powers on behalf of the government
- The development and implementation of high level policy and regulation by a non government entity
- The legal mechanism for putting contracts in place
- Whether the VHA would be able to mandate volumes in contracts and achieve best pricing
- The roles that the Minister, DHS and the VGPB would be required to take in the process
- Trade Practices and Corporations law issues relating to a private company performing the purchasing role.

The PRG received legal advice on the above issues and it became clear that the VHA model would be extremely operationally complex and it would be inappropriate for a body governed under corporate law to undertake the broad role expected of the new Purchasing organization. In any real sense, it was considered the VHA option would be unworkable. However, it was also clear to the PRG that there are substantial benefits that can be gained in the short to medium term by working closely with VHA to ensure that the best use is made of VHA's existing database, contracts, market intelligence and tendering expertise.

Given the above the PRG have confirmed their original recommendation that a Health Purchasing Council be established. Recognising a variety of contracts are already in place and the lead-time required to develop new tenders and contracts, the PRG have further recommended that transition arrangements be put in place with VHA to ensure that best use is made of existing contracts, knowledge and expertise that currently resides with VHA.

The PRG recommendations are as follows:

1. That a Health Purchasing Council (the Council) be established on 1 July 2001 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. Where appropriate the Council should also facilitate access for all publicly funded health agencies to central purchasing contracts.
2. 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 the Council have regard to:
 - i. Clinical needs of patients.
 - ii. Local hospital conditions and requirements.
 - iii. Ability of the suppliers to supply the goods as required by the hospitals.
 - iv. Market and competition issues including the effect of tenders/contracts on the viability of Small and Medium Enterprises (SMEs).
 - v. Regional, industry development and local content issues.
 - b. Promoting 'best value' purchasing by hospitals. In determining 'best value' the Council should consider issues relating to clinical need, price (including whole of life costs) and quality of the services, equipment or goods.
 - c. Promoting collaboration and cooperation between hospitals and with purchasing organizations within, and external to, Victoria, in purchasing, and supply chain management/reform.
 - d. Ensuring that probity is maintained in tendering and contracting activities and that these processes are as transparent as possible.
 - e. Promoting and, where appropriate, implementing best practice supply chain management including e-business initiatives.
 - f. Promoting the use of Victorian Government Purchasing Board (VGPB) 'common use contracts' in partnership with the VGPB.
 - g. In consultation with the VGPB, relevant State Departments/Agencies (e.g. State Development and hospitals, the development of purchasing principles, risk analysis principles, standards, policies and guidelines.
 - h. In consultation with hospitals the development of an annual business plan incorporating a 3-year Rolling Tender Program and Key Performance Indicators.
 - g. Reporting on activities on an agreed basis to hospitals and the Department of Human Services.

3. That legislation be developed, for consideration in the Autumn sitting, to:
 - a. Authorise and facilitate the operation of the Council including the formation of the Council and Product Reference Groups and the employment of Council staff.
 - b. Enable tendering and contracting by the Council on behalf of Victorian Public Hospitals and Metropolitan Health Services
 - c. Provide the power for the Council to make statutory directions with respect to:
 - i. Purchasing and supply arrangements in Hospitals and Health Services,
 - ii. Mandating contracts including the ability to grant exemptions to hospitals from certain contracts where appropriate clinical and other circumstances exist
 - iii. Determining and implementing of standards and policies relating to purchasing of goods, services and equipment in public hospitals.

4. That, to ensure broad representation from the hospital industry, the Council comprise at least eight and no more than ten members appointed by the Governor in Council. Terms of appointment should be for a maximum of three years with members being eligible for reappointment.

5. That the Council include:
 - a. Three people currently employed by a Metropolitan Health Services one of whom will be a CEO of a Metropolitan Health Service.
 - b. Two people currently employed by a rural hospital one of which will be a CEO of a Rural (Public) Hospital.
 - c. One person nominated by the Department of Treasury and Finance to represent both the Department and the Victorian Government Purchasing Board.
 - d. One person nominated by the Department of Human Services.
 - e. A chairperson, and up to two other members, with expertise in the healthcare industry.
 - f. It is further recommended that the Minister, in selecting members of the Council, consider the need to have clinical expertise on the Council.

6. That if a member of the Council, who is nominated to represent either the Metropolitan Health Services or Rural Hospitals, ceases to be employed within the public hospital sector for a period of more than 3 months that he or she automatically cease to be a member of the Council.

7. That, recognising a variety of contracts are already in place and the lead-time required to develop new tenders and contracts, transition arrangements be put in place for the first two years of the operation of the Council. As a part of the transition, and subject to further discussions with Victorian Healthcare Association (VHA), it is expected that these arrangements would include:
 - a. The continuation of the current pharmacy tendering and contractual arrangements with VHA for a period of two years from 1 July 2001 at which time the arrangements would be reviewed by the Council.
 - b. The current Hospital Supplies of Australia (HSA) Pharmacy Advisory Committee becoming a Council Product Reference Group
 - c. For a period of two years, VHA and others will be used for tenders for non-pharmacy medical consumables (subject to conditions relating to conflict of interest, probity requirements, expertise in the area, cost effectiveness, etc being met). The provision of distribution/warehouse services would be considered separately by the Council on a tender-by-tender basis. It is also recognised that there may be

occasions where it will be appropriate to undertake joint tenders or other purchasing arrangements with other government bodies

- d. Current HSA contracts be recognised by the Council but that there be no compulsion on hospitals to purchase from these contracts as they currently stand. These contracts to be reviewed by the Council on their expiration/termination to determine whether they are retendered as Council contracts.
 - e. Discussions take place with hospitals' purchasing areas, Victorian Healthcare Association and other State purchasing organizations to ensure that appropriate use is made of expertise and knowledge available within the industry.
8. That a secretariat be established as soon as possible to support the Council.
 9. That funding for the Council is via a direct allocation from DHS for the first three years of operation (additional Budget funding would not be required).
 10. That before the completion of three years of operation, and in conjunction with a full review of the Council's operation and performance, the funding mechanism be reviewed to determine the most appropriate method of Council funding.
 11. That the Hospitals 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.

2 Introduction and Background

2.1 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 (CEO Austin and Repatriation Medical Centre) 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 on page 42.

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) and outlines the process that has been identified for the implementation of centralised purchasing arrangements and includes recommendations for the formation of a Health Purchasing Council.

2.1.1 Definitions

Definitions used in this paper are detailed at the Attachment: Definitions on page 43.

2.1.2 Abbreviations

Abbreviations used in this paper are detailed at the Attachment: Abbreviations on page 44.

2.2 Background

2.2.1 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. In their final report¹ 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.

¹ Ministerial Review of Health Care Networks - Final Report. Published by Victorian Government Department of Human Services, May 2000. Melbourne, Victoria.

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 Government² in its response to the Review Report accepted the above recommendations and expanded the scope of the project to include equipment.

² Ministerial Review of Health Care Networks - Government Response. May 2000.

3 Context

3.1 Purchasing in Victoria

Hospitals and health services in Victoria purchase equipment, services and goods in excess of \$750m³ per year. These items are supplied by more than 2500 individual vendors and cover in excess of 30,000 items⁴. 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 One-off irregular purchases of low cost equipment or services and regular purchases of food items etc in rural areas.	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 ⁵ Usually best dealt with at local level.	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
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 ⁶	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 Peak Purchasing Council (PPC) purchases approximately 20%⁷ (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% of goods could be

³ Estimated based on total hospital expenditure in FY 99/00.

⁴ 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.

⁵ 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.

⁶ As above.

⁷ Based on information provided by the NSW PPC. It should be noted that this 20% figure has been built up since the early 1990s when the PPC was established.

centrally purchased in Victoria; however, it is likely that as systems are improved and data becomes readily available that this percentage will rise.

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

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 Peak Purchasing Council (PPC) and the Queensland 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 and the changes in purchasing arrangements introduced with the establishment of Health Care Networks in Victoria in the mid 1990s. 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. However, it has been reported that NSW are moving away from supplier panels and towards preferred suppliers arrangements in some categories. 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 a key feature of the NSW model is the 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. In Victoria there have also been a number of examples where the former Networks have, by working closely with the clinicians, been able to achieve product rationalisations and savings.

3.4 Stakeholders

Any centralised 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"> ✓ Suppliers of goods – interest in maintaining/increasing market share ✓ Competitive advantage 	<ul style="list-style-type: none"> ▪ Control costs and pricing ▪ Market presence
Prime Vendors and management service providers e.g. Fauldings, Spotless/Clifford Hallam, Sigma, HSA, API, etc	<ul style="list-style-type: none"> ✓ Interest in changing the traditional internal system to outsourced logistics and warehousing ✓ Commercial opportunities ✓ HSA provide a substantial quantity of medical consumables and pharmaceuticals to Vic Hospitals 	<ul style="list-style-type: none"> ▪ Ability to reduce logistics and administration costs
Victorian Healthcare Association	<ul style="list-style-type: none"> ✓ 'Owner' of HSA ✓ Peak organization – represents interests of metro and rural hospitals 	<ul style="list-style-type: none"> ▪ Need to be aware of and manage any actual, or perceived, conflict of interest in relations to VHA's interest in HSA and their role as the hospital peak organization.
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"> ✓ "What happens to me?" Future role in purchasing and control of purchasing decisions ✓ Costs of goods ✓ Job design 	<ul style="list-style-type: none"> ▪ May act as blockers if change is not managed well and they are not involved in the process
Unions	<ul style="list-style-type: none"> ✓ Staffing issues ✓ Job design 	<ul style="list-style-type: none"> ▪ Need to involve and consult with unions to ensure any changes are implemented
Clinicians - Medical, Nursing, AHPs and their professional organizations	<ul style="list-style-type: none"> ✓ Quality issues ✓ Personal preferences ✓ Funding from companies for conferences, teaching research etc 	<ul style="list-style-type: none"> ▪ May exert political clout ▪ Risk of media involvement
Minister/Government	<ul style="list-style-type: none"> ✓ Cost at system level ✓ Network Review Savings have to be achieved ✓ Probity/transparency ✓ Election commitments 	<ul style="list-style-type: none"> ▪ Approval of new arrangements
DHS	<ul style="list-style-type: none"> ✓ Co-sponsors of change ✓ Cost at MHS and system level ✓ Supply chain efficiency ✓ Legislative change 	<ul style="list-style-type: none"> ▪ Establishment of new organization ▪ Sponsor legislative change
DTF inc VGPB	<ul style="list-style-type: none"> ✓ Cost at system level ✓ Role of VGPB ✓ Submission for funding, legislation, etc 	<ul style="list-style-type: none"> ▪ Role in approval of new arrangements
Boards, CEOs and other Hospital Executives including Chief Finance Officers	<ul style="list-style-type: none"> ✓ Co-sponsors of change ✓ Cost at local level ✓ Locus of Control ✓ Local purchasing decisions 	<ul style="list-style-type: none"> ▪ Support and endorsement is required for successful implementation of changes. ▪ Note that special care needs to be taken to ensure rural hospitals have the opportunity to influence decision-

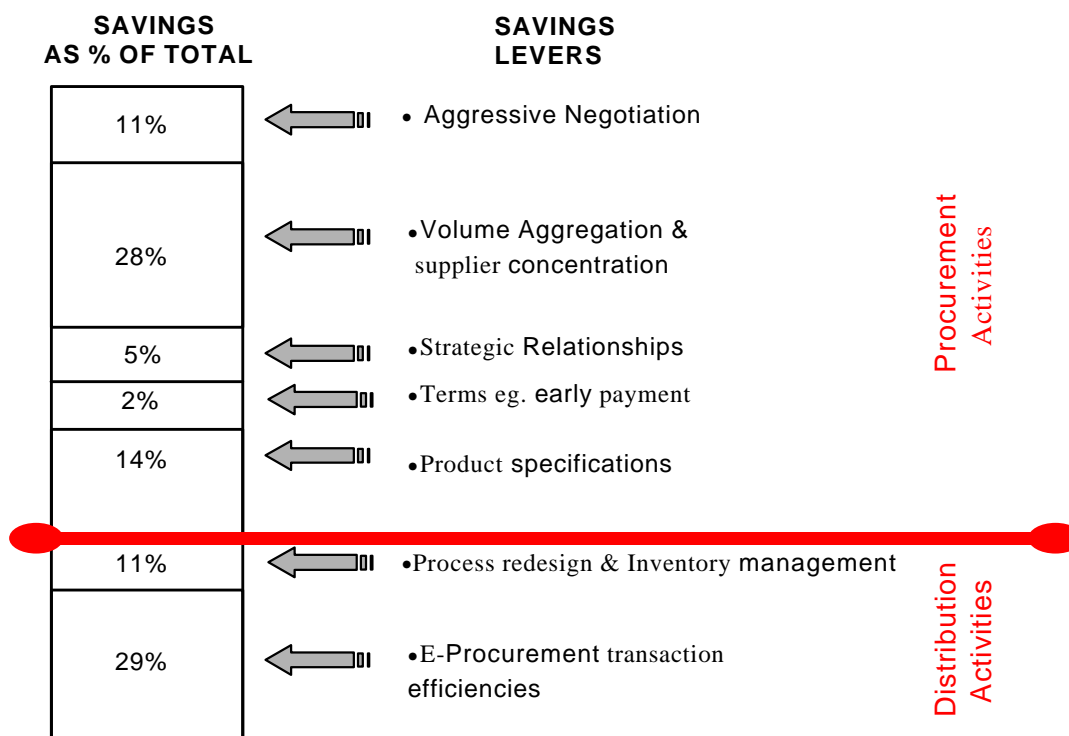
Stakeholder	Nature of Interest	Effect
IT and Systems departments	<ul style="list-style-type: none"> ✓ Control IT systems ✓ Cost of, and time to implement, new systems 	<ul style="list-style-type: none"> making processes. ▪ Ability to get data ▪ Ability to implement e-commerce solutions
Patients	<ul style="list-style-type: none"> ✓ Right product at right time 	<ul style="list-style-type: none"> ▪ Any special clinical requirements need to be considered and accommodated
Other Agencies e.g. Nursing Homes, Hostels, Ambulance, etc	<ul style="list-style-type: none"> ✓ Access to hospital purchasing power 	<ul style="list-style-type: none"> ▪ Unknown
Private not for profit providers	<ul style="list-style-type: none"> ✓ Access to contracts ✓ Maintenance of national arrangements e.g. CHA 	<ul style="list-style-type: none"> ▪ May be able to contribute to buying power
Other state purchasing organizations e.g. NSW Peak Purchasing Council, Queensland Health etc	<ul style="list-style-type: none"> ✓ Collaboration and cost sharing ✓ Possibility of multi-state tenders ✓ Standards issues e.g. EAN etc ✓ Catalog issues 	<ul style="list-style-type: none"> ▪ May offer volume opportunities ▪ Ability to share development costs 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 (i.e. procurement activities) 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.



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 primarily on the activities above the line.

Whilst the consultants that have provided this diagram estimate e-commerce savings to be of a slightly smaller quantum to those available through central purchasing, other reviews⁸ have estimated that substantially more savings are available through broad supply chain reform and, in particular, the implementation of e-commerce. Regardless of which view you accept, it is clear that supply chain management is moving into a dynamic phase where there are going to be considerable challenges that will need to be addressed and considerable rewards that can be harvested.

It is highly likely that the current system does not have the flexibility or structures 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 2-5 years. It is also apparent that large scale collaboration, on a whole of State basis, 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.

⁸ Reviews undertaken by KMPG and PriceWaterhouseCoopers

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 15) 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 within 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** – the model should be able to maximise the volumes/market share committed to contract so as to attract best pricing while remaining cognisant of clinical and other requirements.
- **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 41). It should be noted that these models are functional models and that issues relating to the organisational arrangements are addressed later in this paper under the heading Governance Issues on page 25.

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, VHA/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
Achievable in timeframe	<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 & implementation; requires transfer of some current local tendering and contracting functions to a central body⁹. 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>
Savings	<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.		
Buy in	<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 & 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		
Implement Supply Chain Reform	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.	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'.

⁹ Note that there would remain the need to retain local staff for hospital specific contracting activities.

Criteria	Co-ordinated Model	Centralised Model
Probity and transparency	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 external to the Board then a high level of scrutiny of the process can be exercised by the Board.	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 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.	
Maximise Volumes	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.	
Leverage off current systems	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.

4.3 Conclusion

In many areas the centralised and co-ordinated models would provide similar outcomes; however, there were several key areas where the co-ordinated model provided significant advantages, these included:

- Much greater flexibility in the development and implementation of purchasing arrangements including the ability to enter into collaborative tenders and agreements with a variety of parties including interstate purchasing organizations
- Minimal duplication of functions and staff between the purchasing organization and hospitals, VGPB, VHA etc. Ability to access expertise from hospitals, consultants, other States, VHA etc.
- Lower net costs of the co-ordinated model compared to centralised model
- Increased emphasis on co-operation and collaboration between hospitals and other agencies
- Ability of the co-ordinated model to be more responsive to the needs of hospitals and other customers.

At the workshop the members of the RPG expressed a preference for the co-ordinated model based.

5 Description of the Proposed (Co-ordinated) Model

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 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 to undertake specified State tenders would be negotiated with hospitals and other agents as a part of the development of a tender program.

The question of whether hospitals should be paid for acting as a lead agency has been raised and will need to be addressed by the Council. However, it could be anticipated that in most cases the costs associated with a hospital acting as a lead agency would not lead to any net increase in their overall tendering costs. The burden of tendering will be shared across many agencies and duplication of tenders across multiple agencies removed. It can also be argued that the costs of undertaking the lead agency role would be minimal compared to the benefits derived from locking state volumes in a tendering exercise.

At least initially, the main work undertaken 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 market share to contract pricing, this would be a key outcome of the new organization.

5.1 Significant issues

It is not appropriate to prejudge what decisions will be made by the new central contracting agency; however, there will be a number of important issues that will need to be considered by the agency soon after its establishment. Some of these issues include:

- The priorities that will be attached to various areas of operation i.e. which product lines should be targeted, what items should be tendered, how will a tender program be established, how should e-commerce (e.g. electronic catalogue, product numbering, data standards, etc) and other supply chain reform issues be addressed, etc?
- What process should be in place for mandating use of contract and what types of contracts should mandating apply too?
- How will the exemption process work for mandated 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?
- How will the continued provision of a one-stop warehouse/distribution service to rural hospitals be secured? The role that VHA/HSA will play in future tendering activity?
- Should lead agencies be reimbursed the cost of running state tender processes?
- What are the advantages of further co-operation with other states/organizations and how can it best be achieved?

In the lead up to the Council being established it would be appropriate for the Department of Human Services to develop position papers in areas that will be critical to the success of the new Council. In particular, the development of a tender program and the identification of mandating issues/models in consultation with hospitals, and particularly clinical staff, should be undertaken as soon as possible. In addition discussions should be held with VHA and HSA on the development of appropriate transition arrangements to ensure that hospitals maintain access to the same level of contracting and other services currently in place.

5.1.1 Issues re Victorian Healthcare Association and Hospital Supplies of Australia

Hospital Supplies of Australia¹⁰ is was established in 1938 as a trading division of the Victorian Healthcare Association. Since that time it has provided wholesaler and distribution services to Victorian Hospitals in the areas of pharmaceuticals and medical products. Over recent years, HSA has become the local representative of overseas manufacturers of some products and manages a cytotoxic service for Victorian hospitals. It also supplies a range of other general items (food stuffs, etc) used in hospitals. In providing these services HSA has undertaken a variety of tenders for goods on behalf of hospitals.

It is generally acknowledged that HSA plays a valuable role in the Victorian industry particularly in its 'one stop shop' service for rural hospitals. HSA is able to provide a service to rural hospitals that allows them to order a variety of products¹¹ in one order and have these delivered in the one shipment. It is considered that this service saves a significant amount of time in smaller hospitals and ensures that freight costs are kept to a minimum.

It is also generally accepted that HSA has had some very significant problems in service delivery over the past four years. However, anecdotal evidence suggests that, whilst there is still room for improvement, this has improved in the last twelve months.

Given this historic role of HSA in providing tendering services to some hospitals, the ownership of HSA by VHA, (ownership indirectly by the hospitals), HSA's longer term 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 (including agency arrangements and other 'commercial/competitive' activities) that need to be examined before determining what, if any role, HSA should continue to have in the tendering of hospital supplies.

Whatever arrangements are entered into with VHA/HSA, these should ensure that the expertise and knowledge in the area of tendering are preserved either in VHA or in another appropriate organization.

Assuming that a period of transition would apply, the Council would need to consider whether it is appropriate to undertake a competitive process¹² to determine whether VHA/HSA has an ongoing role in tendering. If HSA were involved undertaking/administering tenders, in any capacity, they would not be able to bid in a tender were they act as an agent or bid for any products or product groups that were the subject of that tender.

¹⁰ Previously known as VHA Trading

¹¹ This may also include breaking packs in the quantities suitable for small centres.

¹² A competitive tender or expressions of interest

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 to achieve the full potential to reduce costs and improve effectiveness, reform in all aspects of the chain from goods production through to consumption is needed. Notwithstanding this, it is also agreed that the operations of the Council should have as its major focus the achievement of best value pricing for medical consumables, pharmaceuticals and equipment.

The inclusion of services within the scope of the project should also be considered. Whilst services¹³ make up a fairly small component of expenditure there may be savings that can be achieved through collaborative purchasing of selected services.

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 also 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:

Tendering and Contracting	<ul style="list-style-type: none"> ▪ Identification of products, or classes of product, that should be tendered centrally. ▪ 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. ▪ Nomination of an agent(s) to undertake the tender on behalf of the Council ▪ Management of an exception process so that hospital may be exempted from using contracted products under certain circumstances
Policy and Guidelines	<ul style="list-style-type: none"> ▪ Development of policy and guidelines for purchasing in the health care sector including consideration of regional and industry development issues ▪ Development of common evaluation processes and documentation ▪ Development of common wording (templates) for contract documents (e.g. Conditions of Tender, Contracts, Expressions of Interest, etc)
Priority setting	<ul style="list-style-type: none"> ▪ 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.
Research and Analysis	<ul style="list-style-type: none"> ▪ 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.

¹³ 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"> ▪ Development of ongoing data collection and forecasting systems for product usage ▪ Development of a product evaluation database and product evaluation program.
Supply Chain Management	<ul style="list-style-type: none"> ▪ Identification and implementation (in conjunction with hospitals) of best practice supply chain management practices including the co-ordination of e-commerce initiatives in hospitals¹⁴ ▪ Sponsoring education and training activities.

More detail on the types of strategies that could be endorsed by the Council are outlined under in the Attachment: Purchasing Strategy on page 39.

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

6 Consultation

In November 2000 the PRG released a consultation paper¹⁵ including draft recommendations for the formation of a Health Purchasing Council. The paper was distributed to all public hospital CEOs, suppliers, industry and professional associations and the Victorian Trades Hall Council. The consultation paper was also available on the Department of Human Services web site. Presentations on the proposed purchasing arrangements were given to the Association of Hospital Supply and Purchasing Officers Annual Conference and a Medical Industries Association of Australia Conference.

6.1 Results of the consultation

Written and verbal comments were received from stakeholders representing all significant interests in the supply of good, services and equipment to hospitals. All Metropolitan Health Services provided comments and approximately 40% of rural hospitals provided either written or verbal comments. The comments received are summarised below:

- There was support from most stakeholders for the concept of centralized purchasing and a coordinated approach. Although many were concerned with the possibility of a reduction of hospital autonomy and control associated with mandated contracts. The ability to opt out of contracts for price and clinical reasons was also raised by many stakeholders.
- Several comments questioned whether the formation of a Council meant that there would not be efficient use of existing infrastructure and would lead to duplication of function. The issue of HSA's future was raised in this context, with one Metropolitan Health Service and one large regional hospital strongly supporting HSA and suggesting that it have the role of Victorian purchaser.
- From those rural areas that provided verbal or written comments, support for HSA was not high with one or two exceptions. Notwithstanding this, all of the rural hospitals who provided comments were very concerned to ensure that the one-stop shop approach to supply of goods (such as currently provided by HSA) continues to be available. There was no support for an increased role for HSA amongst metropolitan supply managers.
- There were a number of questions raised about what decisions the Council will make on issues such as:
 - What contracts would be mandated
 - How would the exemption process work
 - How would tenders be allocated to hospitals
 - Would individual hospitals be compensated if they paid more for a product but overall the State saved
 - How would the tender program be developed
- Suppliers and their associations were generally very supportive of the notion of a Health Purchasing Council.
- Many suppliers raised the issue of probity and transparency in tendering processes, particularly those tenders undertaken by HSA. They were concerned to ensure that appropriate arrangements were put in place to ensure that appropriate probity standards were in place and that processes were transparent.
- Hospitals and suppliers both raised the issue of HSA's activities in other states, and in supplying non-public hospitals in Victoria, as problematic and potentially presenting some conflict of interest issues. Much of this related to HSA's activities in tendering and in wholesaling/agency arrangements.
- Costs – one Metropolitan Health Service questioned the cost of the Council.

¹⁵ Future Procurement Arrangements in Victoria – Consultation Paper. November 2000

- Savings – the method of estimation, and quantum, of the savings was questioned particularly in the light of the dollar devaluation, increases in costs flowing through from labour cost increases, raw materials cost increases, etc.
- Council composition - A number of rural hospitals were concerned about representation for rural hospitals on the council particularly given the range of facilities that will need to be represented e.g. sites that range from small 10 bed MPS's through to the large regional health services such as Ballarat, Bendigo, Barwon etc.
- Questions were asked on how the council would achieve supply chain reform
- There was support for Clinical/Product Committees; however a number of stakeholders felt there should be more discussion on how these committees would function. A number of comments were raised about the problems in pursuing standardization of products and, in particular, how clinical buy in will be achieved.

6.2 Consideration of comments

The PRG considered the comments received at their meetings on 5 and 19 December 2000. VHA representatives were in attendance at the meeting on 5 December and were able to participate in the discussion regarding the future role of VHA and HSA. The principle issue that emerged from the consultation process was the potential to use VHA to undertake the role of purchaser instead of the establishment of a dedicated purchasing council. This issue is discussed in detail below under the heading Issues regarding the Victorian Healthcare Association.

Many of the other issues raised by the hospitals were about what decisions the Council would make in relation to particular issues or questions. Given the level of concern about these issues the PRG considered it would be appropriate for discussion papers to be prepared on the following issues in consultation with hospitals before the formation of the Council:

- Mandating of contracts
- Product exemption process
- Product Reference Groups responsibilities and operation

6.2.1 Issues regarding the Victorian Healthcare Association

The VHA was provided with a full briefing on the proposed procurement arrangements and a number of discussions held with members of the VHA Board. As a result of these discussions it was agreed that a small working party be formed from the PRG and the VHA to jointly examine whether it was feasible for the VHA to take on some, or all, of the role proposed for the Health Purchasing Council.

The working party examined a number of mechanisms by which VHA could undertake the central purchasing role and developed an assessment of the Council proposal in comparison with a VHA proposal in relation to the following criteria/issues:

- Legal/Power – how the organization would be empowered to undertake the role e.g. legislative basis etc
- Mechanism of contracting – what process would be put in place for contracting across the hospitals
- Costs – the cost of establishing and running each organization
- Control and input – how each of the organizations would be controlled and how decision making that is responsive to the needs of the hospitals would be achieved

- Clinician buy-in – how clinicians would be involved in decision making on product selection etc
- Provider Interface – how would the various health care organizations be involved including the role of product reference committees etc.
- Logistics – issues relating to the provision of a logistics services (warehousing and distribution), particularly to smaller rural agencies
- Conflict of interest issues – how any real or perceived conflict of interest issues would be managed.

A full copy of the matrix prepared by the VHA/PRG Working Group is at the Attachment: Comparison of Council and VHA models on page 45.

The working party reported to the PRG on 19 December 2000. After considering the report of the working party the PRG noted that that the functions in the Council model and the VHA model are essentially the same and that the major outstanding issues involve legal authority, transparency and the mechanism of contracting. Following the receipt of legal advice (see discussion under the heading Governance Issues on page 25) on the outstanding issues the PRG concluded that VHA option had significant legal and operational complexities and was, essentially, unworkable.

7 Governance Issues

There are two related but separate issues 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, and the ability to mandate contracts; and,
- The structure that will be in place to govern the organization.

7.1 How should functions be characterised?

In reviewing how the organization will be structured and how it will gain its authority to operate it is appropriate to broadly categorise the proposed functions of the new organization. The functions proposed for the new organization include:

- **Policy Development and implementation:** the organization would be **a policy maker** with the power to set both 'high level' and operational policy. High level policy functions include responsibility for setting probity standards applicable across the whole of the publicly funded hospital sector, developing policy and guidelines for purchasing (including mandating and exempting contracts), making policy with respect to market and competition issues and regional and industry development issues;
- **Purchasing:** the organization would be **a purchaser** of defined goods and services for the publicly funded hospital sector with the power to negotiate and enter into binding contracts on their behalf; and
- **Regulation:** the organization could also be considered **a regulator**, with responsibility for monitoring compliance with its own and broader Government policies and guidelines and taking action where a breach occurs.

7.2 Options for establishing the purchasing organization

There are two options open to the Government in establishing a centralised purchasing organization, these are:

- Option 1 - Create a public statutory body (Council or Board) with defined powers and functions; or,
- Option 2 - Utilise an existing corporation (such as the Victorian Healthcare Association¹⁶) or establish a new corporation under the Corporations Law that is 'owned' by funded health care agencies.

7.3 Discussion of the options

When considering the most suitable option, it is important to ensure that:

- The organization is able to operate efficiently, effectively and transparently;
- Potential conflicts of interest are identified and managed;
- There are transparent mechanisms for dealing fairly with minority group interests or concerns;

¹⁶ VHA is a company limited by guarantee with membership including public hospitals, community health care centres and private not for profit hospitals

- The organization operates within the framework of the policies of the Government and that Government policy objectives (including State wide industry policy objectives) are achieved effectively and efficiently;
- State control over purchasing policy is exerted legitimately where necessary in the interests of the community as a whole; and
- Exposure to risk is minimised.

7.3.1 Option 1 – Statutory Body

The features of the Public Statutory Body include:

- Clearly defined statutory powers which would enable the organization to:
 - enter into binding contracts on behalf of defined classes of publicly funded hospitals – thus avoiding the need for centrally negotiated contracts to be signed off by each individual agency;
 - Mandate and exempt usage of certain contracts by hospitals
- High level policy functions would be carried out by a body with the legitimacy to undertake this role and clear lines of accountability to the Government;
- The capacity to consider broader Government policy objectives (such as industry and regional development issues) would be legitimately part of the body's charter;
- As a statutory body separate from funded agencies, the potential for conflicts of interest would be minimized;
- Ultimately, the State Government would be the regulator – not ASIC; and
- It may be possible to structure a statutory body so that its activities are not subject to the operation of the Trade Practices Act (however, thorough consideration of policy and legal issues is required should this be desirable).

The main disadvantage associated with a statutory body is that it can be less flexible than a corporate body as its functions are subject to legislation. Depending on how prescriptive the legislation is, it can be harder to respond to changes in the purchasing/health environment without changing the legislation.

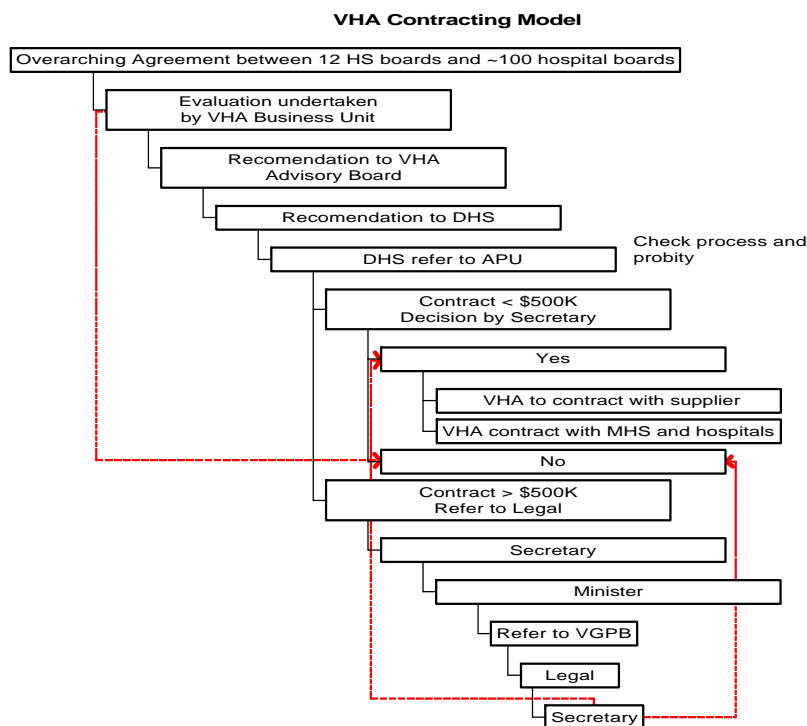
7.3.2 Option 2 – Corporate Body

The main advantage for a corporate organization is that it could be more responsive to the needs of the hospitals as it would be directly 'owned' and controlled by the hospitals. In addition, if the VHA were to undertake the purchasing role they could also make use of infrastructure already in place. This would be achieved at a slightly lower cost than statutory authority model (estimated at \$40-50K p.a.).

There are a number of significant legal and operational difficulties associated with the operation of a corporate body, particularly where it is a policy development and implementation body as opposed to a group buying organization. The corporate model exists to serve the needs of its owners/shareholders, not to perform high-level policy functions on behalf of the State. The State would have considerable difficulty exerting control over a corporation established by health care agencies where public interest considerations are prevalent.

Other disadvantages of Option 2 include:

- No ability to directly contract with suppliers on behalf of hospitals. 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. Contracts would need to go through the Department of Human Services and the Victorian Government Purchasing Board or back to each of the Metropolitan Health Service and rural hospital boards to be authorized. Alternatively Boards could contract individually with suppliers rather than a central body on behalf of hospitals. Either process would be an administratively complex arrangement (see flow chart below) with either duplication of contracting at each MHS/hospital or the involvement of multiple levels of approval. This process could potentially lead to conflict and would significantly increase the time required to put a contract in place. In a worst case scenario the process could be virtually unworkable.



- No power over hospitals that are not members/shareholders of the corporation. (Government would not mandate membership of any particular organization or corporation);
- No clear charter to consider broader policy issues such as industry development issues in its decision making process – it would be bound to act in the interests of majority members/shareholders according to its articles;
- No clear accountability mechanism to Government;
- Minority members/shareholders (e.g. small rural hospitals) would have no direct way of ensuring their interests are adequately addressed (other than resigning their membership and thereby relinquishing ownership);

- Ministerial powers of direction over a corporation are problematic under Corporations Law. If interventionist, the Minister could potentially be deemed to be a director and exposed to the risk of penalties for breach of the Corporations Law. The Board of a corporation could well be faced with conflicting interests – Government interests versus interests of majority members/shareholders. Any Government influence could only occur indirectly rather than directly;
- Mechanism for regulation of a corporation is Corporations Law and the regulator is ASIC, not the State Government; and
- A corporation is subject to Trade Practices Act and as a consequence, is the subject of ongoing scrutiny by the ACCC in relation to market power issues.

7.3.3 Summary

Given that the Network Review recommended that a purchasing model that facilitated mandating of contracts, as compared to a group buying organization with voluntary compliance, should be put in place, the PRG considered that the statutory model is the simplest and allows for the proper attention to high level policy, standards, industry development and regulation. Authority to enter into legal agreements would be facilitated and governed by legislation, which would remove the complications associated with multiple hospital boards involvement and referral to DHS/VGPB.

Given the practical difficulties associated with operating and contracting under the corporate model it could be expected that savings would be lower, or at least more difficult to achieve, compared to an organization operating with statutory powers that has the ability to contract directly on behalf of all hospitals. There are also substantial disadvantages and risks associated with acting under Corporations Law compared with a statutory authority. As it would be established under State legislation, competition and trade practices issues would also be less problematic than if the organization was established under corporations law.

Given the limitations, potential problems and risks associated with using a corporation the establishment of a statutory authority is considered to be the only feasible approach.

7.4 Council and support structures

Having determined that a statutory authority is the appropriate legal mechanism for the purchasing organization the actual composition of that Authority needs to be determined. The Authority would take the form of a board or council with members appointed by the Minister or Governor in Council. It is proposed that the new authority be called the Health Purchasing Council (“the Council”).

The PRG considered it essential that:

- The Council is mainly comprised of current public hospital staff that understand the clinical and other unique health care issues that relate to purchasing.
- At least two representatives on the council should be at CEO level to ensure appropriate feedback and communication with senior hospital managers.
- Due regard is given to the need to have expertise in logistics and clinical representation on the council.
- An appropriate mix of representatives from small, medium and large rural and metropolitan hospitals have membership

The PRG considers that the most appropriate Council would be made up of eight members who would be appointed for terms of up to three years by the Governor in Council. This number allows the council to operate effectively whilst ensuring that representation is fairly spread amongst rural and metro areas and hospitals of varying size and organization.

7.4.1 Council membership

In determining the composition of the Council, an appropriate blend of expertise will be required to consider issues including clinical application, competition and industry development, probity and IT standards, e-business issues, and so on. Given the wide range of issues across a variety of specialities it is suggested that a mix of clinical and non-clinical members be considered in appointing the members of the Council. Organizations such as DHS, DTF (VGPB) also have a significant interest in the outcome of council and a such should be represented. Using the principal stakeholders identified on page 11, the table below examines whether it is appropriate for each category of stakeholder to be represented on the Council.

Stakeholder category	
Metropolitan Health Services	It is expected that purchases by MHS will represent approximately 75% of the purchases that will be made under central contracts. MHS will have a substantial role in the administration of tenders and contracts. It is also expected that e-business initiatives will have a significant impact on the way that goods and services are procured in hospitals in the next few years. Clearly MHS are a very important customer and partner to the Council and as such should be represented.
Rural Hospitals	Whilst rural hospitals represent a smaller proportion of Council business compared to MHS they have special needs and circumstances that require representation at Council level.
Clinical Staff	Nursing, pharmacology and medical staff are key stakeholders in product selection decisions. These stakeholders will be members of various product reference groups that will be formed to manage tender and contracting processes for particular product categories. Notwithstanding this it is considered that some clinical representation on the Council would be desirable.
DHS	DHS as the funder of hospital services has a key interest in ensuring that hospitals supply chain management practices are as efficient and effective as possible and that best value is achieved in product selection and purchasing. It is considered appropriate that there be one member on the Council representing DHS and the Government generally.
DTF/VGPB	It is expected that there are benefits to be gained through increasing co-operation with VGPB in the purchasing of non-clinical items. VGPB also has a role in the monitoring of purchasing in the Government sector to ensure that appropriate probity standards etc are in place. Given this it would be appropriate and beneficial to have a DTF/VGPB representative on the Council.

Suppliers, wholesalers, etc	There would be a conflict of interest if a supplier's representative were included on the Council. The Council could put mechanisms in place to ensure that regular consultation occurred with suppliers and their peak organizations.
VHA	VHA is the owner of HSA and, therefore, it is not appropriate that they be represented on the Council.
Clients/Patients/Consumers	Patients certainly have a stake in ensuring that appropriate supplies are available for their care in hospitals; however, given that the council is mainly concerned with operational management issues and consumers have a voice through health service boards and their advisory committees it would be inappropriate to include them on the Council.

It is recommended that the Council comprise eight members; however, it may be appropriate to appoint up to two additional members where it is considered expertise in the clinical or other areas is not available within the membership of the Council.

The recommended Board structure is set out below:

One 'independent' Chair appointed by the Minister from the health sector
Three MHS Representatives including one Metropolitan Health Service CEO

- Two Rural Hospital Representatives including one rural public hospital CEO
- 1 DHS Representative
- 1 DTF Representative
- Up to two further members appointed by the Minister where additional clinical or other expertise is required.

Nominations for the Board could be received from Hospitals and other health service providers.

7.4.2 Council secretariat

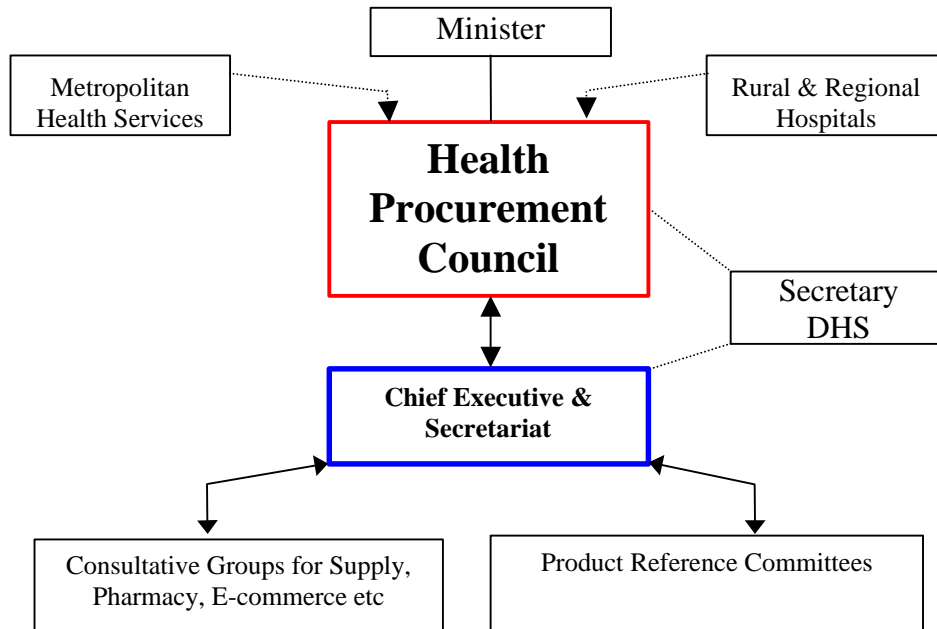
A Secretariat to support the operations of the Council would also need to be established. Given the range of functions and workload involved it is recommended that the Secretariat comprise:

- An Executive Director - responsible to the Council for the operations of the Secretariat.
- Three project managers - cover the areas of tendering/contracting, administration & technology (e.g. web site and e-commerce development etc), and clinical coordination¹⁷.
- Product Reference Committees - either standing committees, or formed as required, 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 Council project managers and membership drawn from appropriate staff including clinical staff nominated by hospitals.
- Consultative/Advisory Groups - Supply Managers and Chief Pharmacists to facilitate communication and co-operation between hospitals. Additional groups could be constituted as required (eg, e-commerce).

¹⁷ Whilst each project manager would have defined areas of accountability and expertise they would work seamlessly across all areas of Council operations

- An administrative officer - support to the Council/secretariat.
- 1-2 Data Analysts¹⁸ - 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 as required.

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



The PRG considered that, in order to facilitate communication with the hospitals and to 'send the message' that the Council would be working closing with, and for, the hospitals that the Council should be accommodated if possible on hospital premises.

¹⁸ These positions may become unnecessary as data collection systems become more accurate and effective.

8 Cost and funding issues

8.1 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 \$30,000¹⁹ in year one and \$10-15,000 thereafter.

8.1.1 Summary of estimated budget costs

Operating costs	\$950,000
One-off establishment costs	\$85,000

8.2 Savings and performance monitoring

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 accepted²⁰. It should be noted that a significant upfront investment will be required in hospitals systems infrastructure and major process redesign to enable these savings to be fully 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. The Council would also be required to report to hospitals on a regular basis on its operations and against agreed performance indicators.

8.3 Funding

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

- Direct or indirect funding from the hospitals via a levy on the hospitals or suppliers rebate, or levy on purchases.
- A direct budget allocation from DHS²¹; or,

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

¹⁹ Dependant on the facilities, cabling, phone systems in place

²⁰ Note some of the reports predict savings of up to 20% in this area.

²¹ 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.

The direct budget allocation is the simplest and easiest method of funding. Accountability issues would be addressed via the development of an agreed business plan (including performance indicators) and by reporting arrangements to the 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.

8.4 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, 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 months²², 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

²² Reports are being received of many suppliers increasing pricing by up to 10% (as at December 2000)

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.

9 Implementation of the Preferred Model

Key Implementation Tasks and timelines

Task	Timeframe	Issues
Enabling legislation <ul style="list-style-type: none"> ▪ Instructions to draftsman ▪ Cabinet approval ▪ Introduce ▪ Enact 	Autumn sitting January 01 January 01 April 01 June 01	
Staffing <ul style="list-style-type: none"> ▪ Appoint Temporary Staff ▪ Commence Permanent recruitment ▪ Complete Permanent appointments 	February 01 June 01 August 01	
Accommodation <ul style="list-style-type: none"> ▪ Temporary accommodation (if necessary) ▪ Permanent accommodation 	February 01 June 01	It would be expected the Council would be accommodated on a suitable hospital site.
<ul style="list-style-type: none"> ▪ Administrative Systems (Accounting, etc) 		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	December 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"> ▪ Website Stage One – information ▪ Website Stage Two – contract data ▪ Website Stage Three – Tendering system ▪ List server ▪ E-commerce systems 	December 00/January 01 June 01 December 01 ²³ 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"> ▪ Call for nominations ▪ Appoint Chairperson ▪ Appoint members 	April 01 May-June 01 June 01	Dependant on the timing of the legislation
Budget and Funding Processes <ul style="list-style-type: none"> ▪ Finalise Budget 	January 01	

²³ Note that it may be possible to co-operate with another State in implementing this system

10 Recommendations

The PRG has determined to make the following draft recommendations to the Government with respect to the implementation of central purchasing in public hospitals in Victoria.

1. That a Health Purchasing Council (the Council) be established on 1 July 2001 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. Where appropriate the Council should also facilitate access for all publicly funded health agencies to central purchasing contracts.
2. 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 the Council have regard to:
 - i. Clinical needs of patients.
 - ii. Local hospital conditions and requirements.
 - iii. Ability of the suppliers to supply the goods as required by the hospitals.
 - iv. Market and competition issues including the effect of tenders/contracts on the viability of Small and Medium Enterprises (SMEs).
 - v. Regional, industry development and local content issues.
 - b. Promoting 'best value' purchasing by hospitals. In determining 'best value' the Council should consider issues relating to clinical need, price (including whole of life costs) and quality of the services, equipment or goods.
 - c. Promoting collaboration and cooperation between hospitals and with purchasing organizations within, and external to, Victoria, in purchasing, and supply chain management/reform.
 - d. Ensuring that probity is maintained in tendering and contracting activities and that these processes are as transparent as possible.
 - e. Promoting and, where appropriate, implementing best practice supply chain management including e-business initiatives.
 - f. Promoting the use of Victorian Government Purchasing Board (VGPB) 'common use contracts' in partnership with the VGPB.
 - g. In consultation with the VGPB, relevant State Departments/Agencies (e.g. State Development and hospitals, the development of purchasing principles, risk analysis principles, standards, policies and guidelines.
 - h. In consultation with hospitals the development of an annual business plan incorporating a 3-year Rolling Tender Program and Key Performance Indicators.
 - g. Reporting on activities on an agreed basis to hospitals and the Department of Human Services.
3. That legislation be developed, for consideration in the Autumn sitting, to:
 - a. Authorise and facilitate the operation of the Council including the formation of the Council and Product Reference Groups and the employment of Council staff.
 - b. Enable tendering and contracting by the Council on behalf of Victorian Public Hospitals and Metropolitan Health Services
 - c. Provide the power for the Council to make statutory directions with respect to:
 - i. Purchasing and supply arrangements in Hospitals and Health Services,
 - ii. Mandating contracts including the ability to grant exemptions to hospitals from certain contracts where appropriate clinical and other circumstances exist
 - iii. Determining and implementing of standards and policies relating to purchasing of goods, services and equipment in public hospitals.

4. That, to ensure broad representation from the hospital industry, the Council comprise at least eight and no more than ten members appointed by the Governor in Council. Terms of appointment should be for a maximum of three years with members being eligible for reappointment.
5. That the Council include:
 - a. Three people currently employed by a Metropolitan Health Services one of whom will be a CEO of a Metropolitan Health Service.
 - b. Two people currently employed by a rural hospital one of which will be a CEO of a Rural (Public) Hospital.
 - c. One person nominated by the Department of Treasury and Finance to represent both the Department and the Victorian Government Purchasing Board.
 - d. One person nominated by the Department of Human Services.
 - e. A chairperson, and up to two other members, with expertise in the healthcare industry.
 - f. It is further recommended that the Minister, in selecting members of the Council, consider the need to have clinical expertise on the Council.
6. That if a member of the Council, who is nominated to represent either the Metropolitan Health Services or Rural Hospitals, ceases to be employed within the public hospital sector for a period of more than 3 months that he or she automatically cease to be a member of the Council.
7. That, recognising a variety of contracts are already in place and the lead-time required to develop new tenders and contracts, transition arrangements be put in place for the first two years of the operation of the Council. As a part of the transition, and subject to further discussions with Victorian Healthcare Association (VHA), it is expected that these arrangements would include:
 - a. The continuation of the current pharmacy tendering and contractual arrangements with VHA for a period of two years from 1 July 2001 at which time the arrangements would be reviewed by the Council.
 - b. The current Hospital Supplies of Australia (HSA) Pharmacy Advisory Committee becoming a Council Product Reference Group
 - c. For a period of two years, VHA and others will be used for tenders for non-pharmacy medical consumables (subject to conditions relating to conflict of interest, probity requirements, expertise in the area, cost effectiveness, etc being met). The provision of distribution/warehouse services would be considered separately by the Council on a tender-by-tender basis. It is also recognised that there may be occasions where it will be appropriate to undertake joint tenders or other purchasing arrangements with other government bodies
 - d. Current HSA contracts be recognised by the Council but that there be no compulsion on hospitals to purchase from these contracts as they currently stand. These contracts to be reviewed by the Council on their expiration/termination to determine whether they are retendered as Council contracts.
 - e. Discussions take place with hospitals' purchasing areas, Victorian Healthcare Association and other State purchasing organizations to ensure that appropriate use is made of expertise and knowledge available within the industry.
8. That a secretariat be established as soon as possible to support the Council.
9. That funding for the Council is via a direct allocation from DHS for the first three years of operation (additional Budget funding would not be required).

10. That before the completion of three years of operation, and in conjunction with a full review of the Council's operation and performance, the funding mechanism be reviewed to determine the most appropriate method of Council funding.
11. That the Hospitals 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.

11 Attachment: Purchasing Strategy

Area	Strategy	Timeframe
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
Policy and Standards	▪ Development of policy and guidelines for purchasing in the health care sector including consideration of regional and industry development issues	M
	▪ Development of common evaluation processes and documentation	S-M
	▪ Development of common wording (templates) for contract documents (e.g. Conditions of Tender, Contracts, Expressions of Interest, etc)	S-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	• Identity unnecessary supplier costs	S-M
	• Common: <ul style="list-style-type: none"> o Conditions of tenders o Contract terms and conditions o Evaluation criteria o Product specifications 	S S S S-M
	• Longer contracts	S-M
	• Reductions in number of tenders	S-M
	• Rationalised ordering arrangements	M

Area	Strategy	Timeframe
	<ul style="list-style-type: none"> • Product standardisation where appropriate 	M-L
	<ul style="list-style-type: none"> • Better forecasting of demand 	M
	<ul style="list-style-type: none"> • Better inventory management, reduced holdings 	M
	<ul style="list-style-type: none"> • Common numbering standards and bar-coding 	M-L
	<ul style="list-style-type: none"> • Standard State/National Catalogue 	M-L
	<ul style="list-style-type: none"> • Payment terms – discounts for shorter terms 	S-M
	<ul style="list-style-type: none"> • Sharing of product evaluation information – reductions in number of evaluations 	S-M
	<ul style="list-style-type: none"> • Rationalise contract management arrangements 	M
Supply chain management	<ul style="list-style-type: none"> • Internal and external prime vendor strategies 	S-M
	<ul style="list-style-type: none"> • Supplier managed inventory, consignment etc 	M
	<ul style="list-style-type: none"> • Warehouse rationalisation, regional/MHS supply services 	M-L
	<ul style="list-style-type: none"> • Education, training and consultancy in supply chain management 	S-M
	<ul style="list-style-type: none"> • Communication and Awareness processes 	S

Timeframe

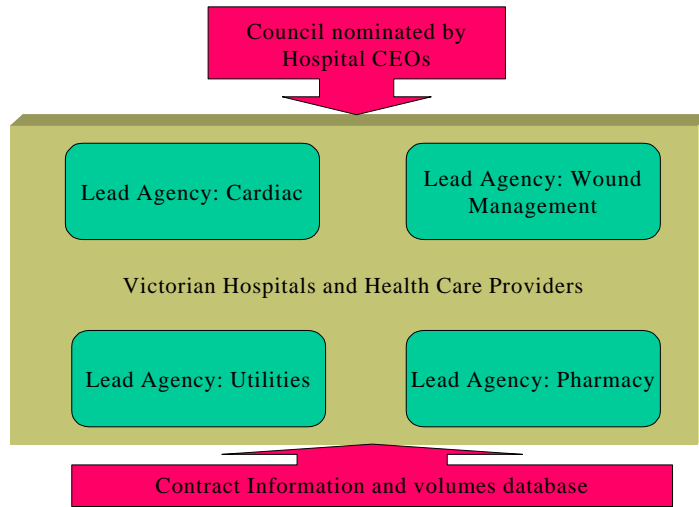
S = short term 12 months

M= medium term up to 3 years

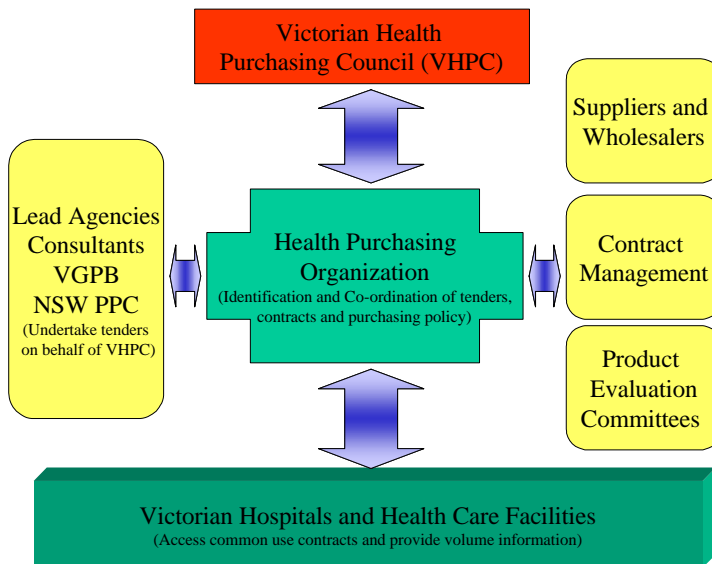
L= long term 3-5 years

12 Attachment: Diagrammatic Representations of Purchasing Models

12.1 'Virtual' model



12.2 Co-ordination model



12.3 Central purchasing board model



13 Attachment: PRG Membership²⁴

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

²⁴ as at December 2000

14 Attachment: Definitions

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.²⁵

E-commerce is any type of business transaction or interaction in which the participants operate or transact business or conduct their trade electronically.²⁶

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.

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.

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 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.²⁷ 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.

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 coordinates and integrates all of supply chain activities into a seamless process, linking and embracing all of the partners in the chain. Supply chain management looks at the network as a whole. It includes not only relationships with other functions within an organisation but also with all trading partner relationships outside the organization

²⁵ *Glossary of Purchasing and Materials Management*, Central Queensland University

²⁶ NOIE, 1999

²⁷ VGPB Panel Common Use Arrangements

15 Attachment: 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
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 up to 500 people) ²⁸
VGPB	Victorian Government Purchasing Board, also known as the Procurement Branch, Department of Treasury and Finance

²⁸ *Where to Go, How to Get There*, DOCITA 1998

16 Attachment: Comparison of Council and VHA models

	<u>Council</u>		<u>VHA</u>	
	Pro's	Con's	Pro's	Con's
Legal/Power	<ul style="list-style-type: none"> Statutory Authority Operates dedicated legislation Powers specified by Act 		<ul style="list-style-type: none"> Government/Boards appoint VHA as agent; or Statutory Power to VHA; or, Contracts between VHA and Boards/Hospitals Recommendations to Secretary and HS Act used to mandate 	
	<ul style="list-style-type: none"> Clearly defined powers Checks and balances can be built into Act Clear accountability to Government and Parliament for outcomes. Organization cannot be substantially/significantly changed without Government approval No issues associated with ability of council to act and enforce contracts 	<ul style="list-style-type: none"> May not be as flexible as VHA model if Act strictly defines processes 	<ul style="list-style-type: none"> May have greater flexibility to change organization to meet needs of the sector 	<ul style="list-style-type: none"> May be very administratively difficult to manage contract and mandating processes with each hospital and the DHS Secretary Minister/Secretary may want arms length relationship with purchasing decisions and not exercise contracting powers. Alternatively Minister/Secretary may want each contract to go through the Accredited Purchasing Unit. Control of mandating is removed from hospital control i.e. DHS Secretary directs Problems associated with a private company (i.e. non government body) exercising statutory financial delegations
Mechanism of contracting	<ul style="list-style-type: none"> Council contract on behalf of Hospitals Risk associated with non compliance with hospitals 		<ul style="list-style-type: none"> VHA acts as agent and contracts on behalf of hospitals, risk/ liability associated with contract rests with hospitals; or, Suppliers contract with VHA and another contract is put in place between VHA and hospitals (modified CPP model). Risk/liability in this instance would be with VHA although VHA may be able to transfer some/all of that risk to hospitals via contract. There would be some form of overarching legal agreement (with a schedule, that can be amended, listing agreed contracted items) between hospitals and VHA to facilitate this. 	
	<ul style="list-style-type: none"> Legislation provides for the Hospital to be a party to the contract with supplier 		<ul style="list-style-type: none"> If VHA can act as an agent i.e. hospital becomes a party to the contract with supplier 	<ul style="list-style-type: none"> Agreement would need to be negotiated with 130 boards on a regular basis. If VHA is unable to act as an agent then VHA is the party to the contract with the supplier.

	Council		VHA	
	Pro's	Con's	Pro's	Con's
Costs	<ul style="list-style-type: none"> Similar cost of operation in either organization 			
	<ul style="list-style-type: none"> Greater establishment costs 	<ul style="list-style-type: none"> Slightly higher establishment costs (\$50-60K one off cost) 	<ul style="list-style-type: none"> Minimal establishment costs and no accommodation rental costs 	<ul style="list-style-type: none">
	<ul style="list-style-type: none"> If sited at a hospital admin costs would be reduced (although hospital may want some reimbursement of their costs) 		<ul style="list-style-type: none"> Slightly lower establishment costs as VHA already have some capacity to accommodate unit No need to purchase equipment such as photocopier, telephone system, etc VHA can provide some admin support e.g. receptionist, etc. May save \$50-60K one off cost and ~\$15-25K pa thereafter. 	
Control and Input	<ul style="list-style-type: none"> All council members, except 2 appointments from Government, are hospital representatives and would need to be employed in the industry Need to look at how nominations are called for the council i.e. what qualifications members should have or who can nominate Council independent from considerations related to an organization with other roles. 		<ul style="list-style-type: none"> Can be argued that VHA model will continue to be more responsive as VHA is a representative body What is the relationship between VHA Board and the purchasing board – how independent can an advisory model be in a VHA structure 	
	<ul style="list-style-type: none"> Hospital would have control of the Council through their majority representation Legislation could be structured to ensure that current members of the Council are hospital staff and could, for example, specify that one metro and one rural CEO be members of the Council or specified organizations could be asked to nominate some of the members. 	<ul style="list-style-type: none"> The Minister and not the hospitals would have the final say in membership of council 	<ul style="list-style-type: none"> The Minister would not have the final say in membership of the VHA tender advisory board. Although the Minister could have an input to this process. As part of arrangement, Minister might require say in some of the appointments. 	
Clinician Buy in	<ul style="list-style-type: none"> Clinician buy in should be similar in both organizations. 			
	<ul style="list-style-type: none"> Clinician buy in through product and clinical committees 		<ul style="list-style-type: none"> Clinicians already involved in VHA processes Clinician buy in through product and clinical committees 	
			<ul style="list-style-type: none"> Could be argued that clinical buy-in could be greater through VHA 	

	<u>Council</u>		<u>VHA</u>	
	Pro's	Con's	Pro's	Con's
Provider interface	<ul style="list-style-type: none"> Product/clinical committees Supply Managers, Pharmacy Directors etc groups All councillors apart from 2 government reps nominated from industry 		<ul style="list-style-type: none"> Interfaces with industry already in place e.g. Product/clinical committees Division structure facilitates feedback from different sectors with hospital/health industry 	<ul style="list-style-type: none"> Some risk that some sectors may be able to influence decisions more than can be justified on clinical, financial or other grounds by virtue that VHA is a membership based organization. Could also argue the contrary, that VHA by its governance/membership structure would ensure that all interests are taken into account/heard
	<ul style="list-style-type: none"> Greater overhead involved in ensuring different sectors (e.g. small rurals, etc) can have input. 			
Logistics	<ul style="list-style-type: none"> Either model could lock in volume and price subject to power/authority issues <ul style="list-style-type: none"> FIS, FOB via HSA or direct 			
	<ul style="list-style-type: none"> HSA is one of a number of options 		<ul style="list-style-type: none"> Decisions are made by the users therefore the best value decision is made in relation to distribution. There is an argument that there is less flexibility with VHA having both tendering and HSA; however, CPP may not support this argument i.e. user decide best value without fear or favour i.e. it is their bottom line 	
	<ul style="list-style-type: none"> Council select the most appropriate distributor with out the complication of owning one of the distributors 			
Conflict of Interest (real or perceived)	<ul style="list-style-type: none"> No conflict of interest issues Totally transparent processes 		<ul style="list-style-type: none"> Ownership of HSA may lead to conflict of interest (perceived or real) 	
	<ul style="list-style-type: none"> No conflict of interest issues Council able to deal with decision where someone will be disadvantaged regardless of the decision outcome i.e. rural metro cost issues 			<ul style="list-style-type: none"> There is at least a perceived conflict of interest. This may be able to be addressed through market testing, transparency of charging by HSA and organizational arrangements which make the decision making process totally independent of the VHA Board. HSA may be paralysed from acting where one section of its membership may be disadvantaged by a particular decision; e.g. a decision that would have a negative financial impact on one group of members.