

Juergen Stoll

The Public Health Sector in Transition

Strategic Challenges and Future
Opportunities of Purchasing Institutions
within the Hospital Market in Germany



HealthCorp Partners
Executive Search & Management Consulting

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Foreword

The term "health economy" has become a fully established term in the public health care scene. It's a term that is made common use of in politics, where a fair amount of initiatives deal with this topic, which is one of great importance to society.

There are currently worthwhile and promising project activities being conducted not only in the health care ministry, but rather also in the ministries for economics, education and research.

The increasing need for health care services and the resources available for them, which continue to become more and more financially limited, often still lead to a lopsided discussion on actual costs and benefits for people.

A boon for the population that will remain at the highest level in health care provision and will lead to possible growth opportunities in the industry sector should enjoy an even greater focus.

A prerequisite for this is that all players in the health care sector work with the available resources under the primacy of quality and economic efficiency. This absolutely requires that, for example, the procurement of medical supplies in health care facilities be organized intelligently.

The users – physicians and nurses – must, together with those holding economic responsibility as well as other participants (industry, service providers and so on), look for better solutions. In order to be able to live up to the enormous complexity of the procurement of medical supplies, which will only increase in the future, the supportive measures of purchasing institutions will grow in importance. Their role as a “bridge builder” between health care institutions and individual suppliers and manufacturers consists of numerous tasks. In addition to the general market observations – both local and global – the focus in the procurement process must go far beyond simply "making purchases" at the best possible prices.

The holistic view of procurement processes and also the full understanding of the treatment costs (total cost of ownership) create data and facts that make it possible to transparently evaluate the economic efficiency of a service. Based on this, founded entrepreneurial decisions can be made. These then ensure that the personal and financial resources are made use of such that increases in productivity can occur in the health care sector.

In order to be able to make use of the medical progress, thus to give as many people as possible access to innovative treatment methods and products in a timely manner, we must find the will for a change and most importantly, the unrestricted readiness of all who participate to interact in an open and honest dialog.

The publication "The Public Health Sector in Transition: Strategic Challenges and Future Opportunities of Purchasing Institutions within the Hospital Market in Germany" is a work I see as one that uniquely and comprehensively describes the situation with respect to procurement management within the health care sector and displays opportunities and pathways towards realizing a level-headed patient-oriented, quality-conscious and economical course of action in this segment.

September 2012

Munich, Germany

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1. Introduction

1.1 Problems, Statements and Goals

Health is an intrinsic human right as well as a central driver in building a foundation for a wealthy community. Health effects global socioeconomic development. Therefore, health care is a big business and is present in the mind of every individual. In most of the mature economies around the world, health care is the biggest industrial sector. In addition, health care has a huge impact on employment due to the fact that most related activities are provided by people. Health care expenditure is growing rapidly. In this context, countries spend a substantial amount of the Gross Domestic Product (GDP) on health. In all OECD (Organization for Economic Co-Operation and Development) countries, the total spending on healthcare is rising faster than economic growth. In 2008, OECD countries devoted 9.0% of their GDP to health care spending (OECD Health Data, 2010). Recently, the German Federal Statistical Office (Destatis *Health Expenditure*, 2011) reported that the expenditure on health in Germany totaled Euro 278.3 billion in 2009. Compared with the previous year, this reflects an increase by Euro 13.8 billion (or 5.2%). As a result, 2009 health care spending as a ratio of GDP increased to 11.6% in Germany (2008: 10.7%).

Therefore, many countries currently face difficult challenges and choices in financing their public health care system. New drugs, technological innovations and scientific breakthroughs in many special medical fields (for example, oncology or cardiac diseases) continually expand the range of health problems that can be treated. At the same time, ageing populations and rising expectations create upward pressure on costs, which stretch the limits of a country's ability to find adequate funding. Macroeconomics, demographics and financial capacity place constraints on a government's ability to improve the efficiency and effectiveness of their respective public health care system. As a result, all countries – whether high, medium or low income – seek to improve the cost structure by applying new health care concepts without limiting the performance of the public health sector (World Health Organization, 2008).

However, reforming the health care system without understanding the relevant costs and how to measure them is an issue. “(...) we do not know the total cost that health care providers incur to deliver care for patients’ medical problems (...).What’s obscure is the full cost of treating the patient’s problem (...). If we truly want to understand costs and where they can be reduced without compromising outcomes, we need to aggregate costs around patient cases.” (Porter 2011, 49-50).

Furthermore, an effective and efficient public health sector is a fundamental parameter for competing economies. Hence, many stakeholders are eager to establish themselves in this field – payors such as governments and insurance companies, as well as general practitioners or hospitals, which function as providers.

There is no doubt that the hospital sector is one of the cost drivers within the German health care system. Overall expenditures in 2009 increased 6.1% or Euro 4.5 billion to Euro 77.1 billion in total for currently 2’084 hospitals in Germany compared to the previous year, as stated by the German Federal Statistical Office in a press release in March 2011 (inpatient hospital care including payments to the education fund alone accounted for EUR 67.2 billion of this figure; ambulatory care, science and education are adding another Euro 9.9 billion to the hospital expenses)¹. Labor costs increased by 5.7% to Euro 45.8 billion and non-labor costs (medical supplies, energy, food and so on) increased by 7.0% to Euro 29.3 billion. Consequently, there is ongoing competition among the most efficient integrated care concepts and the most successful business models for hospitals (e.g. public, for-profit private, and non-profit private) to better manage expenses within the health care sector.

Current concerns over future funding of the public health sector have required the government and health care payors to push health care providers (for example, acute care hospitals) to decrease spending and to increase clinical quality and operating excellence. As a consequence, health care providers are experiencing dramatic

¹ Note: Other publications might show different data. However, for this work, current data from the German Federal Statistical Office was applied.

changes. Especially those providers wishing to succeed must adapt their business models and redefine their value chains accordingly.

Thus, cost-saving models for hospitals become increasingly important against this background. Cost-savings of 2%-5% through the re-negotiation of medical supply pricing, 10%-15% through supplier segmentation and 15%-25% through strategic partnerships with suppliers (e.g. R&D, procurement, logistics, etc.) can be achieved. On average, hospital procurement costs can be reduced by 15%-30% (Drauschke, 2002). Other health care experts assume that through the optimization of supply management, hospitals have the opportunity to reduce the costs of medical supplies by 20%-25% and that there is untapped potential to eliminate up to 20% of the overall processing costs in hospital procurement (A.T. Kearney, 2006). Therefore, a major lever for hospitals is the professionalization of purchasing (either in private groups or through purchasing institutions). It will put buyers in a position of strength. By simplifying the purchasing process and promising better prices to member hospitals, purchasing institutions and private groups are achieving significantly more sales while driving down supplier prices. Already via EU-wide tendering, price reductions of about a double-digit percentage for medical products seem to be achievable (Kruetten et al., 2005). In general, the purchase of medical products appears to be challenging procurement processes in the hospital.

However, the focus on purchasing institutions allows for a delimiting of the boundaries of this publication to manageable dimensions. Thus, I focus on the relationships of producers (for example, medical suppliers or device manufacturers) with institutional customers and provider organizations, and the impact of business-to-business models (but not business-to-consumer), on the health care supply chain.

To this point in time, professional procurement and structured purchasing is still underdeveloped compared to other mature industries like the automotive or retail industries (Roland Berger Strategy Consultants, 2009). There is a vastly untapped potential for purchasing institutions to increase the efficiency and the effectiveness of the health care value chain by leveraging economies of scale on the supplier side and economies of scope on the hospital side simultaneously. Purchasing institutions deliver significant contributions to better balance the cost increase of the health care

system and to coordinate the various activities among the value chain players. Furthermore, they have the potential to advance productivity and to strengthen the competitiveness of the German public health sector.

There is not much literature available describing the role and the future business potential of purchasing institutions along the health care value chain within the hospital environment in Germany. Therefore, the objective of this publication is to give a more detailed understanding of the critical role of purchasing institutions in strengthening competitiveness and in advancing productivity along the value chain.

This is done firstly based on an analysis of the current market. The role and different types of purchasing institutions will be evaluated in more detail. Followed by a discussion of the underlying business model and the current business activities, potential fields of new operations will also be explored.

Secondly, the evolution of purchasing institutions over time are demonstrated and the practical relevance of this work is emphasized in that a purchasing institution, namely “P.E.G. Einkaufs- und Betriebsgenossenschaft eG” (P.E.G.), was approached for real case purposes.

The following hypotheses serve as a starting point for this publication:

(I) Macroeconomics and local drivers will further increase the costs of the public health sector. There is a need to increase the efficiency and effectiveness of the health care system in Germany (Chapter 2).

(II) Structured purchasing within the public health sector is still underdeveloped compared to other mature industries. The full potential of purchasing institutions is not yet identified adequately within the health care environment (Chapter 3).

(III) New ways of alliances and co-operation among the health care value chain players need to be established to promptly ensure access to new therapies and to assure affordability of product and service innovations in the future (Chapter 5).

In this publication, we will analyze and review the role of purchasing institutions within the hospital market in Germany in more detail. Furthermore, the overall concept of efficient supply management will be discussed so as to understand the

value creation of purchasing institutions and to identify optimization opportunities within the procurement process of hospitals. The central role of purchasing institutions is assumed to drive economies of scale on the supplier side and economies of scope on the hospital side.

Hence, purchasing institutions have the potential to connect hospitals to suppliers very efficiently and vice versa. “(...)purchasing cooperatives, which today essentially act as central negotiators for prices and conditions, see themselves in the future as mediators for customized product and service portfolios between the supplier and the hospital.” (Kruetten et al. 2005, 29).

It is my great hope that this publication will be a way to launch the conversation; others will have their own ideas to add.

September 2012

Munich, Germany

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1.2 Methodology

For this publication, theoretical deductive and empirical inductive methods were applied to provide input into the research questions. In other words, a systematic literature review on purchasing institutions within the public health sector was conducted and field interviews with a sample of selected key players of the health care value chain were performed. The literature review was of great importance to get an overview of the current theories and discussions related to the topic. A decision was made to use the case study methodology in form of expert interviews rather than large scale questionnaires. The interviewed experts were key players of selected medical suppliers. The output of the interviews was very helpful in gaining a strong understanding of the opportunities and challenges for co-operations and strategic partnerships between the various health care value chain players (e.g. purchasing institutions ↔ medical supplier industry). The interviews were conducted in person, except in a few cases when it was not possible to coordinate logistics for a personal meeting. All interviews were audio recorded with the permission of the interviewee in order to preserve the accuracy of statements and quotations.

Eight interviews were conducted in total. However, a wide range of medical supply manufacturers and suppliers were covered (commodities, high-tech devices, disposables, equipment, capital goods). Interviews were conducted with different companies as outlined below:

- BD Becton Dickinson
- B. Braun
- Covidien
- Johnson & Johnson
- Smiths Medical
- Siemens Healthcare

From a functional perspective, different functions within the health care industry were covered in the course of the interviews: From General Managers and Sales & Marketing Directors to tactical and strategic Account Managers and Consultants.

2. Major Challenges of the Health Care Sector

2.1 Macroeconomic Drivers

Public spending on health and long-term care is a major source of fiscal pressures in most OECD countries. Health care costs have typically grown faster than income (even as incomes have increased). Advances in drug development and medical technology will continue to improve the survival rate of severely ill and injured patients, who will then need extensive therapy and care. Innovations will continue to enable earlier diagnoses of many diseases, which often increase the ability to treat conditions that were previously not treatable.

However, financial limitations, new legislations and regulations have a significant impact on future growth opportunities for the health care industry. It becomes more challenging for the pharmaceutical, biotech and medical device industry to get appropriate funding for existing drugs and medical products as well as for future innovations. Therefore, governments have to ensure a favorable market environment to encourage the development of more efficient and effective therapies and to increase patient access to new diagnostic methods to shorten treatment cycles.

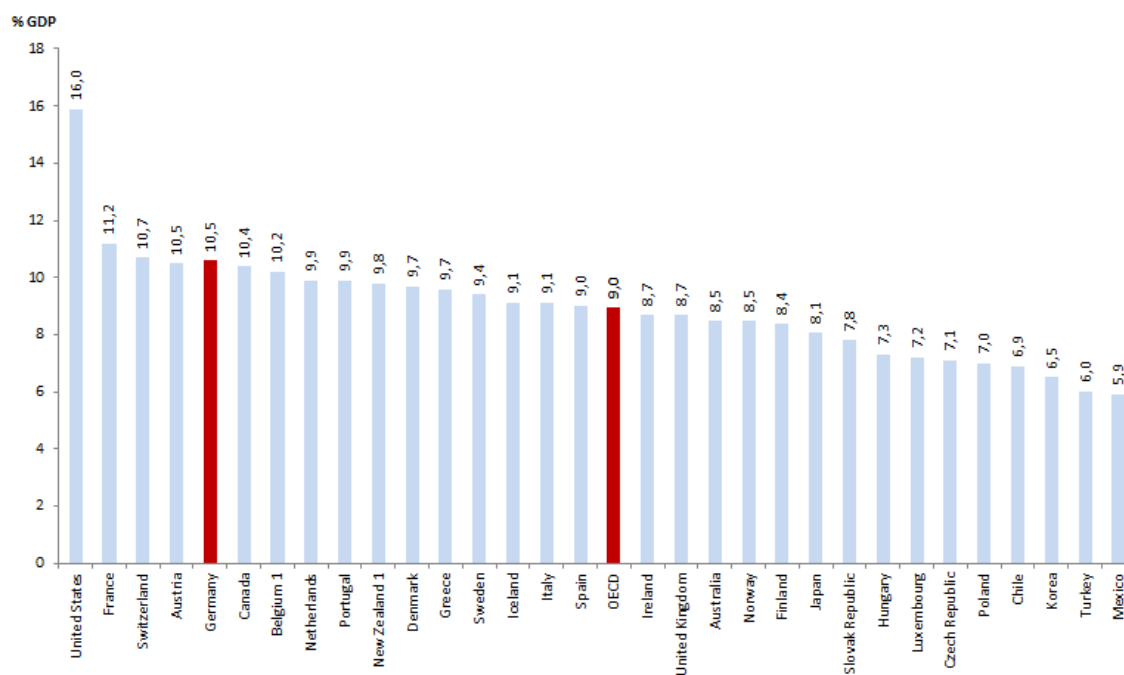


Figure 2-1: Health expenditure as a share of GDP, 2008 (Source: OECD Health Data 2010)

In 2008, OECD countries devoted 9.0% of their GDP to health spending. For Germany, total health spending accounted for 10.5% of GDP. Only the United States (16.0%), France (11.2%) and Switzerland (10.7%) had a higher share (Figure 2-1). There is also a huge heterogeneity among OECD countries in the level of per capita health spending (Figure 2-2). However, the spending levels per capita reflect a wide array of market and social factors, as well as countries' diverse financing and organizational structures of their health systems. In 2008, spending on health goods and services per person in Germany rose to US\$ 3'737. This is 22.1% higher than the average of all OECD countries. Still, OECD data also shows that per capita health spending from 2000-2008 grew in real terms by only 2.7% per year in Germany, the lowest growth rate among all OECD countries, were OECD countries averaged 4.2% (see also Health at a Glance OECD 2009, 160 and Destatis *Health Expenditure*, 2011).

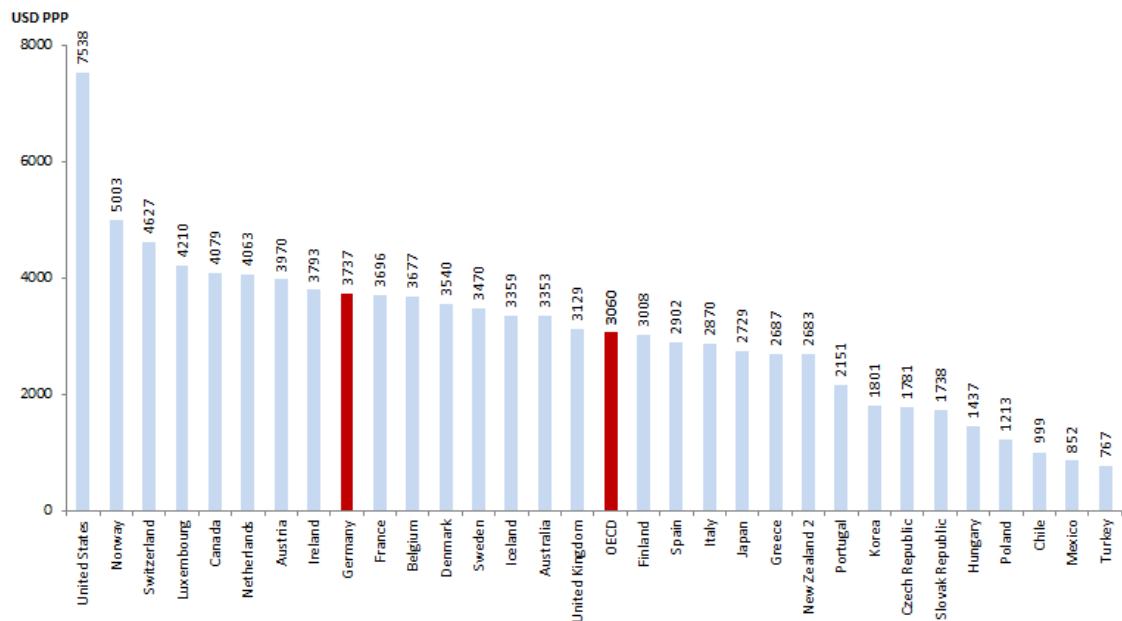


Figure 2-2: Health expenditure per capita, US\$ PPP, 2008 (or latest year available). Data is expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalize the cost of a given 'basket' of goods and services in different countries. (Source: OECD Health Data 2010)

This data reflects the effect of cost-containment policies designed to achieve stable contribution rates by employers and employees. Up to now, several drivers have

contributed to a moderate health care spending in Germany (Busse et al. 2004, 186):

- spending caps for sectors (e.g. ambulatory) or individual providers
- introduction of reference prices for pharmaceuticals and a mandatory manufacturer rebate
- educational approaches to enhance generic and rational prescribing
- reducing the number of hospital beds
- restricting the number of high cost medical equipment
- introducing or increasing co-payments for certain services etc.

In addition, at the beginning of 2011, AMNOG (“Gesetz zur Neuordnung des Arzneimittelmarktes”) came into effect to decide on 'cost-benefit' ratios for new drugs and to better align pricing with existing drugs.

Anyhow, German policy-makers are faced with the challenge of improving the performance of the public health sector. In addition, technological advances and macroeconomic factors, such as aging populations or insufficient public funding, are challenging both payors and providers.

The effect of ageing on public health expenditures per capita has been weak in the past, but it is generally expected that it will increase in the future. In other words, since the level of health care services claimed is proportionate to the age of an individual, overall demand and expenditure for the population as a whole can be expected to rise in the years to come. Therefore, projections on size and composition of the German population give a good indication for the future need of health care resources.

Today, about 82 million people live in Germany. By 2050, the population is projected to shrink below 70 million as stated by the German Federal Statistics Office. From 2010 to 2050, the German population is projected to grow older (Figure 2-3).



Figure 2-3: Projection to the future changes in the age structure of the population in Germany under the following assumptions: constant birth rate at 1.4 children per woman, annual net migration 100'000 persons. (Source: destatis: Population Projection, 2011)

The percentage of the population that is 20 years old or younger is estimated to shrink slightly from 18% to 15% and the percentage of the population 20–64 years of age is projected to decline from 61% to 51% in 2050. In contrast, the percentage of the older population is projected to increase significantly. During the period 2010 - 2050, the percentage of the population 65+ years of age is projected to increase from 21% to 34%. In other words, the population 65+ years of age will rise from 21 million to 23 million people roughly. This is an increase by 2 million older people as projected by the German Federal Statistics Office.

As the population ages, the need and demand for health care will increase, because older people are more likely to suffer from chronic diseases and to seek medical care and other services associated with the aging process. It is unlikely that the existing health care system of public financing will be able to maintain the level of health care to which the public has grown accustomed. Thus, additional private sources of funding, efficiency increases, and quality excellence will be required to continue to be able to fund the health care system in the future. In these days of public deficit containment and rising costs, the funding of health care is becoming more challenging.

The World Health Report 2000 (WHO, 2000) identified the three overall goals of a health care system: achieving good health for the population, ensuring that health

services are responsive to the public and ensuring fair payment systems. Thus, hospitals have a central role in achieving these goals, but hospitals do not act alone. The government, and those acting on its behalf, has the responsibility to create the environment and conditions in which hospitals can function to ensure the long term sustainability of a competitive hospital system. In other words, the government and institutional payors must invest wisely in improving the performance of hospitals. Therefore, hospitals are increasingly subject to pressure to improve performance by complying with the existing legislative requirements.

2.2 Microeconomic Drivers

Since 1993, and more dramatically since 2003, the German hospital sector has experienced considerable changes due to fixed budgets, the possibility of deficits and profits, the introduction of prospective payments methods, and increased opportunities to offer ambulatory treatment. From 2003, the German modification on the Australian DRG system (a brief explanation of the DRG system in Germany will be given on the next page) is the sole system of financing recurrent expenditures of acute hospitals except especially for psychiatric care and certain defined services. It replaces the mix of reimbursements per diem, per case (mainly elective surgery) and for expensive procedures that existed between 1993 and 2003.

The German Federal Statistical Office reported in 2011 that expenditures for the German public health sector exceeded Euro 278 billion for 2009. An increase by Euro 13.8 billion (or 5.2%) when compared to the previous year. Hospitals consume the largest amount of the overall health care budget. The total spending on acute care hospitals totaled Euro 77.1 billion for 2009 , followed by the spending on ambulatory physician's offices - Euro 42.8 billion - and pharmacies - Euro 40.1 billion - (Destatis *Health Expenditure*, 2011).

For 2009, spending on acute care hospitals increased by Euro 4.5 billion (or 6.1%) when compared to 2008. Thus, it is evident, that hospitals are a major cost driver in the public health sector. However, it is widely believed that hospitals can be made to function more efficiently and that many patients can be treated more cost-effectively in other settings. As hospitals work to improve efficiency, care needs to shift from

between various purchasing alliances, but rather healthcare providers should always consider the other cash distributions received from or as a result of the purchasing institution relationship, including volume rebates/bonus payments from suppliers, dividends – specifically with registered cooperatives – or kickbacks (as a result of purchasing institutions’ collected revenues exceeding expenses). Furthermore, they should also consider the cash distributions received from the individual value-added service offerings based on the purchasing institution’s specific business model. Nevertheless, caution should be used to ensure that the benefits are quantifiable.

4.5 Example: The Business Model of the P.E.G. Purchasing Institution

Being the first hospital purchasing institution in Germany, P.E.G. (Privatlinik-Einkaufs- und Betriebsgenossenschaft eG) was established 1970 as a cooperative for private hospitals only. As a registered cooperative, the non-profit purchasing institution was owned by their member hospitals. Since then, the legal form of the P.E.G. has not changed, but the pursued business model has greatly evolved over time matching today’s challenges of health care providers (Figure 4-3). Nowadays, the membership to P.E.G. is open to every health care provider. P.E.G. currently has about 660 members representing more than 2’330 health care providers like hospitals, rehabilitation clinics, care units, nursing homes and others.

Following the new membership concept, a re-naming of the cooperative was put into effect in 1994. Since then, the purchasing institution is registered under the name “P.E.G. Einkaufs- und Betriebsgenossenschaft eG“ (P.E.G.). Thus, every health care provider can apply for P.E.G. membership to participate from purchasing and service benefits. To become a member of the purchasing institution, providers must acquire a specific number of partnership shares of the cooperative. As a consequence of this business model, members of the P.E.G. become owners of the purchasing institution. The number of partnership shares that must be acquired is based on the number of sickbeds of the health care provider. As such, the size of the provider is taken into account when applying for membership. However, the maximum number of partnership shares is limited to 20 shares per member. This ensures balanced voting power among the members, for example, larger hospitals do not necessarily have more voting power than smaller ones. One partnership share must be acquired for

every 10 beds until reaching the maximum number of 20 partnership shares. The purchase price is Euro 50 per share. There is a yearly dividend of 10% per share. There are no membership premiums to be paid.

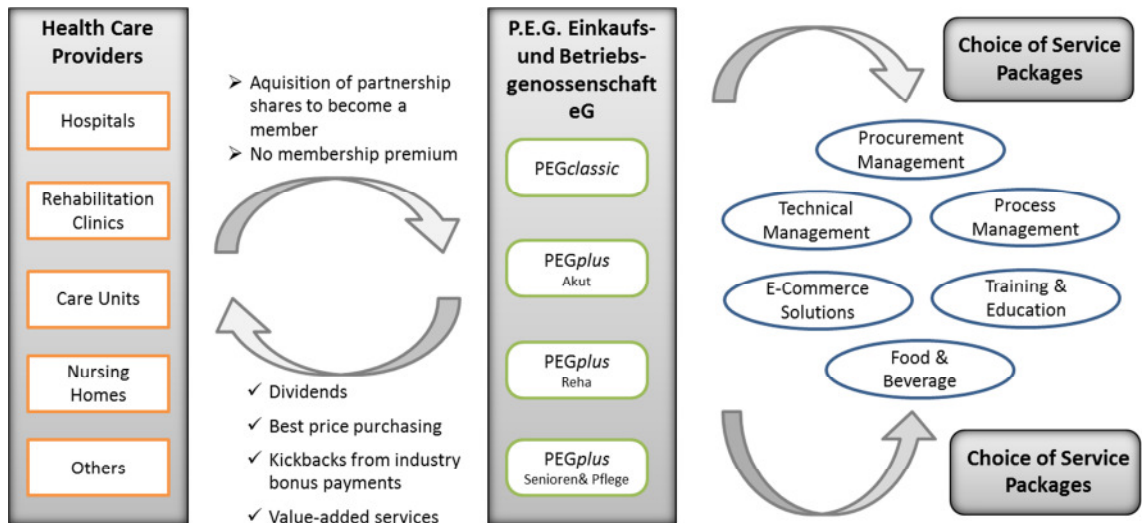


Figure 4-3: Principle of the business model of the P.E.G. Einkaufs- und Betriebsgenossenschaft eG

As mentioned in one of the previous chapters, the competitive advantage of the P.E.G. purchasing institution is a well-established hybrid model, allowing members to choose between a binding and a non-binding purchasing program, based on the health care provider needs and strategic intent.

When becoming a member of the P.E.G., providers will automatically be enrolled in the non-binding purchasing program called PEGclassic. So, as members, providers benefit from specific service offerings of the purchasing institution (service features will be discussed in the next chapter in more detail) without losing purchasing flexibility. Members of the PEGclassic program can benefit from pre-negotiated master agreements for a variety of medical supplies and services with preselected suppliers or they can negotiate on their own with a preferred medical supplier, trying to get a better purchasing price from the supplier than the purchasing institution. Assuming that product pricing is driven by purchasing volume, it would not be consistent if a single health care provider would get a better deal from suppliers than a purchasing institution. However, the PEGclassic program leaves the purchasing

decision up to the individual health care provider. Thus, there is a risk that the individual provider can miss the opportunity of standardization that will drive significant cost reduction along the supply chain by increasing the quality of patient care simultaneously.

To further increase the economic benefit for health care providers, P.E.G. established the *PEGplus* program for their members in 2004. The program was modified in 2008 and since then also includes consulting services. According to the various provider categories (e.g. hospitals, care units, rehabilitation clinics and so on), a range of packages based on the *PEGplus* program are provided to match the needs of the individual member type:

- *PEGplus* Akut: ⇒ hospitals
- *PEGplus* Reha: ⇒ rehabilitation centers
- *PEGplus* Senioren & Pflege: ⇒ nursing homes and care units

The program *PEGplus* is based on committed (binding) purchasing of medical supplies. Thus, the program offers a set of advantages to product suppliers including greater contract compliance, greater standardization on that supplier's products (over a rival's products), and increased market-share penetration in member accounts of the P.E.G. purchasing institution. In exchange for the committed volumes, suppliers will offer lower unit price contracting than that negotiated with individual providers or agreed for other non-binding purchasing programs (e.g. *PEGclassic*). As a consequence, members who are enrolled in the *PEGplus* program immediately benefit from best price product purchasing, as they get charged for the lowest unit price based on the master agreement between P.E.G. and the individual product supplier or service vendor. To be clear, the driver for the significant cost reduction of medical supplies is the volume commitment to industry. Therefore, participating members of the *PEGplus* program are obliged to order at least 80% of their needs for medical supplies based on various categories through the purchasing institution's contract agreements with suppliers. On the other hand, this approach increases the degree of standardization (e.g. single or dual-sourcing) reducing supplier, logistical and warehousing complexity at the provider level. Furthermore, the *PEGplus* program provides tools to analyze consumption rates and purchasing behavior while

offering e-procurement solutions to further increase the efficiency of the procurement process within the provider’s supply chain. There is a joint approach with the individual provider to implement “best-processes” based on best-practices. A comprehensive view of the individual procurement process is an imperative to success (Figure 4–4).

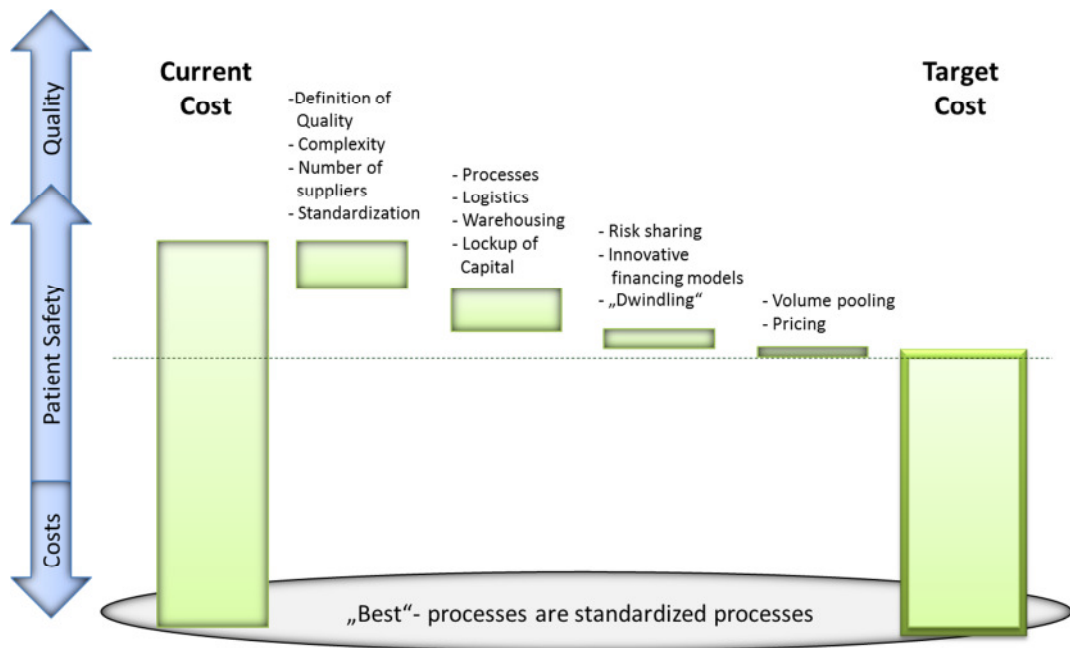


Figure 4-4: A comprehensive view on reducing procurement costs (Source: Adapted from P.E.G. Einkaufs- und Betriebsgenossenschaft eG)

The P.E.G. purchasing institution has also other sources of revenues in addition to the bonus payments from industry. Based on specific member requests, or if not included in the chosen purchasing program, particular value-added services like consulting or education programs will be charged directly to the individual member.

Furthermore, supplying partners from the industry benefit from the P.E.G. membership network. To keep their members informed regularly, P.E.G. has established a journal (known as *PEGaktiv*) to highlight the recent activities of the purchasing institution. In addition, the journal also provides a platform to industry partners conveying their messages about innovative therapy concepts, new product solutions, or specific product knowledge throughout the P.E.G. member community.

suppliers and providers. However, they are considered to coordinate various activities among the supply chain parties and hence to increase the quality and efficiency of the health care supply chain.

Finally, this thesis has highlighted some joint initiatives of purchasing institutions. Through these initiatives, purchasing institutions take responsibility as gatekeepers for patient-safety, quality, innovation and cost-effectiveness in public health care.

7.2 Outlook

The cost constraints within the public health sector will last. They are driven by an aging population, medical innovation and rising expectations of the society. The economization of the public health sector will achieve a new advanced level of sophistication, affecting the business models of many players within health care (i.e. suppliers, manufactures, providers and purchasing institutions). Hence, it can be assumed that further consolidation activities will take place in the hospital purchasing landscape. Nevertheless, a commercialization of health care must be avoided.

A significantly lower number of purchasing organizations than today will exist and their bargaining power will increase. Large, professional, binding purchasing institutions and other binding models of collective buying will shape the landscape together with competition-oriented individual hospitals and hospital chains. There will be much more emphasis placed on supply chain management. The pricing of the individual product becomes less important. Purchasing institutions will advance their business model by providing a comprehensive range of sophisticated services to generate long-term process cost savings. They will take a broader perspective of the total cost of treating a patient's medical condition.

A significant improvement in the health care value chain will occur when health care providers employ point-of-use systems to capture product information. This will permit value chain players to analyze and forecast demand for their services and initiate cost efficiencies across the entire stretch of the chain. The information gathered by purchasing institutions will facilitate better product comparisons and a better analysis of cost-effectiveness. Such comparisons will lead to improved



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