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Auditor General

Victoria

Health procurement in Victoria

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AUDITOR GENERAL
VICTORIA

The Hon. Monica Gould MP
President
Legislative Council
Parliament House
Melbourne

The Hon. Judy Maddigan MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance audit report on *Health procurement in Victoria.*

Yours faithfully

JW CAMERON
Auditor-General

5 October 2005

Foreword

Significant sums are expended on goods and services across the health system each year. In Victoria's public health system, expenditure on purchases of goods and services amounted to $1.6 billion in 2003-04, second only to payroll costs. It is important therefore that every avenue is explored to ensure that the procurement activity undertaken by public health service providers is efficient and cost-effective.

With this in mind, in July 2001, the Victorian government launched a procurement model for the state's public health sector that provided for central procurement, while retaining the flexibility for hospitals and health services to buy locally.

This audit examines the extent to which the activities of public hospitals, health services and Health Purchasing Victoria, the central procurement agency, have delivered savings and other benefits in procuring health goods and services.

This report provides a timely assessment of the progress achieved and identifies the need to review the effectiveness of the current arrangements.

JW CAMERON
Auditor-General

5 October 2005

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1. Executive summary

1.1 Health procurement

Goods and services constitute the second largest cost in the health sector – second only to payroll. Victoria's public hospitals and health services[1] spend some $1.6 billion each year on goods and services. The effective management of these costs is therefore an important element of any strategy to run hospitals efficiently and effectively. Hospitals can help minimise costs by buying at lower prices or by minimising inefficiencies in supply activity, i.e. reducing procurement costs and improving supply chain management.

In mid-2001, a procurement model was created in Victoria aimed at providing hospitals with the economies and benefits that could come from purchasing high volume supplies at lower prices through a central purchasing facility. Hospitals retained the flexibility to buy locally where central contracts were not in place or planned.

It was expected that central purchasing would:

- deliver savings to the health sector of $6-10 million in the first year
- deliver ongoing savings of more than $20 million a year for the sector
- ensure that small hospitals could get the same cost-benefits as larger metropolitan hospitals
- lead to real savings from collective purchasing of imported hospital equipment[2].

To this end a central procurement agency, Health Purchasing Victoria (HPV), was created in July 2001.

Our audit focused on determining the extent to which the activities of public hospitals, health services and HPV had delivered savings and other benefits in procuring health goods and services since then.

[1] In this report, the term "hospitals" is used to refer to "public hospitals and health services".

[2] Victorian Government media release, Minister for Health, 1 June 2001.

1.2 Have the procurement activities of hospitals and Health Purchasing Victoria delivered savings and other benefits to the health sector?

1.2.1 What was achieved?

Hospitals have made savings by introducing their own procurement initiatives. These initiatives, including collaboration between hospitals to aggregate purchasing power and streamlining internal processes to improve efficiency, varied in scale and sophistication across the hospitals we visited. Some hospitals are making specific and targeted efforts to reduce their procurement costs but generally, hospitals in Victoria have a way to go before their procurement activities can be considered best practice.

Central procurement has clearly delivered savings to hospitals through better prices for some goods. Small hospitals, in particular, have benefited from the central contracts put in place.

Estimating savings, particularly from central contracts, is difficult. The sector is hampered by significant data issues, both in terms of the quality of systems in hospitals, and the lack of comparable data complicated by issues such as the lack of standard nomenclature and codification for products. HPV estimates that in 2004-05 it delivered savings of around $6.9 million to the sector. As a result of sampling and data issues we consider the level of savings could differ from HPV's estimate.

Prices established by HPV compared favourably with those of other Australian comparable entities against which we benchmarked.

While some hospitals have identified cost savings from central procurement, they have not assessed whether, overall, they have gained as a result of its introduction, i.e. whether the savings have outweighed any loss of benefits through the elimination of special deals that previously existed with suppliers, such as training support or provision of free capital equipment. Despite this, most CEOs, supply managers and pharmacy directors of the 10 hospitals visited during the audit agreed there was a need for a central procurement agency.

Central procurement was to deliver "best value" to hospitals. While the term has not been defined by either the Department of Human Services (DHS) or HPV, it is generally understood to be more than just best price. In the absence of a definition, after considering aspects including product quality and fitness for purpose, market viability, service deliverables, training support and viability of potential suppliers, HPV's central procurement activities were driven by price.

1.2.2 What affected the level of achievement?

Some $145.7 million of goods purchased by the public health sector (9 per cent of goods and services purchased) in 2004-05 was delivered through central procurement arrangements established by HPV.

On the face of it HPV has, in its 4 years of operation, made a small impact from supplying or facilitating access to the supply of goods and services to hospitals and providing sector support and encouraging improvement. There are reasons for this apparent lack of performance.

While the value of centralised procurement was recognised by government, HPV was launched on 1 July 2001 into an environment where previously, hospitals had a high degree of autonomy in their purchasing and procurement activities. Major hospitals were not convinced that the central procurement model could deliver better prices than they could negotiate themselves. There were also raised expectations about what HPV could deliver to the sector through savings and other benefits and the speed with which they would be delivered. These circumstances, compounded by a lack of strategy, affected how HPV was received by the sector and the level of co-operation it received from hospitals.

It took some time for HPV's organisational and governance arrangements to be developed. In 2002, the central procurement model changed and, as a result, arrangements needed to be put in place to enable HPV to negotiate contracts on behalf of hospitals and to bind hospitals to those contracts. These factors meant that it took some time for HPV to get underway.

There are a number of other entities at the state and national levels whose activities affect procurement practice in the public health sector such as e-commerce and IT development. While HPV collaborated with some on an ongoing basis, collaboration with others was spasmodic.

Existing whole-of-government contracts provide central procurement for a substantial range of goods and services, including fuel, motor vehicles, software, hardware, and telephony. There are also contracts already in place in hospitals, local purchasing arrangements, and goods and services not suitable for procurement through central arrangements. These arrangements reduce the volume of goods and services that need to be centrally procured by HPV. The value purchased by hospitals through these arrangements is unknown. However, the portion of goods and services expenditure available for central contracting is significantly less than $1.6 billion. It would have been inefficient for HPV to establish contracts where such arrangements existed.

Other issues could have been dealt with, and overcome by HPV, with action at the right time. For example, when the central procurement model changed, and HPV's workload increased, it should have acted earlier to increase its capability. As a result, it has found it difficult to deliver the range of activities covered by its legislative mandate and has focused to a greater extent on the parts of its mandate related to contracting and tendering.

1.2.3 Moving forward: Focusing on better outcomes for the health sector

Hospitals need to build on their current procurement initiatives to further harness efficiencies and improve their effectiveness. HPV can exercise its mandate for facilitating supply and encouraging sector improvement to develop a better practice model for logistics management in hospitals.

While it has delivered savings, central procurement has not delivered all the anticipated benefits. HPV needs to start targeting its central contracting activities to goods with the potential to deliver larger savings to the sector, such as medical equipment and prostheses.

It is in the best interests of DHS and hospitals to reduce the costs of health sector purchasing. Improved collaboration between all parties and a well-managed, and appropriately resourced central procurement agency can play an important part in delivering better procurement outcomes for hospitals and the whole public health sector. However, HPV is not accountable to either DHS or the hospitals: it reports directly to the Minister for Health, and the sector currently lacks a leader to coordinate and drive action towards a shared vision of the best outcome for the sector. HPV has neither the influence, nor the incentive, to perform that role. At best, HPV is a mechanism to assist DHS and hospitals to achieve their outcomes. Neither DHS or hospitals have taken the leadership role.

After 4 years of operation, it is timely to review the procurement model to examine whether it is meeting the needs of the sector and whether all parties involved, i.e. DHS, hospitals and HPV, are contributing adequately to the delivery of better outcomes. There is a need to consider:

- where the leadership in the model should reside, and what the appropriate accountability arrangements are, to drive a more cohesive approach to procurement
- how the key entities, i.e. DHS, hospitals and HPV, can work together better to ensure a consistent focus on achieving the best outcomes for the sector
- how to achieve the right balance in the model to ensure HPV is effective in facilitating supply to hospitals
- clarifying the mandate of HPV to reduce the potential for duplication, inconsistent directions or unfulfilled expectations, by:
  - considering which entities are best placed to undertake particular tasks, i.e. "what is best done by hospitals" and "what is best done by HPV"
  - identifying the parts of the health market to be subject to central procurement
  - defining "best value" to enable HPV to appropriately scope its activities
- developing a funding model that provides the right incentives to HPV to maximise its effectiveness.

The following recommendations are made.

Recommendations

Recommendations 3, 4 and 10 are considered to be the highest priority.

1. **That DHS, hospitals and HPV determine which goods and services should be subject to central procurement and which should not, in order to provide HPV with a clear direction and scope for its activities.**
2. **That HPV develop a tender program based on a robust evidence-based methodology, and which meets the needs of hospitals.**
3. **That the current procurement model be reviewed by DHS to ensure that it is operating to best effect in the public health sector.**

4. **That DHS, hospitals and HPV work together to establish better relationships in the interests of achieving better procurement outcomes for the health sector.**
5. **That hospitals and HPV work together to better coordinate data delivery to make more effective use of resources.**
6. **That HPV analyse public health sector expenditure to identify potential areas for its intervention, and to provide a better basis for allocating HPV's resources to deliver the best return to the sector.**
7. **That HPV take a lead in addressing obstacles to efficient and effective health procurement, and supply chain management.**
8. **That HPV review its communication strategy, in consultation with hospitals, to better focus its communication efforts.**
9. **That HPV review its current practices, particularly relating to data management, to ensure efficient resource utilisation.**
10. **That HPV develop relevant and appropriate qualitative and quantitative performance indicators, and set measurable, auditable targets for monitoring and reporting on its performance.**
11. **That all hospitals develop procurement/supply management strategies derived through an evidence-based understanding of barriers and opportunities, and which identify key savings initiatives and targets.**
12. **That all hospitals develop their IT systems and staff skills to ensure that relevant and appropriate data are available for internal monitoring of procurement activities and the savings achieved, to inform their decision-making, and to provide to HPV to assist its central contracting and tendering activities.**
13. **That all hospitals identify a senior executive with overall responsibility for identifying, implementing and reporting on organisation-wide procurement initiatives and that hospital boards maintain a focus on procurement.**

Responses of agencies covered by the audit and DHS have been included below. Their detailed responses are set out in Appendix E of this report.

RESPONSE provided by Secretary, Department of Human Services

We welcome the report on procurement practices in the Victorian public health sector, which identifies the importance that procurement practices play in achieving supply chain efficiencies and reduced costs for the sector.

Overall the report is balanced and effectively identifies areas for improvement in procurement practices.

We note the positive impact by HPV and we look forward to the implementation of improvement initiatives that align with the Auditor-General's recommendations, and that will allow HPV to demonstrate even more significant achievements in centralised procurement in the future.

DHS recognises the importance of best practice by all supply chain participants, including hospitals and HPV, to enable streamlined and efficient procurement processes.

DHS agrees with those recommendations that relate to its operations (recommendations 1, 3 and 4).

RESPONSE provided by Chair, Health Purchasing Victoria

The report provides a fair, balanced and independent assessment of the procurement practices within the Victorian public hospital sector. It also raises a number of issues regarding HPV's involvement in reforming procurement and supply chain operations in the public health sector.

HPV accepts the Auditor-General's report as a further milestone in its evolution. As with all organisations and sectors, there is always an opportunity for improvement and we are pleased to be able to use this document to guide our future strategic directions. Our current review of the HPV Strategic Directions Statement (2002-05) provides an opportunity to consider the inclusion of the report's recommendations as part of our action plan for the future. It is also a timely and useful reminder to all stakeholders of the complexity involved and the buy-in required by all parties to achieve the desired outcomes.

HPV is developing a number of business cases to assign effective allocation of resources to deliver the full impact of the HPV charter.

HPV agrees with all the recommendations made.

RESPONSE provided by Chief Executive Officer, Austin Health

We consider the report provides a fair and balanced account of the matters subject to investigation. Austin Health hereby accepts the recommendations made in the report.

RESPONSE provided by Chief Executive Officer, Bayside Health

The report is fair and provides a balanced and professional analysis of the history, problems and achievements of HPV. In particular, the lack of definition of "best value" has made it difficult to assess HPV's performance and make decisions about its direction. The data in relation to Bayside Health that is included in the report is accurate.

The report makes specific recommendations that when acted upon will assist all parties realise greater value. It is essential that these recommendations be implemented in a timely fashion to assist HPV to plan its future and to maximise the benefits that be gained commencing in the current financial year. All 13 recommendations in some way relate to Bayside Health.

Bayside Health agrees with all the recommendations made.

RESPONSE provided by Chief Executive Officer, Benalla and District Memorial Hospital

In my view, the report is fair and balanced.

In terms of conclusions and recommendations, I accept these as being valid.

We appreciated the opportunity to be part of the audit.

RESPONSE provided by Chief Executive Officer, Melbourne Health

Melbourne Health believes the report provides a fair and balanced assessment of current procurement practices in relation to this organisation and its dealings with Health Purchasing Victoria.

In relation to Part 5 of your report regarding hospital procurement, Melbourne Health agrees with recommendations 11, 12 and 13 and advises that we currently have systems in place covering these recommendations.

RESPONSE provided by Acting Chief Executive Officer, Peter MacCallum Cancer Centre

Peter MacCallum Cancer Centre is satisfied that the performance audit report for health procurement practices presents a fair and balanced view of all the issues raised and that I agree with all the recommendations.

RESPONSE provided by Chief Executive Officer, Southern Health

We acknowledge that this report is a thorough and complex document that addresses a number of topics across the sector. Generally speaking, it is our opinion that the proposed report is a fair, reasonable and balanced assessment of the current situation within the sector. There are, however, significant sections of the proposed report that we cannot comment on, due to non-relevance to Southern Health. These sections of the proposed report specifically relate to HPV.

For example:

- *Clause 4.3.4 Funding model - Whilst health services may have knowledge of HPV's funding model, they cannot influence it or influence how any funding model is tied to any incentive mechanism.*
- *Clause 4.3.9 Measuring performance - We are not aware of HPV's performance indicators or targets. We do, however, agree that the level of performance needed to achieve HPV's desired outcomes is unclear.*

Our statement above on the proposed report's fairness and balance is therefore limited to the areas of the proposed report that are relevant to Southern Health or where we have knowledge of activity or information.

Southern Health agrees with all recommendations apart from recommendations 5 and 7 with which it partially agrees.

2. Health procurement

2.1 What is procurement?

Procurement covers the activities associated with buying goods and services to support an entity's business operations. It is broader than purchasing because it encompasses:

- planning or needs analysis
- strategic sourcing
- purchasing
- order management
- ongoing cost and supplier performance management.

Procurement is just one part of a supply chain. The supply chain is the network of facilities and distribution options including people, processes and technology that, among many things, acquires intermediate and finished products, and distributes the products to customers. Managing the supply chain synchronises the activities of entities with their suppliers and customers.

Effective supply chain management can deliver major efficiencies to entities through improved management of production, inventory, distribution and payments. Cost savings can be passed on to consumers.

Internationally, it is recognised that there are significant opportunities for the health care sector to improve supply chain management.

2.2 Value of purchasing by Victorian public hospitals and health services

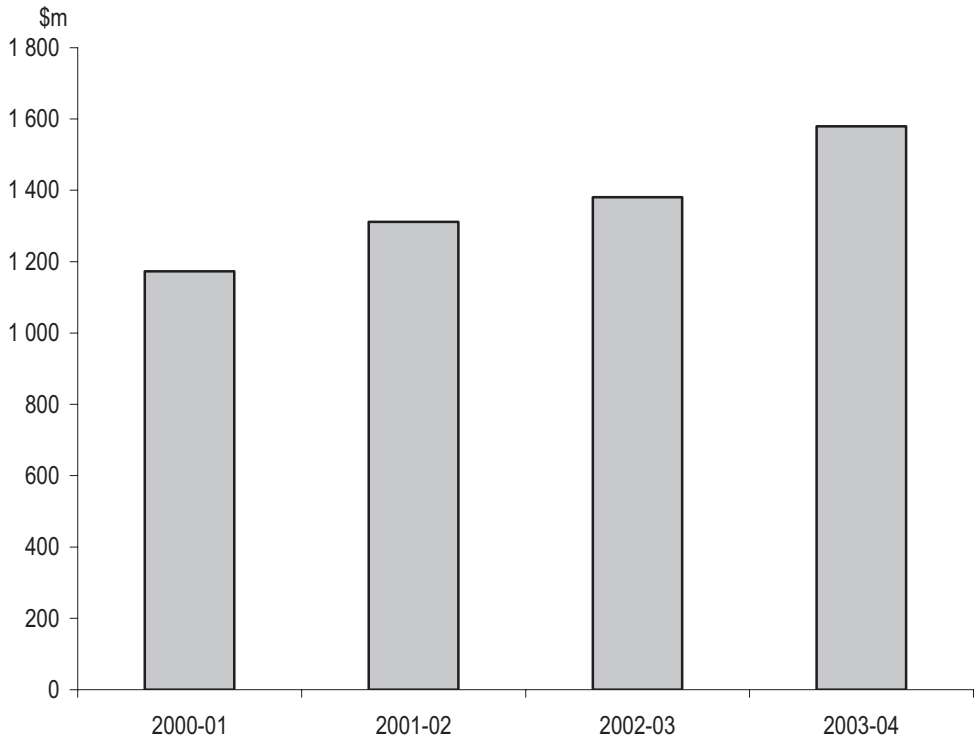
The value of purchasing by Victorian public hospitals and health services[1] is significant. In 2003-04, expenditure on goods and services for the state's 79 hospitals was $1.6 billion. Metropolitan hospitals accounted for $1.2 billion (75 per cent) of this amount. Across the state, expenditure ranged from a low of $304 000 at Manangatang and District Hospital to a high of $190 million at Southern Health.

Hospital expenditure falls into 5 types: salaries, goods and services, depreciation, borrowing costs and capital. Spending on goods and services is typically the second largest item for hospitals, after employee costs.

Figure 2A shows that expenditure on goods and services increased from $1.2 billion to $1.6 billion (33 per cent) from 2000-01 to 2003-04.

[1] In this report, the term "hospitals" is used to refer to "public hospitals and health services".

FIGURE 2A: EXPENDITURE ON GOODS AND SERVICES BY HOSPITALS

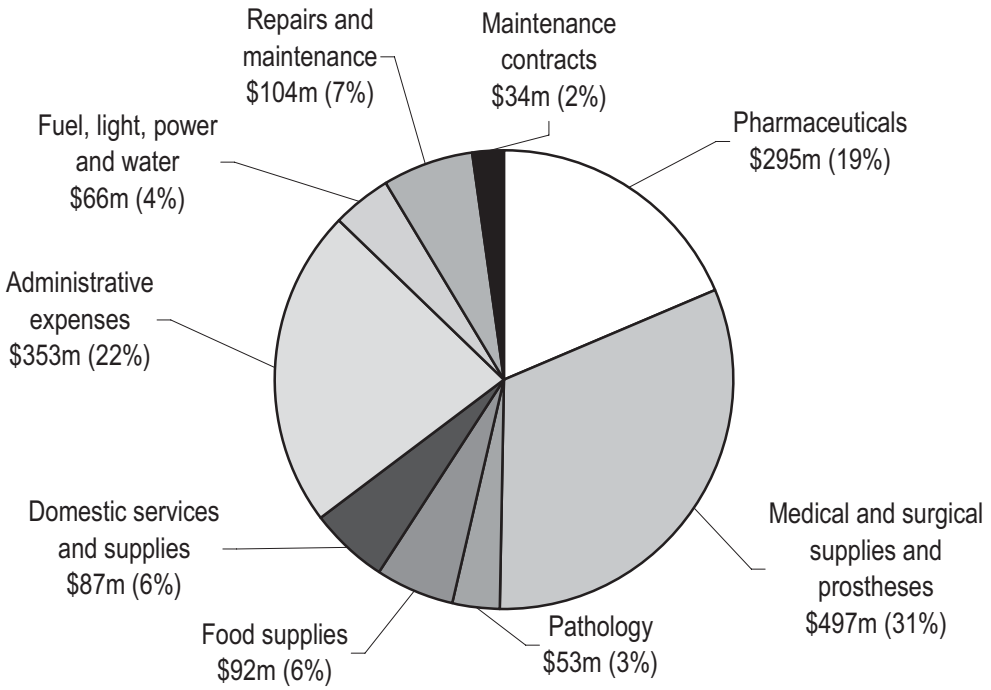


Source: Department of Human Services.

Medical and surgical supplies, and prostheses[2] and pharmaceuticals represented around $792 million (50 per cent) of the total expenditure on goods and services for 2003-04. A breakdown of the categories of goods and services expenditure for 2003-04 is given in Figure 2B.

[2] Prostheses covers anything implanted, including orthopaedic joints, trauma repair (rods, screws and plates), pacemakers, heart valves, vascular implants, cardiac and neurological stents.

FIGURE 2B: PROPORTION OF ANNUAL HEALTH EXPENDITURE ON GOODS AND SERVICES BY CATEGORY, 2003-04



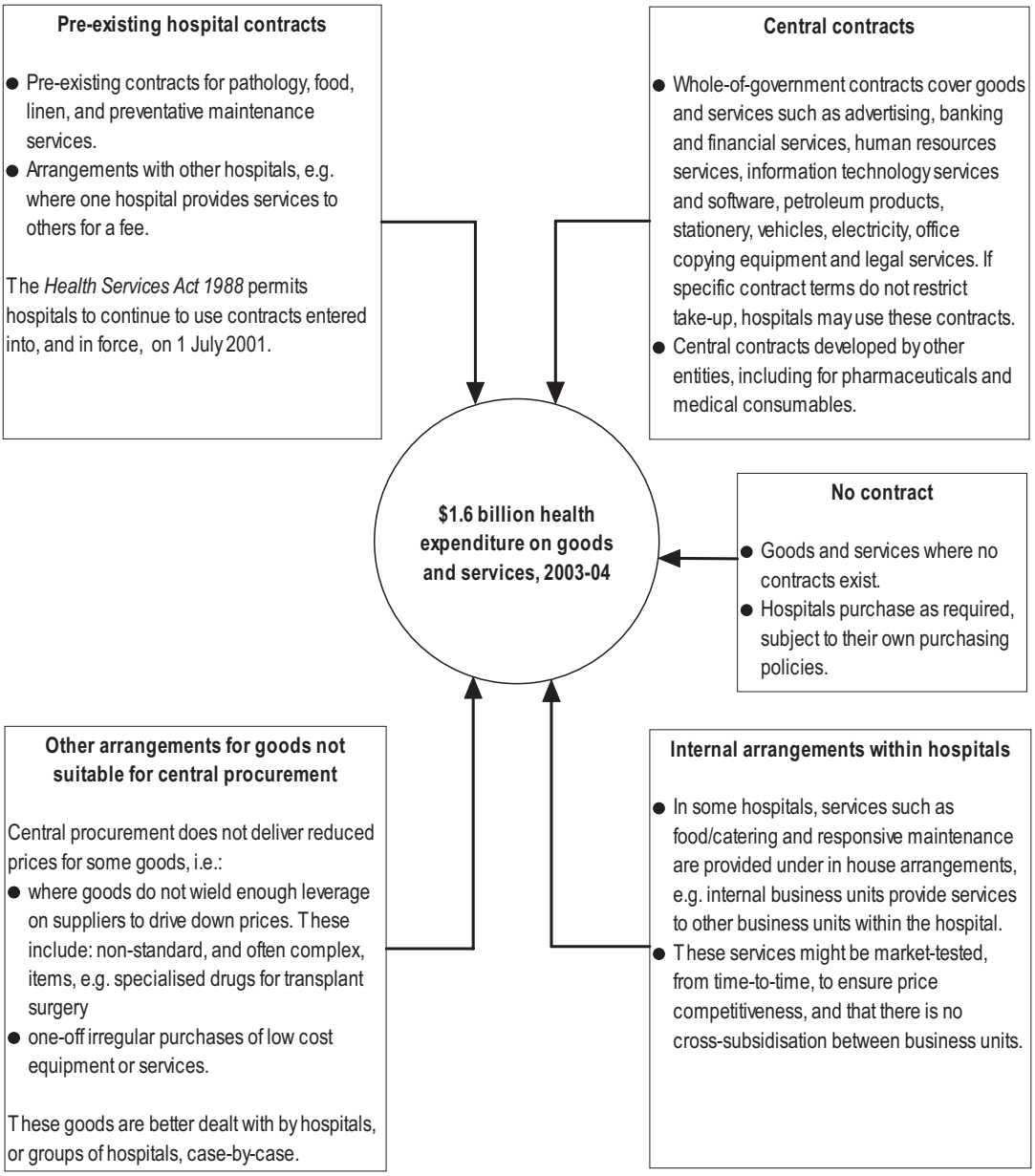
Source: Department of Human Services.

With such high volumes of expenditure, it is important that the health sector continuously seeks ways to minimise costs to free up resources for other priorities. Hospitals can reduce costs by buying at lower prices or by minimising inefficiencies in supply activity, i.e. reducing procurement costs and improving supply chain management.

2.3 Health purchasing and procurement arrangements

There are many purchasing arrangements available to Victorian hospitals as shown in Figure 2C.

FIGURE 2C: PURCHASING ARRANGEMENTS AVAILABLE TO VICTORIAN HOSPITALS



Source: Victorian Auditor-General's Office.

Data of the level of expenditure by hospitals under each of these arrangements is not available. However, the extent to which other arrangements apply, such as pre-existing contracts and internal arrangements in hospitals, and the volume of goods not suitable for central procurement, impacts on the volume of hospital purchasing that can be centrally procured.

2.3.1 Central purchasing

In 1999, the Ministerial Review of Health Care Networks was established to advise the Minister for Health on new governance and management structures for metropolitan hospitals, and to identify savings by reducing the costs of bureaucracy. In May 2000, the review recommended that the then 7 health care networks be disaggregated and replaced with 12 metropolitan health services. It acknowledged the economies and benefits that could come from purchasing large volumes of supplies at lower prices.

Recognising that these benefits could be lost by disaggregating the networks, the review recommended the introduction of mandatory centralised purchasing by hospitals for pharmaceutical and general medical supplies. It estimated that this would save the health sector $5-6 million annually. The government accepted these recommendations and extended them to include medical equipment.

At the time of the review, Hospital Supplies of Australia Pty Ltd (HSA), the trading arm of the Victorian Healthcare Association, provided a central purchasing function for hospitals throughout Australia. HSA was based on a model of voluntary collaboration.

During the mid-to-late 1990s, the number of Victorian hospitals doing business through HSA decreased. A reason for this was that the Victorian metropolitan health care networks considered that they were large enough to secure at least as good, if not better, prices themselves. As well, regional supply arrangements existed in a number of rural areas, which meant that those hospitals did not have to rely on HSA to secure better prices.

By 2001, HSA's Victorian business was mainly with metropolitan hospital pharmacies and the smaller rural hospitals. In 2002, HSA was sold to a commercial pharmacy wholesaler.

2.3.2 Central procurement

Following the ministerial review, a Procurement Reference Group (PRG) was set up to consider arrangements for supply for all Victorian public hospitals. In early 2001, the PRG recommended a procurement model where the participants (i.e. a central procurement body and the hospitals) would establish a structure to coordinate and manage the procurement process. Lead hospitals would undertake all, or much of, the actual tendering and contracting, which would enable them to use their existing infrastructure and avoid unnecessary duplication. Initially at least, the central body was to focus on identifying tender opportunities, authorising agents to undertake tenders and approving tender evaluations.

In mid-2001, Health Purchasing Victoria (HPV) was created by amendment to the *Health Services Act 1988*. At the time HPV was created, the government announced that:

- it expected savings to the health sector of $6-10 million in the first year
- it expected ongoing savings of more than $20 million a year for the sector
- collective purchasing would ensure that small hospitals could get the same cost-benefits as larger metropolitan hospitals
- the real savings would come from collective purchasing of imported hospital equipment[3].

Despite its name, and the recommendations of the ministerial review, HPV does not undertake centralised purchasing. It is responsible for the wider functions of procurement and supply chain management, i.e. to:

- supply or facilitate access to the supply of goods and services to public hospitals and other health or related services on best value terms
- provide advice, training and consultancy services for the supply and management of goods and services, and the disposal of goods by public hospitals and other health or related services
- develop, implement and review policies and practices to promote best value and probity for the supply and management of goods and services, and the disposal of goods by public hospitals
- monitor compliance by public hospitals with purchasing policies and HPV directions, and to report irregularities to the minister
- establish and maintain a database of purchasing data of public hospitals and supply markets for access by public hospitals
- ensure that probity is maintained in purchasing, tendering and contracting activities in public hospitals
- foster improvements in the use and application of purchasing systems and trading by electronic transactions by health or related services.

[3] Victorian Government media release, Minister for Health, 1 June 2001.

The Health Services Act provides for the appointment of members of HPV who, in effect, constitute the agency's board of management. At the time of the audit the Act provided for up to 10 members including:

- a Chair with expertise in the healthcare industry
- 1 from the Department of Human Services
- 1 from the Department of Treasury and Finance
- 3 from public health services (including one Chief Executive Officer (CEO))
- 2 from public hospitals (including 1 CEO) and
- up to 2 with expertise relevant to the functions of HPV.

At the time of the audit, there were 9 HPV members[4].

When established in 2001, HPV had 3 staff and a budget of $1 million. It currently has the equivalent of 11 full-time staff and in 2004-05 received funding of $1.3 million to initiate and manage central procurement of goods and services. Its funding is provided through the Department of Human Services (DHS). While HPV periodically reports to DHS on its activities, it is not accountable to DHS for its performance. It is directly responsible to the Minister for Health.

2.4 This audit

Our audit focused on determining the extent to which the activities of public hospitals, health services and HPV had delivered savings and other improvements in procuring health goods and services.

We asked the following key questions:

- What value of hospital spending was covered by HPV contracts and had HPV contracted the full range of goods and services purchased by hospitals?
- What savings had been delivered by HPV and had small hospitals achieved the same cost-benefits as larger metropolitan hospitals?
- Had HPV addressed the full range of sector support and practice improvement activities specified in its mandate?
- What factors had affected HPV's ability to deliver?

[4] The Health Services Act was changed in early August 2005 to provide for the appointment of between 8 and 12 HPV members including a Chair with knowledge of, or experience in purchasing, logistics or supply chain management, 1 employee of the Department of Human Services, 1 employee of the Department of Treasury and Finance, 2 hospital CEOs and between 3 and 7 people with knowledge, skills or experience relevant to the functions of HPV.

- Had selected hospitals recognised the importance of procurement?
- What initiatives had the selected hospitals introduced to deliver procurement savings and efficiencies, and what savings had they delivered?

More information about the conduct of the audit and a list of participating agencies are provided in Appendix A of this report.

3. Centralised procurement: Contracting and tendering, and the savings delivered

3.1 Introduction

The functions covered by Health Purchasing Victoria's (HPV's) legislative mandate can be grouped into 2 main categories:

- supplying or facilitating access to the supply of goods and services
- providing sector support and encouraging practice improvement, i.e. providing advice, training, support, developing policies and procedures, fostering improvement etc.

A major part of supplying or facilitating access to goods and services is through central tendering and contracting. In this part of the report we examine HPV's central tendering and contracting activities.

We asked the following questions:

- What value of hospital spending was covered by HPV contracts?
- Had HPV contracted the full range of goods and services purchased by hospitals?

  In assessing this, we also considered:
  - Had HPV had formally analysed the range of goods and services purchased by hospitals to guide its efforts or priorities?
  - How had HPV determined its tender program?

We also wanted to know what savings had been delivered by HPV and whether small hospitals had achieved the same cost-benefits as larger metropolitan hospitals.

We confined our examinations to the central procurement activities of HPV, i.e. we did not examine the central contracting activities of the Victorian Government Purchasing Board (VGPB) or savings delivered under its contracts.

3.2 What value of hospital spending was covered by HPV contracts?

Expenditure by hospitals under HPV contracts for 2004-05 is estimated at $145.7 million or 9 per cent of the sector's estimated $1.6 billion spend on goods and services. There were 17 contracts in place: these covered approximately 12 500 items and involved around 180 suppliers.

Figure 3A shows the contracts and the annual value of those contracts.

FIGURE 3A: ANNUAL VALUE OF CURRENT HPV DEVELOPED CONTRACTS

Contract	Annual spend on contract
	($m)
Sterilisation cleaning agents	0.3
Aids and appliances	0.6
Needles and syringes	1.9
Static pressure reduction foam mattresses	(a) 2.0
Supplements and associated feeding equipment	(a) 2.0
Domestic paper	2.6
Contrast media	3.1
Medical and surgical gloves	3.4
Monitoring products	3.6
Medical sutures and skin staples	3.8
Operating room consumables	(a) 3.8
Wound care products	(a) 3.9
Respiratory products	(a) 4.1
Sterilisation consumables	4.1
Continence management	6.5
IV fluids	(a) 10.0
A-Z pharmaceutical	90.0
Total	**145.7**

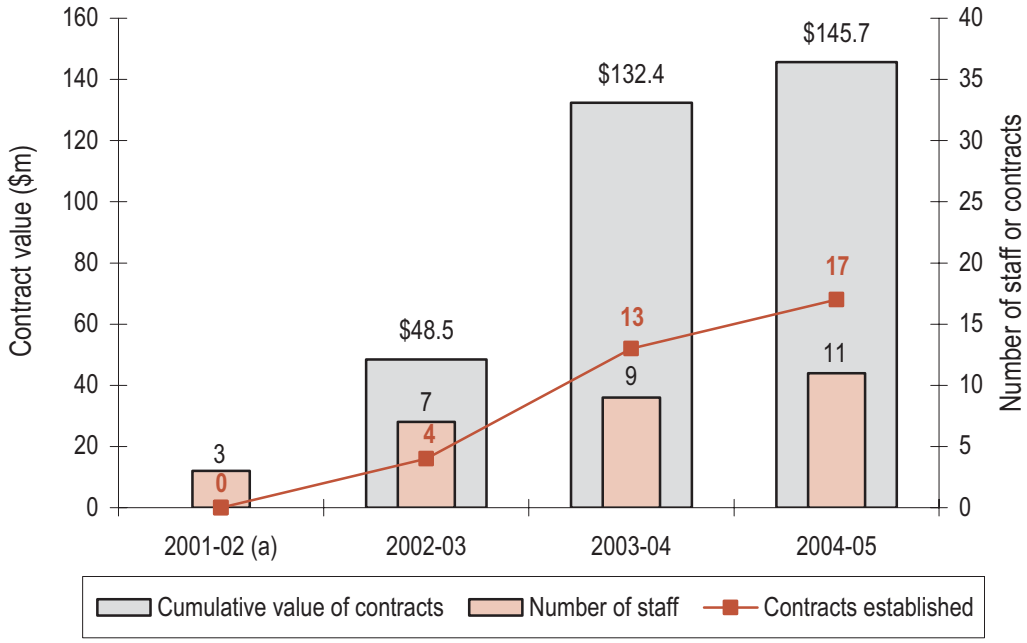
(a) Estimate based on data provided to HPV during the preparation of tenders. Actual annual expenditure is not available until supplier reports have been submitted.

Source: Health Purchasing Victoria.

The A-Z pharmaceutical contract was the largest contract by far. Combined spending on the remaining 16 contracts was $55.7 million. Of these, 2 contracts, sterilisation cleaning agents, and aids and appliances were quite small: $250 000 and $555 800, respectively.

The number of contracts developed by HPV increased from 4 ($48.5 million) in 2002-03 to 17 ($145.7 million) in 2004-05. Figure 3B shows the annual value and cumulative number of HPV contracts and staff since it was established.

FIGURE 3B: ANNUAL VALUE AND CUMULATIVE NUMBER OF HPV CONTRACTS AND STAFF



(a) During 2001-02, no contracts were established by HPV. At that time, hospitals were responsible for conducting tenders and HPV was responsible for identifying tender opportunities and evaluating tenders. In that year HPV focused on developing data collection methodologies, standard tender documents, product lists and the Pharmacy Advisory Group.

Note: During the period 2001-02 to 2004-05, HPV established 18 contracts, but one of these, the M-Z pharmaceutical contract, expired during the period.

Source: Health Purchasing Victoria.

On the face of it HPV has, in its 4 years of operation, made a small impact on its role of supplying or facilitating access to goods and services to hospitals. However, there are a number of reasons for this and these are discussed in the next sections of this report.

3.3 Had HPV contracted the full range of goods and services purchased by hospitals?

The *Health Services Act 1988* does not limit HPV's central tender and contract development activities to goods and services typically linked to clinical care. HPV's activities can cover all goods and services expenditure by hospitals, including:

- medical-related goods and services such as:
  - medical and surgical consumables
  - prostheses
  - pharmaceutical
  - medical equipment
  - pathology services.

- general goods and services such as:
  - fuel, light, power and water
  - domestic services and supplies
  - food services and supplies
  - motor vehicles
  - administrative supplies.

A representation of the spending categories is given in Figure 2B.

We expected to see that HPV had contracted a wide range of goods and services purchased by hospitals, including medical equipment.

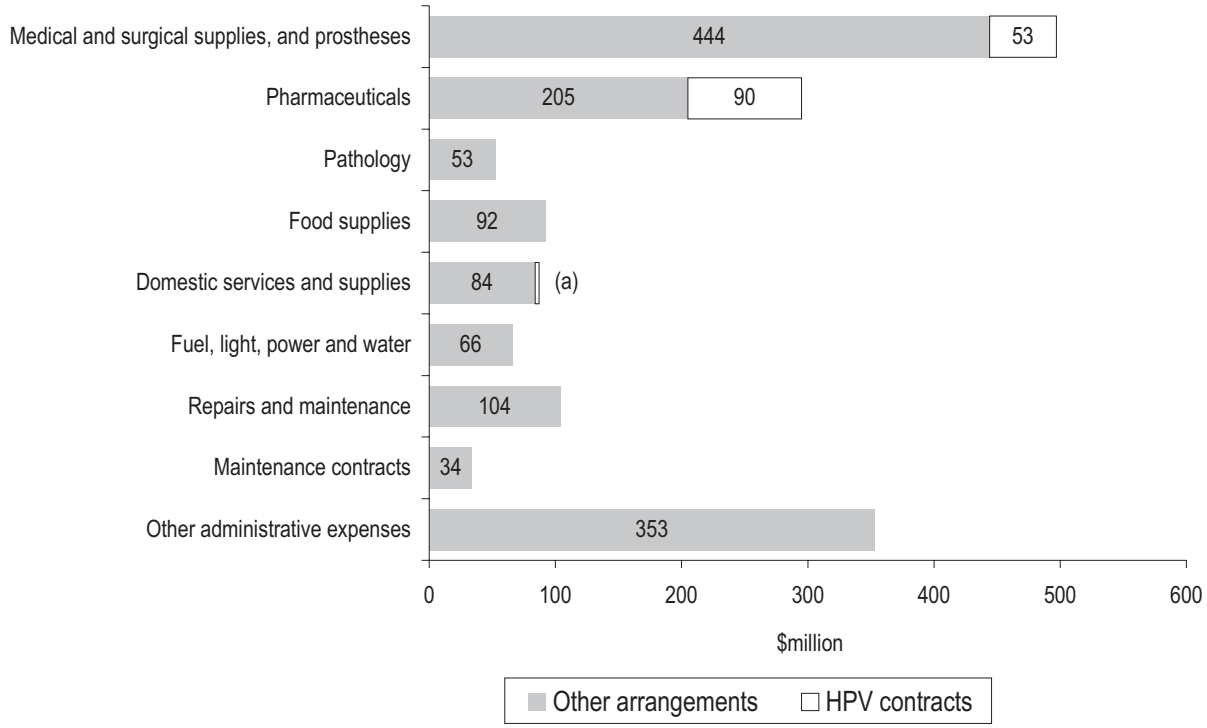
We found that HPV's central tender and contract development activities had focused on medical and surgical supplies and pharmaceuticals, i.e. the segments that represent $792 million (around 50 per cent) of the goods and services expenditure for 2003-04. HPV contracts covered around 18 per cent of the $792 million medical and surgical supplies and pharmaceuticals segments[1]. It had not contracted for medical equipment, prostheses, pathology services or general goods and services, and its emphasis was on procuring goods rather than services[2].

Figure 3C shows the total annual health goods and services expenditure by category and the amount purchased under HPV contracts.

[1] Because actual figures for 2004-05 for the total value of goods and services expenditure were not available at the time of the audit, the percentage has been calculated based on the total for 2003-04.

[2] There is one exception to this: the tender for enteral feeds includes equipment and service to homes.

FIGURE 3C: ANNUAL HEALTH GOODS AND SERVICES EXPENDITURE AND AMOUNT PURCHASED UNDER HPV CONTRACTS



(a) Includes a contract for domestic paper valued at $2.6 million.

Note: Actual data for 2004-05 was not available at the time of the audit. The Figure is based on the total goods and services expenditure for 2003-04 ($1.6 billion). "Other administrative expenses" includes insurance, telephones, computers, printing, stationery etc.

Source: Health Purchasing Victoria.

HPV's A-Z pharmaceutical contract ($90 million) covered 31 per cent of the sector's total annual expenditure on pharmaceuticals in 2003-04. HPV's remaining 16 contacts ($55.7 million) covered 10 per cent of the sector's total annual expenditure on medical and surgical supplies and prostheses and domestic services and supplies.

HPV will re-tender its pharmaceuticals contract shortly. It expects that the new tender will market test most of the sector's annual pharmaceutical market of around $300 million.

As mentioned earlier, there are a number of reasons why HPV has not contracted more goods and services over its 4 year life. For example, many goods purchased by hospitals have been market-tested repeatedly and as a result, the potential for making major savings procuring these goods is now low. There are other goods and services for which central procurement is not the best option.

Public hospitals spend around $300 million a year on pharmaceuticals.

There are also other arrangements in place which reduce the volume of goods and services to be centrally procured. For example, existing whole-of-government contracts provide central procurement for a substantial range of goods and contracts purchased by hospitals, including fuel, motor vehicles, software, hardware, and telephony. Local purchasing arrangements, and goods and services not suitable for procurement through central arrangements also mean that the portion of expenditure on goods and services available for central contracting is significantly less than $1.6 billion. These arrangements are shown in Figure 2C.

There are, however, goods that are not currently centrally procured, and which carry large profit margins. Examples include prostheses and medical equipment. Central procurement can be used to drive down these prices, and to deliver substantial savings.

3.3.1 Had HPV formally analysed the range of goods and services purchased by hospitals to guide its efforts or priorities?

The initial announcement from government about the central arrangement indicated that it would provide savings on imported hospital equipment, and that when purchasing goods HPV must consider local employment growth or retention, the effect on the viability of small and medium-sized businesses, and the local conditions and requirements of health services. We saw no evidence that overarching decisions had been made by the health sector about which goods and services would be subject to central procurement arrangements and which would continue to be procured by hospitals or purchased through other arrangements.

In the absence of such guidance, we expected to see that HPV had formally analysed the range of goods and services purchased by hospitals to decide where it should focus its attention for maximum effect. We found that HPV had obtained some data to assist its analysis. Specifically, it had:

- obtained data on the level of expenditure by the sector on goods and services in 2000-01 and 2001-02 in broad categories, e.g. medical and surgical supplies, food supplies and domestic services and supplies. However, the data did not provide expenditure levels for specific items within those categories, e.g. needles and syringes, medical and surgical gloves, domestic paper
- requested details of contracts in place in individual hospitals for products listed on its tender program, in April 2004 and also when preparing specifications for each new tender. However, many hospitals did not provide the requested information.

Despite these efforts, HPV did not have an overall picture to assist its general planning or analysis of the need for central contracts. For example,:

- it was not aware of the extent of take-up of whole of government contracts by hospitals
- it did not have a comprehensive picture of the value of goods and services subject to pre-existing contracts in hospitals, including the number of contracts, or when they were due to expire.

We note that HPV recently revised the purchasing policy that applies to all hospitals. Under the revised policy "*hospitals and health services, when planning future procurement activities are to consider whether these procurement activities may suit the establishment of a new HPV contract that may potentially lead to improved value for other HPV clients. Such opportunities should be discussed with HPV*"[3].

[3] Victorian Government, *Victorian Government Gazette*, G23, 9 June 2005, pp. 1197-1201.

This will assist HPV's knowledge of the contracts in place to better inform its future planning. It will also enable HPV to share information with other hospitals so that they may also contract with the supplier. However, there remains a need for the sector as a whole to determine which goods and services should be subject to central procurement and which can be procured or purchased through other arrangements that exist. This will enable HPV to clarify the scope of its future activities.

3.3.2 How was HPV's tender program determined?

We expected to see that HPV had formally analysed the range of goods and services purchased by hospitals and existing arrangements in place, identified where the greatest returns could be delivered and developed its tender program based on that information.

HPV's initial tender program, a provisional 5-year program, was developed in late 2001. Its content was broad and included "any item that HPV was likely to tender in the next few years".

Tender priorities for the initial program were determined with key hospital representatives and supply managers, including the Country Supply Network and the Supply and Purchasing Alliance[4]. Information about the South Australian, Western Australian and Tasmanian tender programs was also obtained for comparison. The overriding objective was to obtain some "quick wins", i.e. to put contracts in place where they would quickly deliver savings.

The initial tender program was developed from anecdotal information rather than using an evidence-based approach that identified and assessed tender opportunities available to HPV. The basis, while not ideal, was understandable given the lack of data and the short time frame for its development.

In September 2003, a revised tender program covering the period 2004-06 was developed. A number of major categories such as implanted prosthetic devices and non-clinical goods and services, e.g. HR services, financial services, utilities and vehicles, were removed from the initial program. These non-clinical services were removed as they were covered by whole-of-government contracts.

[4] The Country Supply Network consists of supply professionals from the Barwon, Grampians and Loddon-Mallee regions.The Supply and Purchasing Alliance is a predominantly metropolitan forum of supply managers and is now formally referred to as the Metropolitan Supply Managers' Forum.

We did not see a strategic approach to developing the 2004-06 tender program. For example, there was no formal analysis of the market, or of where the best returns could be made. In the absence of comprehensive data, the products in the tender program were identified taking into account the local knowledge of a number of supply managers and clinical advisers and comments from hospitals. We saw no evidence that HPV and the hospitals took the opportunity to strategically re-position the tender program at that time, i.e. moving from an emphasis on quick wins to an emphasis on tackling some of the more difficult contracts that would provide larger benefits to the sector. For example, cardiac devices and medical equipment such as linear accelerators, anaesthetic machines and X-ray machines, all of which had delivered demonstrated benefits in other jurisdictions where central procurement or purchasing has been implemented, were not included.

3.4 What savings were delivered by HPV and had small hospitals achieved the same cost-benefits as larger hospitals?

We focused on "savings" delivered by HPV contracts, by which we meant reductions in price per item. We did so because hospitals and the industry told us that their immediate expectation was that HPV would deliver savings.

It is difficult to compare savings achieved under a centralised purchasing arrangement with those that might have been achieved if there was no centralised arrangement. For instance, there is no means of knowing what the purchase price for an item would have been if HPV had not developed a central contract for that item.

Saving estimates are also dependent on:

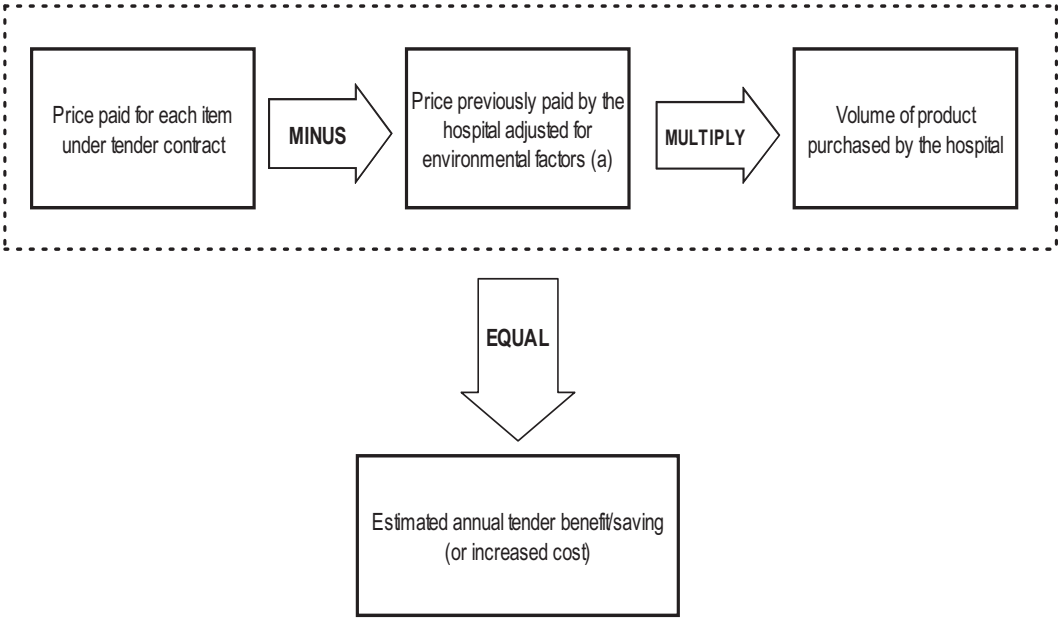
- the availability of data on price, usage and special deals from hospitals
- the value of "special deals" offered by suppliers to purchasers, in a myriad of deals entered into by hospitals. For example, where suppliers provide capital equipment such as infusion pumps free of charge, or fund staff training and staffing positions if hospitals purchase related consumables

- the impact of economic changes and market influences. These include changes in the consumer price index (CPI); exchange rate fluctuations; or market factors such as drugs "coming off patent", the timing of tenders and the last price increase. For example, in an environment where the CPI is 2 per cent and the Australian dollar has fallen by 10 per cent, against the US dollar, an increase of one per cent in the tendered price for an item with overseas content would represent a positive tender outcome.

3.4.1 HPV's estimate of savings

In October 2003, HPV engaged a consultant to develop a methodology for evaluating benefits/savings from its contracts. Figure 3D shows the methodology developed.

FIGURE 3D: DATA METHODOLOGY FOR DETERMINING BENEFITS



(a) Environmental factors (market changes and market influences) include changes in the CPI, exchange rate fluctuations and drugs "coming off patent".

Source: Paxton Partners, *Review of data methodology and other matters*, Melbourne, October 2003.

HPV calculated savings using the methodology above. It sought to obtain data from all hospitals on all of its contracts. It estimated that its contracts delivered savings of around $6.9 million in 2004-05 across all hospitals. This estimate was based on available data for 8 contracts from a different number of hospitals for each contract. For example, data were supplied by only 5 out of 79 hospitals for the domestic paper tender, whereas 33 out of 79 hospitals supplied data for the medical and surgical gloves tender.

We reviewed HPV's savings estimates and noted the following difficulties in estimating the statewide savings:

- Savings estimates for individual contracts were based on comparisons between rates tendered by suppliers and pre-tender rates from a very small number of hospitals. For example, for the savings projection for the A-Z pharmaceutical contract, the total number of hospitals that provided data was 6 out of 79. Their expenditure represented approximately $10 million or 11 per cent of the total annual value of the tender. Forty per cent of that data was provided by one hospital. In view of the number and variation in size of hospitals, it is not statistically meaningful to estimate total savings to the state on the basis of this sample.
- HPV estimated savings based upon data for 8 of its 17 contacts, representing expenditure totalling $106.7 million. Savings were not estimated for the remaining 9 because data were lacking in 4 contracts and HPV was waiting for sales data from suppliers for 5 contracts. The combined annual expenditure for these 9 contracts was around $39 million.
- HPV did not use a sampling methodology for determining items to be sampled within a contract. Items were included if data were available.
- The price and volume data provided by hospitals was not verified. For example, a consultant engaged by HPV to review the A-Z pharmaceutical contract found that in its calculation of estimated tender savings, HPV used 39 items with anomalies in the price data[5].
- Specific decisions about data filtering in the A-Z pharmaceutical contract were not documented and could not be explained by HPV. It was, for example, unclear why some information provided by hospitals was used in the calculations and why other information, particularly price data, was not.

As a result of these sampling and data issues, we consider the level of savings could differ from HPV's estimate. (Comments on the availability of data are presented later in this report).

The work by HPV demonstrates that there are significant methodological and statistical difficulties associated with attempting to estimate the total savings to the state for HPV contracts. Absolute proof of savings can only be gained by HPV obtaining pre- and post- HPV contract prices and data on usage during the contract period. However, this is reliant on hospital providing pre-HPV contract prices. Most hospitals have not provided appropriate data to HPV.

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[5] Paxton Partners, *Review of A-Z Pharmaceutical tender*, Melbourne, April 2004.

3.4.2 Calculating savings

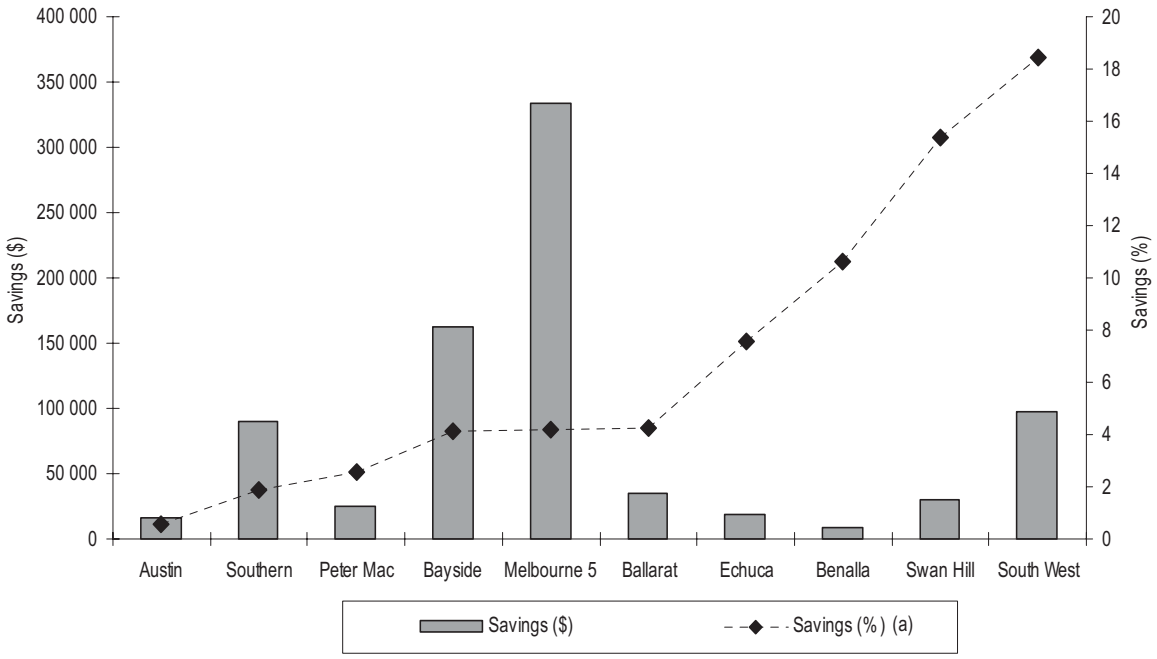
Given the difficulties identified above, we sought only to calculate the extent of savings for a sample of items and contracts at a sample of hospitals, to assure ourselves that savings had indeed been made.

We obtained and verified data for a "basket of items" from which we estimated the savings for those items for 4 contracts in 10 hospitals. We selected 67 items, of which 34 were pharmaceuticals and 33 medical and surgical supplies. Our approach is outlined in Appendix B. We did not attempt to estimate total savings to the state. In our view, the sample data provide an accurate estimate of savings for the 4 contracts in the 10 hospitals, but it does not provide a statistical basis to estimate total savings to the state.

Analysis of savings by hospital

We found that the 10 hospitals had saved a total of $816 000 or 4 per cent of expenditure as a result of purchasing the basket of 67 items from HPV contracts, based on their 2004 purchase volumes. Figure 3E shows the savings for each selected hospital.

FIGURE 3E: ESTIMATED SAVINGS BY SELECTED HOSPITAL, 2004



(a) The savings from the HPV contract as a percentage of the price previously paid by the hospital, using the volume purchased in 2004.

Note: Melbourne 5 includes Melbourne Health, Western Health, Northern Health, Royal Women's Hospital and Royal Children's Hospital. Under arrangement, Melbourne Health provides purchasing, warehousing and distribution services to these hospitals.

Source: Victorian Auditor-General's Office.

The data showed that the benefit from HPV contracts varied across hospitals:

- The non-metropolitan hospitals achieved greater savings overall in percentage terms (19 per cent) compared with metropolitan hospitals (3 per cent).
- In dollar terms, Melbourne 5 had saved the most because they had a much greater purchasing volume than any other hospital. Proportionally, however, they had not saved as much as the majority of the non-metropolitan hospitals.
- In proportional terms, South West Health saved the most (18 per cent), whereas Austin Health saved the least (one per cent).

Although all selected hospitals achieved savings, in 80 instances individual hospitals paid more for certain items, for an additional cost of $506 000. Seventy of these items were pharmaceuticals. However, we recognise that that when attempting to secure best prices for the entire state, it is inevitable that some individual hospitals will pay more for some items. This is because they may have previously negotiated better prices in their own right for some individual items subsequently included on the HPV contract.

Our calculations of savings did not take into account the impact of:

- any loss of "special deals" that hospitals were previously able to negotiate with suppliers
- any action that may have been taken by suppliers to offset price reductions delivered under HPV contracts, by increasing prices for non-contract items
- potential costs associated with changing to the HPV contract item, e.g. changing the wall fittings for glove dispensers
- economic changes and market influences. For example, during 2003-04 the Health CPI went up by 6.6 per cent, but over the same period the HPV contract provided a saving of 2 per cent on pharmaceuticals. This means that the savings from the HPV pharmaceuticals contract for the basket of goods were much greater when the movement in the Health CPI was taken into account.

We found that few chief executive officers (CEOs), supply managers and directors of pharmacy in the 10 hospitals knew whether they had achieved savings as a result of HPV's contracts. Only 2 hospitals (Bayside Health and Melbourne 5) could provide contract-by-contract summaries of annual savings. For 13 of the 17 contracts[6] Bayside Health estimated savings of $476 000 or about 7.6 per cent for the 2004 calendar year. For 12 of the 17 contracts[7] Melbourne 5 estimated savings of $1.1 million or about 12 per cent for the financial year 2004-05.

A detailed comparison was made between the record of actual savings by Bayside Health and Melbourne 5 and our estimate of savings for 3 contracts (continence management products, medical and surgical gloves, and needles and syringes). Five out of 6 of these comparisons revealed very similar results between our estimate (based on the sampled "basket of items") of savings by Bayside Health and Melbourne 5 and their record of actual savings.

Analysis of savings by contract type

We found that the volume of savings varied significantly from contract to contract. Based on our sample of 67 items for the 10 hospitals, we found the following overall savings:

- 2 per cent for pharmaceuticals
- 10 per cent for continence management products
- 15 per cent for medical and surgical gloves
- 16 per cent for needles and syringes.

The estimated savings for each hospital accessing the pharmaceuticals contract and the combined contracts for continence management products, medical and surgical gloves, and needles and syringes, are shown in Figures 3F and 3G.

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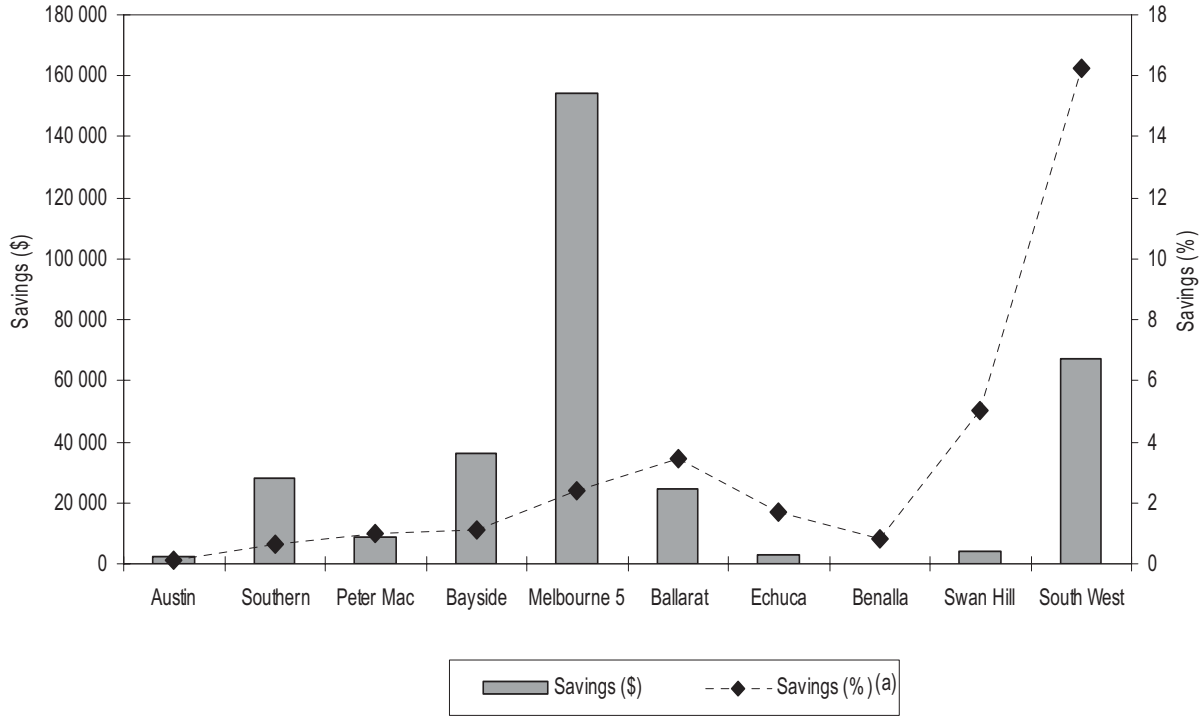
[6] Savings data were not provided for the A-Z pharmaceutical, static pressure reduction foam mattresses, operating consumables and IV fluids contracts.

[7] Savings data were not provided for the A-Z pharmaceutical, static pressure reduction foam mattresses, IV fluids, aids and appliances, and contrast media contracts.

FIGURE 3F: PHARMACEUTICALS: ESTIMATED SAVINGS PER SELECTED HOSPITAL, 2004

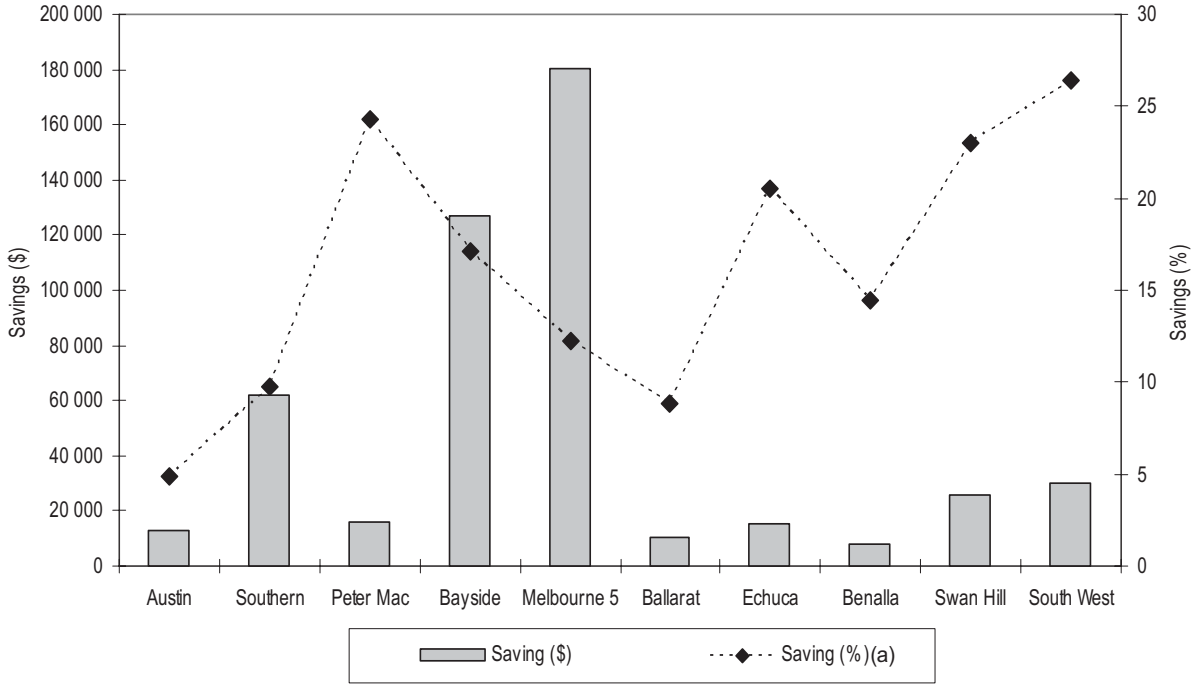


(a) The savings from the HPV contract as a percentage of the price previously paid by the hospital, using the volume purchased in 2004.

Note: Our savings calculation compares the prices delivered under the A-Z pharmaceutical contract for the basket of items, with prices delivered under the pre-existing M-Z pharmaceutical contract (negotiated by HPV) and the A-L pharmaceutical contract (negotiated by HSA) for those items. We did not compare current prices with the previous M-Z pharmaceutical contract negotiated by HSA prior to the establishment of HPV.

Source: Victorian Auditor-General's Office.

FIGURE 3G: COMBINED CONTRACTS FOR CONTINENCE MANAGEMENT PRODUCTS, MEDICAL AND SURGICAL GLOVES, AND NEEDLES AND SYRINGES: ESTIMATED SAVINGS PER SELECTED HOSPITAL, 2004



(a) The savings from the HPV contract as a percentage of the previous price paid by the hospital, using the volume purchased in 2004.

Source: Victorian Auditor-General's Office.

More detailed information about the savings for each hospital for the selected items for the 3 contracts presented in Figure 3G is shown in Appendix C.

Other benefits from HPV contracts

Although we have examined savings delivered by HPV contracts, there are other benefits that should be considered when assessing the impact of its contracts. These include:

- reducing not only the duplication of resources in purchasing across hospitals but also time spent by staff seeking quotes leading to reduced processing costs and savings in administrative time
- producing better management information: the existence of HPV has meant that information is becoming available where previously there was very little. As contracts are put in place, more information becomes available from supplier reports. Over time, this will make it easier to compare prices
- decreasing opportunities for inappropriate arrangements such as gifts given by suppliers to purchasers.

We have not assessed the impact of these benefits in our analysis above.

3.4.3 Benchmarking HPV's performance with other entities

We carried out a benchmarking exercise to measure HPV's savings performance. In it, we compared prices paid for the same basket of 67 items under HPV's contracts with those paid under the contracts of:

- Health Services Purchasing and Logistics Group, Queensland Health, (Queensland Health)
- New South Wales Health Peak Purchasing Council (NSWHPPC)
- 2 Victorian private hospitals:
  - St Vincent's Health
  - Epworth Hospital.

It should be noted that there are many factors which make the benchmarking exercise complex. For example, the price negotiated in different jurisdictions, can be affected by:

- the extent of decentralisation of the purchasing and procurement functions and hospital governance
- differences in volumes purchased. The greater the volume purchased the greater potential for volume discounts
- different contract arrangements. For example, all HPV contract prices include delivery to the hospitals whereas Queensland Health prices for non-metropolitan hospitals do not include freight as this is paid separately
- better payment terms
- the number of times an item has been previously market tested, as the price in one jurisdiction might be comparatively low because the item has been market tested many times.

Other factors that affect the benchmarking exercise include:

- the age of the prices being compared
- the market conditions at the time the comparator price was set and whether the market has risen or fallen since that time
- the order in which the jurisdictions negotiated contracts, as prices negotiated in one jurisdiction can be used in another, as the starting point for negotiating a new contract.

The results should, therefore, be taken as a broad indicator only.

Figure 3H provides a summary of the results of our exercise showing the number of individual items from our sample of 67 for which each of the benchmarked entities had delivered the lowest contract price.

FIGURE 3H: LOWEST CONTRACT PRICES PER ENTITY ON THE BASKET OF 67 ITEMS – COMPARISON BETWEEN HPV AND OTHER PURCHASING ENTITIES

	Number of items				
Item type	**HPV**	**Entity A**	**Entity B**	**Entity C**	**Entity D**
A-Z pharmaceutical	17	15	16	(a)	(a)
Continence management products	8	4	-	2	6
Medical and surgical gloves	1	-	-	8	1
Needles and syringes	3	7	-	-	-
Total (b)	**29**	**26**	**16**	**10**	**7**

(a) Did not provide pharmaceutical pricing data.

(b) The number of items adds to 88, instead of 67. For 21 items, more than one entity had the lowest price.

Note: Agencies have not been identified due to the confidentiality of the data.

Source: Victorian Auditor-General's Office.

HPV had achieved the lowest price for 29 individual items, the most of all the benchmarked entities.

Benchmarking savings by item and category

HPV's performance for the 67 items varied significantly from contract to contract. We found that HPV's price was lowest (or equal lowest) for:

- 50 per cent of the pharmaceuticals
- 53 per cent of the continence management products
- 10 per cent of the medical and surgical gloves
- 38 per cent of the needles and syringes.

Further savings potential for Victorian hospitals

There were wide variations between HPV's prices and those of the benchmarked entities for a number of items. The difference between the highest and lowest price by entities ranged from zero to 155 per cent across all the 67 items, but for 39 items (58 per cent) the difference was less than 20 per cent. This indicates that there is scope for HPV to deliver further savings when these items are re-tendered. Details of the variance between highest and lowest price by entities for each item are shown in Appendix D.

Figure 3I shows the opportunity for additional annual savings the selected hospitals could achieve if the benchmarked lowest price is accessed when these contracts are re-tendered.

FIGURE 3I: ADDITIONAL ANNUAL SAVINGS BASED ON BENCHMARKED LOWEST PRICE

Contract	Annual savings based on 2004 purchase volumes
	($'000)
A-Z pharmaceutical	1 049.3
Continence management products	65.2
Medical and surgical gloves	261.9
Needles and syringes	112.3
Total savings	**1 488.7**

Source: Victorian Auditor-General's Office.

In reality, the scope for savings is less than this. There are reasons why hospitals may not be able to buy at the lowest price, e.g.:

- the lowest price paid is affected by factors such as quantities purchased or delivery arrangements
- clinicians may require a higher-quality, more expensive item to be purchased because of personal preference or clinical reasons.

3.5 Conclusions

Apart from initial pronouncements by the government about procuring medical equipment and considering the impact of central purchasing on regional areas, there has been no overarching direction about what goods and services purchased by hospitals should be subject to central procurement, and which should continue to be procured by hospitals.

In the absence of such direction, and in consultation with a number of supply managers, clinical advisors and a small number of hospitals, HPV focused its tendering and contracting activities on a portion of the market for medical consumables and pharmaceuticals, i.e. $145.7 million of the total $792 million market for these goods. It had not established central contracts for medical equipment, the more difficult items such as implanted prostheses and pacemakers or general goods and services.

On face value, HPV has made a small impact in supplying or facilitating access to goods and services over its 4 years of operations. There are reasons for this apparent lack of performance. There are goods and services for which central procurement is not the best option. Whole-of-government contracts exist that can provide a substantial range of goods to the public health sector. These arrangements as well as contracts already in place in hospitals and local purchasing arrangements mean that the value of goods and services available for central contracting is significantly less than the $1.6 billion spent by the sector on goods and services.

HPV did not have a comprehensive picture of the range of goods and services available for procurement or existing procurement arrangements in place, including the current level of take-up of whole of government contracts or pre-existing arrangements in hospitals. Such information would have helped it better plan its future tender program and determine where it could have helped achieve the greatest benefits from its work. HPV had not developed a robust evidence-based methodology for identifying and prioritising tender opportunities. It was not, therefore, clear whether HPV was effectively focusing its resources on those areas that will maximise best value.

There is an expectation by hospitals that HPV should now move into those areas where larger returns can be delivered. However, such decisions, and what HPV's contribution should be, need to be considered with other sector participants, particularly the Department of Human Services (DHS), to ensure that there is a common focus on the best outcome for the sector.

We acknowledge that there are a number of challenges in determining savings to the state from HPV contracts. Most of these relate to the availability and quality of reliable data. Therefore the level of savings could differ from HPV's estimate for 2004-05 of $6.9 million.

The evidence from our examination of a basket of items suggests savings of $816 000 for the 67 items examined by us despite an upward trend in the Health CPI. The non-metropolitan hospitals selected achieved greater savings than the selected metropolitan hospitals, in percentage terms, but not in absolute terms.

The prices established by HPV compared favourably with other comparable Australian entities against which we benchmarked. However, we note that savings will become more difficult to obtain once the best opportunities have been exploited; that is, as HPV re-tenders contracts, it will become increasingly difficult to deliver greater savings.

Recommendations

1. **That DHS, hospitals and HPV determine which goods and services should be subject to central procurement and which should not, in order to provide HPV with a clear direction and scope for its activities.**
2. **That HPV develop a tender program based on a robust evidence-based methodology, and which meets the needs of hospitals.**

4. Central procurement: Providing sector support and encouraging improvement

4.1 Introduction

When Health Purchasing Victoria (HPV) was established in July 2001, Victorian hospitals expected it to deliver savings quickly. HPV has delivered savings. As is clear from its legislation, however, HPV's mandate is about more than just delivering savings. As mentioned earlier, the functions covered by the mandate can be grouped into 2 main categories:

- supplying or facilitating access to the supply of goods and services
- providing sector support and encouraging practice improvement, i.e. providing advice, training, support, developing policies and procedures, fostering improvement etc.

In this part of the report, we examine how well HPV has achieved its mandate for providing sector support and encouraging procurement practice improvement.

We asked the following questions:

- Had HPV addressed the full range of sector support and practice improvement activities specified in its mandate?
- If not, what factors had affected HPV's ability to deliver?

4.2 Had HPV addressed the full range of sector support and practice improvement activities specified in its mandate?

HPV has taken a number of sector support and practice improvement initiatives. It has:

- facilitated a small amount of training through the Procurement and Contracting Centre for Education and Research, the training arm of the Victorian Government Procurement Board (VGPB)
- been active on the National Supply Chain Reform Taskforce[1], chairing some sub-groups and providing support for projects. For example, the Chief Executive Officer (CEO) chairs a project at the Monash Medical Centre focused on e-commerce in the pharmaceutical supply chain

[1] Established in 2000 to facilitate the adoption of electronic supply chains in hospitals. It consists of representatives of governments, the health sector and suppliers. It follows the national action plan endorsed by the Australian Health Ministers Advisory Council in 2001 and focuses on establishing a standards framework, connecting trading partners electronically, coordinating supplier engagement strategies, developing a standardised approach to contract terms and conditions, and establishing consistency in methodologies for state and local-level performance measuring.

- facilitated one peer review with 2 reviews underway
- developed a tender manager's pack for hospitals containing templates for tendering and contracting-out, sample contracts and probity requirements
- championed the establishment of the Hume Region and Gippsland Regional purchasing alliances and provided secretarial services for 4 such groups and the Metropolitan Supply Managers' Forum
- issued a number of practice recommendations for consideration by hospitals
- recently introduced a certification process for hospitals to certify their compliance with HPV purchasing policy.

One key activity of HPV has been the implementation of an electronic tendering package to improve the quality of tender responses from suppliers and its own tender evaluations. This initiative came out of the National Supply Chain Reform Taskforce. HPV's CEO is actively encouraging the take-up of this technology throughout the sector.

We asked CEOs, supply managers and pharmacy directors of 14 hospitals[2] about their experience with HPV, and what they expected from HPV, in terms of sector support and practice improvement. We found that:

- most did not believe that HPV needed to develop purchasing or probity policies. They already had policies in place or relied on VGPB policies. However, CEOs and pharmacists from some country hospitals suggested that HPV could develop templates to guide hospitals when they were developing policies
- most, particularly pharmacists, did not see a need for HPV to provide consultancies. Many believed that it did not have the expertise or the resources to deliver these services. Others suggested that HPV could develop benchmarks and key performance indicators for the sector. There was some support for HPV to facilitate peer reviews between hospitals
- some were waiting for the rollout of the *healthSMART* financial management system by the Department of Human Services (DHS) before expanding e-commerce. Others had their own initiatives. Some mentioned that HPV could facilitate software improvements
- although they did not depend on HPV for action, some believed that it should provide leadership in e-commerce, e.g. developing a scoping study to define e-commerce for the sector
- most said they would welcome training facilitated by HPV. Some said training should be provided by professionals or an accredited body rather than HPV.

[2] We spoke with 11 CEOs, 10 supply managers, 10 pharmacy directors and one director of nursing.

HPV had focused to a lesser extent on:

- monitoring compliance with policies[3], including whether hospitals purchased goods from HPV contracts where an exemption was not in place[4]
- facilitating introduction of systems in hospitals to improve the quality of data
- rationalising supplier product codes to enable production of better quality data about products and volumes purchased
- standardising product lines by managing clinical choice, i.e. consulting with clinicians to identify the products that need to be kept in stock in order to meet the clinical needs of patients, and those to be eliminated or ordered only as required
- encouraging better practice in hospitals by raising the profile of supply chain management and its contribution to the business, and encouraging a greater focus on logistics
- encouraging take-up of e-commerce.

The last 5 of these aspects are critical to effective supply chain management and procurement, and while hospitals may act individually to address them, a greater effort is required if major savings are to be made across the sector. These are key areas where HPV can lead, assist with resolving barriers, or facilitate sharing of better practice across the sector.

We consider that HPV had not addressed all of the sector support and practice improvement activities in its mandate.

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[3] While hospitals are required to purchase from HPV contracts, they can still purchase goods and services from contracts that were in place before HPV was established. Hospitals can also procure goods and services in their own right where those goods and services are not under contracts developed by HPV, or are not listed for development in HPV's tender program.

[4] The Health Services Act allows exemptions to be granted by HPV, where appropriate, to public hospitals from purchasing particular items from HPV contracts, where clinical or operational grounds or other special circumstances exist. For example, where there is an incompatibility between the item under contract and the equipment used by a hospital to administer a clinical treatment. To date, exemptions have been granted for only 15 items (5 medical and surgical items and 10 pharmaceutical items). There have been 25 applications made.

4.3 What factors had affected HPV's ability to deliver?

Given that HPV had not addressed all of the sector support and practice improvement activities in its mandate, we considered why this was the case. We looked at the following potential obstacles to the success of HPV to see whether, or how, it had addressed them:

- operating environment
- take-up of the procurement model
- the clarity of HPV's mandate
- funding model
- resourcing
- communicating with hospitals
- data availability
- working with other entities
- measuring performance.

4.3.1 Operating environment

HPV was launched on 1 July 2001 into a difficult environment:

- Prior to its creation, hospitals had a high degree of autonomy in their purchasing and procurement activities. HPV was established with the power to mandate hospitals to comply with its policies
- Major hospitals were not convinced that the central procurement model could deliver better prices than they could negotiate themselves
- The health sector expected central procurement to deliver savings quickly because the annual budget for hospitals was reduced by $6 million because of the estimated savings of $5-6 million from centralised purchasing.

In the first year, much of the machinery was not in place to enable the procurement model to operate effectively. The first meeting of HPV's members was not held until the end of August 2001; the permanent CEO did not start until February 2002; the organisational structure and the governance arrangements were still being developed, and a number of legal matters needed to be addressed.

All of these matters affected the way in which HPV was accepted by the sector and how the hospitals and HPV interacted.

4.3.2 Take-up of the procurement model

HPV was created as part of a procurement model in which its role was to coordinate and manage central procurement for the Victorian health sector. Initially at least, it was to focus on:

- identifying tender opportunities
- authorising agents to undertake tenders
- approving tender evaluations.

Lead hospitals were to undertake all, or much of, the actual tendering and contracting.

At the time HPV was established, several hospitals thought that if they engaged in centralised tendering as per the model, they would be in breach of National Competition Policy because they did not have an exemption under the *Trade Practices Act 1974*. The hospitals sought legal advice about the need for an exemption and in December 2003 an amendment to the *Health Services Act 1988* was made to provide the necessary protection.

HPV was resourced to operate under the model outlined above and did so until early 2002. Then, faced with a lack of progress by hospitals in putting central tenders and contracts in place; a major contract due for re-tendering; and the need to get more tenders and contracts underway because of expectations of the sector, HPV took up the hospitals' central tendering and contracting role.

In order to take over the tendering role, HPV needed legal authority to act as an agent for the hospitals. This authority could be given by direction of the secretary of the Department of Human Services under the Health Services Act. However, when the direction was not immediately forthcoming, HPV used its own legislative powers to develop a purchasing policy, enabling itself to contract on behalf of hospitals and to bind them to the contracts it developed. The purchasing policy came into operation on 1 July 2004.

In the interim to overcome the issue of legal authority, a proposed "tender operating model" was ratified in September 2003. It set out how HPV and hospitals would work together for central tendering. It set out the roles and responsibilities of each party, and included requirements for:

- hospitals to provide data to HPV on a timely basis during the tender development phase
- hospitals to purchase from HPV contracts

- HPV to develop tenders and to set up Product Reference Groups (PRGs) and the Pharmacy Advisory Group (PAG)[5].

Since 2003, HPV's CEO, hospitals, health services and DHS have tried to finalise the model to satisfy all parties, but the length and complexity of the process has strained working relationships.

We spoke to the CEOs, supply managers and pharmacy directors of the 10 hospitals visited during the audit and found that:

- most agreed there was a need for a central procurement agency
- none objected to working within the tender operating model in principle
- many had favourable comments about the PRGs and the PAG. Others were concerned that, because each PRG and PAG comprised representatives of a relatively small number of hospitals with limited communication with unrepresented hospitals, the specifications developed did not always provide for the needs of those not represented. However, data from HPV showed limited response rates from the sector when asked to nominate members to participate in these groups
- many wanted HPV's tender program expanded to include items where bigger savings could be made, e.g. prostheses.

Despite these comments, the tender operating model is still contentious and frustrates relationships between HPV and hospitals generally. Only 17 of 79 hospitals had formally accepted the model. Negotiations have been ongoing and have diverted some HPV resources from other activities.

HPV considers that June 2005 revisions to the purchasing policy have addressed the outstanding issues and that the new policy replaces the need for the tender operating model.

We believe that the situation needs to be monitored, and in the event that it continues to frustrate relationships, action be taken so that central procurement can operate more effectively.

4.3.3 Clarity of HPV's mandate

An understanding of its mandate is critical to the success of HPV, particularly when resources are scarce and need to be targeted effectively. Part of HPV's mandate is to supply, or facilitate the supply of, goods and services on "best value" terms, and to develop, implement and review policies and practices to promote best value.

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[5] PRGs and the PAG are required under the tender operating model. They advise on the selection of appropriate clinical and non-clinical products on behalf of the sector. PRGs comprise personnel with experience and knowledge of the goods being tendered (e.g. supply managers and directors of nursing) and are set up for tenders relating to non-pharmaceutical goods. The PAG mainly comprises pharmacists and relates to pharmaceutical tenders.

Best value implies more than savings through best price. In the health industry, effective procurement can deliver much more than lower prices. For example, deciding to buy more expensive products that deliver better clinical outcomes for patients rather than cheaper products may represent better value to hospitals by reducing patient length of stay, the need for longer-term treatment, or hospital readmissions.

HPV ensures that decisions about individual products procured are made considering provisions of the therapeutic goods legislation and other input from the PRGs and the PAG about product quality and fitness for purpose. It also considers the impact of awarding contracts, on the long-term viability of the market. As well as these aspects, in assessing tenders it considers service deliverables, training support and the viability of potential suppliers. After these considerations, HPV's focus is on securing the best price.

Best value is not defined in the Health Services Act, but it needs to be clarified if HPV is to ensure that it gives appropriate focus its procurement activities.

4.3.4 Funding model

HPV negotiates and receives funding through DHS, as part of the government's annual budget process. The level of funding is not tied to a specified level of performance or delivery of quantified outputs. This means that HPV receives the agreed level of annual funding regardless of the number of contracts it puts in place, the level of savings it delivers, or the breadth of activities it undertakes during the period. For example, there is no change in funding for not addressing its entire mandate or if it delivers savings in excess of a pre-established annual target, or to encourage it to tackle the more complex areas of the market.

We believe that the current funding model does not provide an incentive for HPV to maximise its effectiveness.

4.3.5 Resourcing

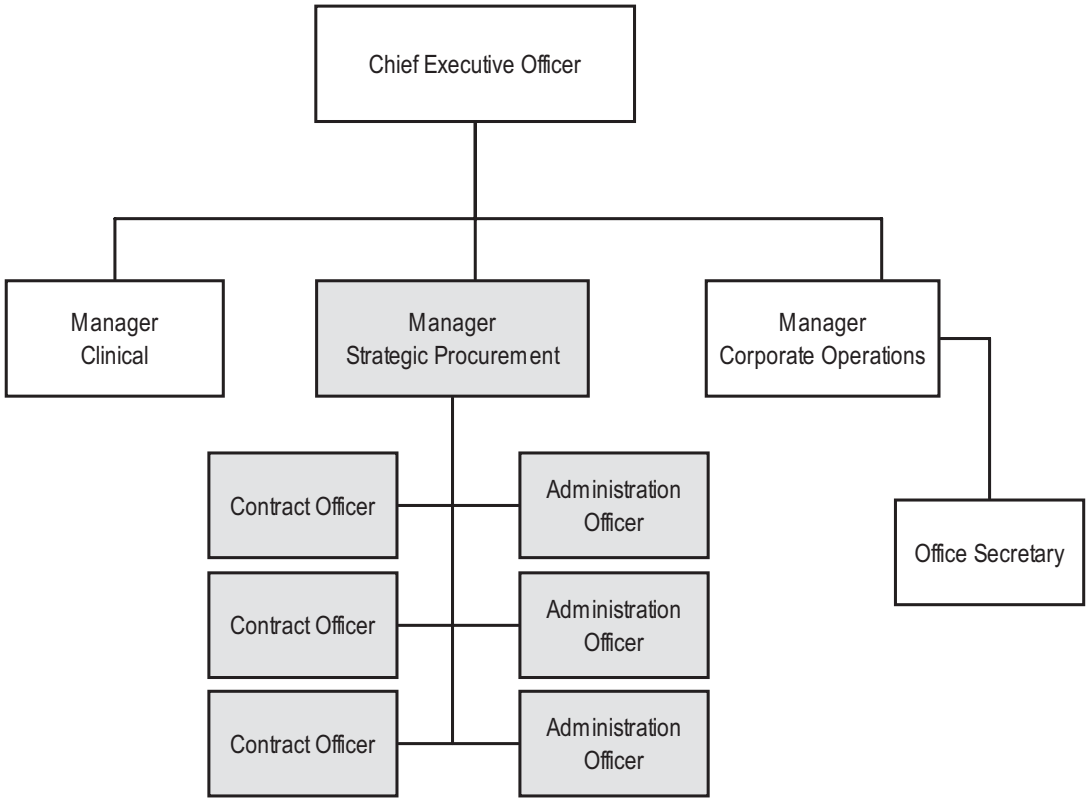
As indicated previously, when the procurement model changed, HPV did not seek additional resources to support its expanded role, but continued to operate on its original funding basis until the end of 2003-04. Because of this, HPV substantially limited its activities to delivering only part of its mandate, i.e. contracting and tendering.

A review of HPV's strategic directions documents, annual reports and minutes of meetings of members for those years showed no evidence that the members had formally advised HPV to limit its focus during that period.

HPV did not seek additional funding until its 2004-05 budget submission, when it received an additional $300 000, which brought its annual funding to $1.3 million. In December 2004, the HPV members directed that the agency focus on increasing the number of contracts in place and managing those contracts, rather than delivering the full range of activities in its mandate.

In 2001, HPV had 3 full-time staff. The staffing levels have increased progressively over time and HPV currently has the equivalent of 11 full-time staff. Figure 4A shows the current organisational structure.

FIGURE 4A: HEALTH PURCHASING VICTORIA'S ORGANISATION CHART



Source: Health Purchasing Victoria.

Seven HPV staff are involved with tendering, contracting and contract management, full-time. Another manager deals with the PRGs established for each tender and the PAG. Apart from one manager who has responsibility for corporate administration, only the CEO is available to address the other aspects of the mandate.

Before a tender goes to the market, HPV staff spend considerable effort improving the quality of data to include in the specification. They also spend time collating and analysing supplier data on purchases made on HPV contracts to determine potential savings expected. Because of the focus on delivering as many contracts as possible, and to prove the level of savings, managers, as well as contract and administration officers, are extensively involved in these tasks. This has reduced the ability for managers to focus on resolving issues that impact on HPV's success.

There is a need for HPV to re-visit its priorities, and the way it allocates its resources, if it is to act on the range of activities set out in its mandate. There was no evidence that HPV had identified the level of resources needed to adequately service its entire mandate.

We were advised that HPV is now developing a business case for additional resources. It intends to brief the minister about the difficulty of meeting its mandate, to seek additional funding, or to seek changes to its mandate.

4.3.6 Communicating with hospitals

Cooperation and good relationships between all parties are critical to the success of the Victorian health procurement model. We asked CEOs, supply managers and directors of pharmacy of the 10 hospitals about HPV's communication with them.

We received some negative comments from hospitals about the tone of communications from HPV. We received many negative comments about the frequency and quantity of HPV's communications. HPV primarily communicates via the email system. It was suggested that HPV review its communications methods, tailor its distribution lists, or exercise some discrimination in the number and content of its emails. Some commented that they tend to overlook or delete emails from HPV because there are so many, and they are directed to so many people within each hospital that everyone assumes someone else will respond. HPV advised that the volume and breadth of its email communications were directly in response to requirements by hospital CEO's that they be included in every email sent to their hospitals.

HPV's CEO has presented a series of roadshows and forums for hospitals. Comments about these suggested that HPV interacts less with the pharmacies in hospitals than it does with the supply areas.

HPV also prepares and distributes a regular newsletter to stakeholders and maintains a website where it posts key information such as policies and procedures and tenders under way. There were positive comments about the newsletter. Some respondents were not aware of the website, or did not have passwords to restricted areas of the website where they could access key information.

HPV advised that its early communication strategy was to "over communicate". HPV has not evaluated the effectiveness of its communications strategy. An evaluation would help HPV to better focus its communication efforts and to address the level of criticism from hospitals.

4.3.7 Data availability

Valid, timely and relevant data on hospital purchasing is essential to the effective planning, development and management of statewide contracts.

Before HPV was established, Hospital Supplies of Australia Pty Ltd (HSA), the trading arm of the Victorian Healthcare Association (VHA), provided a central purchasing function to Victorian hospitals. HSA accumulated extensive data about Victorian hospital purchasing.

HSA was sold to the private sector shortly after HPV was established, but there were no provisions for the transfer or sharing of data with HPV. As a result, HPV suffered, and continues to suffer, from a lack of historical data on the sector's purchasing patterns. This has:

- impaired HPV's ability to budget and plan
- affected its ability to fully harness the sector's purchasing power when putting tenders into the market, e.g. for the A-Z pharmaceutical tender, data provided to HPV by hospitals indicated that the market was worth around $62 million a year. Supplier data subsequently revealed the market to be around $90 million a year. The contract is now about to be re-tendered and more sophisticated data gathering by HPV has revealed that the market is actually around $300 million a year
- made measuring savings/gains or losses difficult
- resulted in significant inefficiencies because of the level of effort needed to collect, collate and improve the quality of data.

Data is a complex issue in the health sector for the following reasons:

- There is no standard nomenclature or codification for products in the health sector. Suppliers have their own coding systems and as hospitals record different descriptors for products in their supply systems, it is difficult to collate data about the same product from multiple hospitals.

- Products come in different pack sizes, e.g. a carton of 112 continence pads compared with a carton of 192, so volumes recorded may relate to different pack sizes in different hospitals. This affects how easily price and volume data can be compared and analysed.
- Hospitals have a range of IT systems. Some have unsophisticated reporting capabilities, and there are multiple systems that are incompatible. This makes it difficult to extract and collate data.
- There are multiple supply chains in hospitals, e.g. supply, pharmacy, IT, engineering and maintenance, food services, biomedical equipment, and capital equipment. They may bypass the main supply recording systems making it difficult to ensure all data are captured in the central supply system.

The level of IT skills in hospitals also affects the ability to provide quality data.

These problems are not unique to Victoria and make it difficult for central procurement agencies to obtain the data to operate efficiently and effectively.

We observed that the quality of data provided to HPV by hospitals was variable. Some of it was poor. An example of quality problems in the response by hospitals to a specific data request, is shown in Figure 4B.

FIGURE 4B: ENTERAL FEEDS AND ORAL SUPPLEMENTS TENDER DATA: DATA QUALITY PROBLEMS

Detail	Number
Number of hospitals with price and usage data	10
Number of line items (price and usage data) in survey population	372
Number of line items (price and usage data) in survey response	(a) 94
Response rate (per cent)	25.3
Quality of data received: • In varying formats despite a standard template being provided to hospitals • In different ways: some electronically, some in hardcopy • Some lacking "product size" or "supplier product code" (the unique identifier of each line item) • Inconsistent data in the "product description" and "supplier product code" fields • Inconsistencies between data from hospitals and data from suppliers, e.g. inconsistencies in "units of measure".	

(a) Fifty-six from one hospital.

Source: Paxton Partners, *Review of data analysis for the enteral feeds and oral supplements tender*, Melbourne, December 2004.

We also observed that most hospitals did not provide data when requested by HPV. This is particularly disappointing given the potential for all agencies to achieve better purchasing outcomes through shared effort. Some hospitals advised that it was not always easy to comprehend what was being sought by HPV. HPV needs to determine why the responses are not forthcoming and act to address any problems perceived by hospitals.

HPV's ability to obtain better data will improve as it delivers more tenders and supplier data[6] become available. However, the data problems will continue while HPV relies on data supplied by hospitals, unless those systems and the data they produce improve and skills issues are addressed.

Entities in other Australian jurisdictions, such as Queensland, have undertaken central health procurement for much longer than HPV. As a result they have built up considerable experience, market knowledge and data. Their data could give HPV an indication of market size for one-off tenders. HPV advised that it had used data from other states to gain a rough estimate of the size of Victoria's market, with varying levels of success. We observed that HPV continues to expend a great deal of effort improving the quality of the Victorian data to set the base for its tender specifications.

HPV should reconsider whether this effort is well spent and whether its resources would be better spent on other activities, including implementing initiatives or working with other entities to address the data issues.

4.3.8 Working with other entities

It is important that HPV collaborates effectively with other entities, to avoid duplication of effort, to ensure HPV's interests in supply chain management are adequately considered, and to leverage off their achievements.

In addition to the National Supply Chain Reform Taskforce, there are other Victorian and national entities that deal with health supply chain issues, including those in Figure 4C.

[6] Suppliers provide data to HPV quarterly. The data show the volume and products purchased by public hospitals.

FIGURE 4C: OTHER GOVERNMENT ENTITIES IMPACTING ON THE VICTORIAN HEALTH SUPPLY CHAIN

Entity	Activity and purpose
Department of Human Services (DHS)	The *healthSMART* program, managed by the DHS's Office of Health Information, is driving the introduction of a financial and supply management system to support financial management, including general ledger, assets and material management for hospitals. Hospitals are being encouraged to take-up the system, but it is expected by DHS that some will choose to retain their existing systems or move to alternatives. DHS has also established a common chart of accounts which is being progressively introduced in hospitals. This will provide greater standardisation of charging across hospitals, which will make analysis of spending easier and enable benchmarking of data.
National E-Health Transition Authority (NEHTA)	NEHTA was established in mid-2004 as a transition team to advance national information management and information communication technology (IM&ICT) priorities identified as requiring urgent attention by the National Health Information Group and Australian Health information Council. NEHTA is also to finalise the establishment of a national IM&ICT entity. NEHTA's priorities for 2004-05 were: • clinical data standards • patient, provider and product identification standards • supply chain • consent models • secure messaging and information transfer • technical integration standards[7].

Source: Victorian Auditor-General's Office.

HPV is active on the National Supply Chain Reform Taskforce. It chairs a working group responsible for developing standard terms and contracts, as well as sub-groups setting up an electronic tendering package and benchmarking[8]. It has had little involvement with National E-Health Transition Authority because that entity is in its infancy.

Given the overarching interest of DHS in the performance of the Victorian health sector, we believe that it is in its interests for HPV to be an effective participant in the sector. We, therefore, expected to see that the 2 entities worked together to deliver the best outcomes for the sector.

[7] National E-Health Transition Authority, *NEHTA Fact Sheet,* v06 doc, 2/12/2004.

[8] HPV has taken a lead in this project aimed at improving the tender evaluation process and quality of tender responses from suppliers. It is collaborating with New South Wales Health Peak Purchasing Council and Queensland Health.

We found that DHS administers funding to HPV and its officers meet regularly with HPV's CEO to discuss the agency's progress. However, there is no funding agreement between the 2 entities and DHS has no legislative authority over HPV, which reports directly to the Minister for Health.

We found that HPV had been included in the design phase of the *healthSMART* program which includes software for supply management by DHS but has not been involved in the further development or roll-out of the program. It was not asked to contribute to another project aimed at developing the common chart of accounts for hospitals. While HPV does not have resources to allocate to these projects, as a minimum, it should be engaged so that its data needs can be considered as the projects go forward.

To enable HPV to plan its approach to achieving its legislative objectives, a more collaborative relationship needs to exist between HPV and DHS.

Collaborating with peak purchasing entities from other states

Both Queensland (Queensland Health) and New South Wales (New South Wales Health Peak Purchasing Council [NSWHPPC]) have long-established central procurement entities. Although these entities operate under different models, they have at some stage had to address, or were faced with, many of the issues that HPV faces, e.g. developing tender specifications when data are poor or limited, standardising product lines and dealing with clinical preference.

HPV often collaborates with these entities on day-to-day matters. It has also collaborated to deliver some specific initiatives such as a shared tender with the NSWHPPC and an electronic tendering package with Queensland Health and the NSWHPPC. It should continue to collaborate with these entities to learn from their experiences, to leverage off their achievements, and to form a critical mass to address issues such as standardising supplier product codes. However, care needs to be taken to ensure that collaboration extends only to matters that will improve operational efficiency. Collaboration between them should not extend to matters that breach National Competition Policy.

4.3.9 Measuring performance

We reviewed HPV's performance indicators and targets to see whether they provided an objective basis for monitoring and measuring its performance.

We found that HPV's strategic directions statements for 2000-01, 2001-04 and 2002-05 outlined key performance areas/indicators and strategies for each strategic direction, but apart from aiming to deliver savings of $5-6 million in 2000-01, there were no quantifiable performance indicators or measurable targets.

The 2002-05 strategic directions statements are linked to desirable outcomes, however, the key performance areas/indicators are output or activity-focused, e.g.:

- number of HPV contracts in place
- value of contracts
- compliance with legislative requirements
- data modelling
- probity compliance.

HPV's operational plans provided "success criteria", but these focused purely on qualitative outputs. There were no quantitative targets to enable measurement of performance.

The level of performance needed to achieve HPV's desired outcomes is unclear, and monitoring and assessment of HPV's actual performance is difficult because of the lack of quantitative targets.

We reviewed HPV's annual reports for the 3 years to 30 June 2004, to judge the accuracy and quality of its reporting against the strategic directions. We found that this was affected by the lack of performance targets. The achievements reported by HPV did not give a clear picture. It was, therefore, not possible to determine the extent to which the directions had been met, the quality or quantity of the outputs delivered, or the significance of the achievements claimed.

4.4 Conclusions

HPV's activities were mainly directed to central tendering and contract development. It had given comparatively less focus to providing sector support and encouraging practice improvement in hospitals. It had not focused on logistics or raising awareness of the importance of supply chain management.

Some of the reasons why HPV had not delivered on its entire mandate were within its control; others were not. HPV was launched into a difficult environment, with limited set-up arrangements. As a result, its progress was affected, particularly in its first year. The procurement model quickly changed. This, and the long process of putting the necessary legal arrangements in place, has further affected HPV's ability to address its entire mandate to date.

Although HPV and many hospitals have worked together, the inability to gain agreement from hospitals on the tender operating model adversely affected HPV's operations and relationships between the parties. It remains to be seen whether the recently revised purchasing policy will address the problems previously experienced. Data, particularly the lack of standard nomenclature or codification for products, is a significant issue affecting efficient and effective central procurement in the health sector.

HPV was slow to seek the capability to enable it to deliver under the changed procurement model. We saw no evidence that the HPV members had directed, or that the CEO had sought approval, to limit HPV's activities to central tender and contract development in its first 3 years of operation.

The current funding model does not provide an incentive for HPV to maximise its achievements because the level of funding is not tied to a specified level of performance or delivery of quantified outputs.

So that HPV can carry out its entire mandate, there is a need to:

- address its capability issues
- clarify its mandate, particularly in terms of "best value"
- improve relationships and communicate better with hospitals
- address the sector's data problems.

HPV needs to:

- take greater advantage of opportunities to work with, and leverage off, others
- manage more strategically
- develop an objective basis for measuring its performance to improve the quality of its performance reporting and to enable objective assessment of its performance.

The cooperation of the DHS, hospitals and HPV will be needed to resolve many of these matters.

Recommendations

3. **That the current procurement model be reviewed by DHS to ensure that it is operating to best effect in the public health sector.**
4. **That DHS, hospitals and HPV work together to establish better relationships in the interests of achieving better procurement outcomes for the health sector.**
5. **That hospitals and HPV work together to better coordinate data delivery to make more effective use of resources.**
6. **That HPV analyse public health sector expenditure to identify potential areas for its intervention, and to provide a better basis for allocating HPV's resources to deliver the best return to the sector.**
7. **That HPV take a lead in addressing obstacles to efficient and effective health procurement, and supply chain management.**
8. **That HPV review its communication strategy, in consultation with hospitals, to better focus its communication efforts.**
9. **That HPV review its current practices, particularly relating to data management, to ensure efficient resource utilisation.**
10. **That HPV develop relevant and appropriate qualitative and quantitative performance indicators, and set measurable, auditable targets for monitoring and reporting on its performance.**

5. Hospital procurement: Initiatives introduced and savings delivered

5.1 Introduction

Hospitals continue to spend significant effort and resources procuring goods and services. During 2004-05, hospitals purchased goods and services valued at around $1.5 billion outside of Health Purchasing Victoria (HPV) contracts. Medical and surgical supplies, including prostheses ($444 million), and pharmaceuticals ($205 million) comprise 43 per cent of this figure. Given the scale of this activity, it is important that hospitals act on opportunities to achieve savings and efficiencies.

To determine whether hospitals had introduced initiatives to deliver savings and efficiencies from procurement, we visited 10 hospitals[1] throughout Victoria and asked 3 main questions:

- Had they recognised the importance of procurement?
- Had they developed savings targets for their procurement initiatives and quantified the savings achieved?
- What initiatives had the selected hospitals introduced to deliver procurement savings and efficiencies?

5.2 Had selected hospitals recognised the importance of procurement?

Approaches to procurement vary. Some organisations think of it as a backroom activity with little impact on their success. Better practice organisations ensure that procurement is given a prominent focus by management. They consider it critical to their viability and believe that it can ultimately contribute to better outcomes. Better practice organisations also recognise that procurement and supply chain management is most effectively managed when a senior executive champions improvement initiatives, and when there is strong support from the chief executive officer (CEO) and/or the board.

We asked key staff in the 10 hospitals to describe their hospital's vision and objectives for procurement and found that almost all had a clear vision for procurement, reflecting the hospital's priorities and the maturity of its procurement processes and systems.

[1] We used a structured questionnaire to gather specific information about local initiatives to achieve savings, and information on the extent to which procurement was managed strategically within each service. We interviewed the chief executive officers of the selected hospitals, staff in charge of procurement/supply and other related staff.

Examples of common goals that were articulated by selected hospitals include:

- to improve the efficiency of the supply function
- to test the market for all major purchases
- to evaluate and standardise the variety of commonly purchased products
- to aggregate purchasing power to maximise savings
- to contain costs by continuing to leverage on economies of scale
- to improve and/or maximise the efficiency of existing processes.

In most cases, we found that combinations of the above goals were being pursued by individual hospitals, especially where the procurement function had only recently begun to evolve and/or mature. Within these services, the focus was on evaluating, redesigning and reforming procurement practices so as to better capitalise on potential savings.

We found that within one of the metropolitan hospitals significant reforms had already taken place resulting in the establishment of a comparatively more mature procurement model. Within this service, the emphasis centred more around monitoring and maximising the efficiency and effectiveness of existing processes, and on continuing to leverage off their buying power so as to contain costs.

Some hospitals acknowledged that procurement had not always had prominence. All now regarded it as a key priority and as important in contributing to overall savings. There had been a growing focus on delivering savings through procurement as part of a program aimed at stopping rising budget deficits, in recent years. Financial pressures were cited as key drivers of recent procurement initiatives in 4 of the hospitals we visited.

We examined whether procurement in the selected hospitals was centrally led by a senior executive and overseen by the CEO and board, and found that:

- only 5 had a senior champion for procurement; of these, 4 were in the metropolitan area
- where there was no senior champion, procurement and supply chain management practices were more likely to be disconnected and uncoordinated. These hospitals were also less likely to have formally reviewed their practices, fully explored opportunities for efficiencies or to have developed organisational strategies
- of the 5 hospitals that had a senior champion, 4 provided regular updates to both the CEO and the board about the progress of their activities and initiatives.

Among the remaining hospitals, there was less frequent oversight of procurement activities by the CEO and board. In these cases, the CEO and board were involved on an ad hoc basis, either to approve major purchases or in response to emerging issues.

5.3 Had the selected hospitals developed savings targets for their procurement initiatives and quantified the savings achieved?

Measuring and monitoring savings against pre-determined targets enables assessment of the effectiveness of initiatives. We expected to see that the selected hospitals had quantified savings achieved from initiatives introduced to improve procurement. We also expected to see that they had set pre-determined savings targets to assist in the assessment of their effectiveness.

In examining the savings achieved, we relied upon estimates provided by individual hospitals. As different hospitals are pursuing different initiatives, actual savings reported by them are not directly comparable. Despite this, the data provide a context for discussion of the initiatives.

5.3.1 Savings estimated by hospitals

We found that only 3 of the 10 hospitals had developed specific targets. Because most had set no targets, they did not have an objective basis for assessment of effectiveness.

A small number of hospitals consciously avoided specifying savings targets for some initiatives, as their priorities were on containing their procurement costs rather than savings. Usually, this was because associated goods and services had been market tested many times and the scope to achieve additional savings was considered to be relatively low.

Examples of savings targets for key procurement initiatives are shown in Figure 5A.

FIGURE 5A: EXAMPLES OF SAVINGS TARGETS FOR SELECTED HOSPITALS FROM KEY PROCUREMENT INITIATIVES, 2004-05

Hospital/initiative	Savings target
	($)
Melbourne Health	
Melbourne Health regularly reviews the inventory levels in all stores to ensure that the volume and type of inventory held in those stores reflects current usage patterns and needs. As part of this process, targets are set for either the reduction in the value of inventory commitment or stock usage.	**211 000**
Bayside Health	
Bayside Health developed savings targets for each major initiative within its Consumables Improvement Project. Targets are at May 2005:	
Renegotiating price agreements	584 000
Sourcing lower-priced product with same functionality	513 000
Addressing clinical practices which unnecessarily drive excessive consumable use	682 000
Removing inefficiencies in ordering processes	10 000
Reducing waste in sterile product management	18 000
Reducing cost of hiring charges for minor equipment	340 000
Reducing the use and cost of stationery/linen	300 000
Total	**2 447 000**
Southern Health	
Southern Health developed a number of purchasing initiatives that are being implemented as part of its financial recovery plan. Targets are listed below:	
Supplier rationalisation	200 000
Office products purchased	150 000
Ward consumables	200 000
Document hardware	100 000
Standardise prostheses	30 000
Total	**680 000**

Source: Victorian Auditor-General's Office.

Four of the 10 hospitals (3 metropolitan and one non-metropolitan), had quantified savings from their key initiatives. Two other hospitals (one metropolitan and one non-metropolitan) had estimated savings. In some cases, delays in the implementation of the initiatives meant that the savings were not comparable with the targets set.

Five of the 10 hospitals monitored the performance of their procurement and supply management activities using customer satisfaction surveys and key performance indicators.

5.4 What initiatives had the selected hospitals introduced to deliver procurement savings and efficiencies?

Opportunities to reduce procurement costs come not only from tendering and encouraging competition, but also from addressing practices that contribute to supply chain inefficiencies. Savings and efficiencies can come from:

- paying cheaper prices for goods and services
- exploiting economies of scale to contain market prices
- managing inventory and distribution better
- reduce transaction costs by ordering more efficiently
- making better purchasing decisions by sharing and using available information better.

While specific strategies may vary according to local priorities, there are a number of key initiatives hospitals can introduce to achieve savings or achieve efficiencies from procurement. These include:

- aggregating purchasing for goods and services to take advantage of volume-based discounts, and to reduce the number and cost of transactions
- working with clinicians to reduce the variety and range of, and unnecessary expenditure on, commonly purchased items
- understanding and forecasting usage and demand to better inform purchasing decisions
- streamlining procurement processes including managing supplier lists, and inventory management practices with the aid of information technology
- developing savings targets and mechanisms to monitor the efficiency of procurement and supply chain processes, and the savings delivered.

All hospitals we visited had introduced at least one initiative aimed at delivering savings or efficiencies in procurement. Some had introduced a range of initiatives. Metropolitan hospitals had implemented a wider range of initiatives than the non-metropolitan hospitals. We found that the smaller hospitals were more selective in addressing procurement and supply chain issues. They made decisions in the context of the quantity of their purchasing spend and whether the benefit to be achieved would justify the effort required. We found that of the 10 hospitals, only some had considered:

- partnering with other hospitals to share inventory management and distribution services

- improving the management of deliveries from suppliers
- establishing better linkages between disconnected internal requisitioning and stock control systems.

Most of the selected hospitals were aware of the potential benefits of these latter initiatives, but they had given them less emphasis either because resources were allocated to other priorities or existing practices were considered adequate.

While all hospitals had introduced initiatives, hospitals in Victoria have a way to go before their procurement activities can be considered best practice.

Further discussion of the initiatives we observed, along with examples in the selected hospitals, follows.

5.4.1 Aggregating demand

All hospitals we examined actively used HPV contracts to purchase medical and surgical consumables where available, and several used whole-of-government contracts, particularly for such things as stationery, power and vehicles.

All hospitals had implemented initiatives to aggregate demand. Most of the larger metropolitan hospitals had aggregated demand for medical equipment and consumables across all of their campuses. For example, Bayside Health aggregated demand across the Alfred Hospital, Caulfield General Medical Centre and Sandringham and District Memorial Hospital. Similar arrangements existed across Melbourne Health and Southern Health. The stand-alone metropolitan and non-metropolitan hospitals also internally aggregated their demand. Although the individual items covered by these activities varied, collectively they covered a wide range of medical equipment and consumables.

Several hospitals had developed external partnerships to further consolidate purchasing power. Melbourne Health, for example, provided procurement and purchasing services to Western Health, Northern Health, the Royal Women's Hospital, the Royal Children's Hospital and co-located private health services. This resulted in significant buying power for non-HPV contracted items.

Some non-metropolitan hospitals cited geographical isolation as a reason for concentrating on internal initiatives instead of pursuing partnerships. However, 5 had formed alliances with other hospitals, including local private clinics and/or nursing homes. Hospitals within the central south-western region of Victoria had established a Country Supply Network and consolidated purchasing arrangements that enabled participating hospitals to achieve savings and efficiencies. Further information about this can be found in Figure 5B.

FIGURE 5B: USING REGIONAL NETWORKS TO AGGREGATE DEMAND

Country Supply Network

The Country Supply Network Forum meets every 2 months and consists of supply professionals from the central south-western region of Victoria. The forum provides an opportunity for these professionals to network, share information on pricing and good practice, to benchmark activities and to adopt a collaborative approach to problem solving.

Through the network, member hospitals have entered into a number of group-based buying agreements with suppliers by pooling information and identifying common suppliers for certain goods. Using this approach, member hospitals have struck aggregated volume-based buying agreements with key suppliers which, in turn, entered into individual agreements with each member hospital.

Source: Victorian Auditor-General's Office.

Although we found that all selected hospitals had implemented initiatives to aggregate demand, their decisions were based on limited analysis of consumption patterns and stock holdings. This means that decisions made might not lead to maximisation of savings or efficiencies. The availability and usage of data is discussed later in this part of the report.

5.4.2 Standardising products and improving controls over purchasing

Users, including clinicians, nurses and ward staff, have a major role in selecting equipment or consumables purchased by hospitals. However, catering to the individual preferences of all users can lead to increased costs because:

- a wider range of items is held in stock
- additional maintenance and training costs are incurred to support the use of a wider range of items
- additional process costs are involved in purchasing, receiving and paying for a wider range of items
- a larger than necessary supplier base has to be maintained
- there is reduced scope to attract volume discounts by aggregating demand[2].

[2] United Kingdom Audit Commission, *Goods for Your Health: Improving Supplies Management in NHS Trusts*, London, 1996.

Selecting equipment and consumables for hospitals requires sound procedures. These must ensure that the function of an item is clearly specified and that the available options are soundly evaluated. Hospitals should strive to balance the need to maintain a degree of variety (so as to minimise the risk to continuity of supply in the event of a product recall) with the benefits of standardisation.

Eighty per cent of the hospitals examined in this audit had implemented initiatives to standardise products and control purchases. Most were in the metropolitan area. Typically, these initiatives included establishing product evaluation committees that involved clinicians in the selection and evaluation of new clinical products, and in programs to review and reduce the variety of commonly purchased items.

Some hospitals had also improved controls for purchasing throughout the organisation. These initiatives mainly centred on establishing clearer guidelines and restrictions on which items could be requisitioned and purchased. Figure 5C provides examples of key initiatives.

FIGURE 5C: STANDARDISING PRODUCTS AND IMPROVING CONTROLS OVER PURCHASING: INITIATIVES IN SELECTED HOSPITALS

Melbourne Health

Melbourne Health established a Product Review Committee (PRC) to control the introduction of new medical equipment and clinical consumables. Its role was to assist in the development of purchasing policy and in the evaluation of equipment and consumable supplies to be used in a clinical setting within Melbourne Health (excluding drugs and IT-related products). When considering the introduction of new equipment or consumables, the product evaluation process considered a range of issues, including clinical requirements, quality, cost, and standardisation with existing equipment and products, as well as ongoing educational requirements.

The PRC considered all medical devices and equipment with a value less than $5 000, medical and surgical consumables, and any product with clinical implications, prior to its introduction to the clinical setting. No product that has been rejected by the PRC can be introduced into the hospital.

Echuca Regional Health

In developing a tender for prostheses, the chief executive officer as well as the hospital's orthopaedic surgeon and nursing staff were involved in rationalising the range of knee and hip prosthetics required. Based on current volume, the projected annual saving is estimated at $150 000.

Ballarat Health Services

Due to escalating costs, Ballarat Health Services considered capping the number of procedures using prosthetics to enable the hospital to maintain service levels. This led to an initiative to rationalise a range of prostheses, which represented an annual spend of around $2 million. A key consideration in rationalising the products was the need to ensure that clinical outcomes for patients would not be compromised.

Source: Victorian Auditor-General's Office.

5.4.3 Improving information technology and the use of e-commerce

Efficient procurement and supply chain management depends heavily on information technology (IT). Many associated processes such as requestioning, ordering, inventory management and payment of accounts lend themselves to automation. Automating these processes, eliminating redundant steps and linking them electronically can improve efficiency.

Six of the hospitals we visited had implemented initiatives to improve their IT. Most (i.e. 4) of these were metropolitan hospitals. Five of them had focused on automating or improving their internal requisitioning processes and 2 of these were also developing electronic catalogues. Another had implemented a demonstration project to illustrate the benefits of implementing e-commerce within its pharmaceutical supply chain. Figure 5D provides details of selected initiatives.

FIGURE 5D: IMPROVING INFORMATION TECHNOLOGY AND THE USE OF E-COMMERCE: INITIATIVES IN SELECTED HOSPITALS

Melbourne Health

Melbourne Health's Infrastructure Group provided purchasing, warehousing and distribution services to Melbourne Health, Western Health, Northern Health, the Royal Women's Hospital, the Royal Children's Hospital and co-located private health services. Around 2004, the group established an online requisitioning system using a software platform. The system, which includes an electronic catalogue of goods and services, was accessible to all of the group's customers via a secure intranet. Customers from different sites were able to access the catalogue to requisition goods and services. The group then processed the requisition centrally.

Bayside Health

To improve its procurement/supply management functions, Bayside Health is developing an electronic requisitioning system and common catalogue as part of a multi-faceted strategy. The common catalogue of medical and surgical consumables is being developed with clinical leaders to rationalise choice where possible, aiming at achieving better prices (through more volume to fewer suppliers) and improved resource allocation. Cataloguing for around 70 per cent of the Alfred Hospital's expenditure in these areas is already completed. The new requisitioning system is scheduled to start in August 2005. The new system will also automate labour-intensive, manual processes with the aim of delivering efficiencies.

Southern Health

During 2003-04, Southern Health's Pharmacy Department at Monash Medical Centre (MMC) developed an e-commerce supply chain initiative known as the MMC project, in conjunction with 3 suppliers. The project's objective was to demonstrate the improved trading efficiencies and cost savings that could be achieved through electronic data interchange and improved supply chain management. The project was supported by the Victorian Government's e-Commerce Exhibition Projects Program. According to Southern Health, the project demonstrated significant efficiency improvements, particularly in the areas of ordering, dispatch and receipt of goods.

Source: Victorian Auditor-General's Office.

Most non-metropolitan hospitals thought that the limitations of systems were barriers to improving procurement process. However, only 2 out of the 5 were actively trying to improve their systems.

IT problems included a lack of automation surrounding manual ordering processes, antiquated stock control systems, and the difficulty of extracting useful management information. As discussed earlier, some hospitals said that they were waiting for the introduction of the *healthSMART* financial management system developed by the Department of Human Services before expanding their e-commerce activities.

5.4.4 Using data to inform purchasing decisions

To help maximise efficiencies and savings from procurement, hospitals need to understand the demand for, and usage of, goods and services at the line item level. This knowledge can improve purchasing through a better understanding of:

- the optimum purchasing cycles for specific products
- the minimum stock levels to be maintained for specific products
- how to best take advantage of opportunities for aggregation of purchasing or inventories.

To achieve this, hospitals need reliable data on supply and demand at a product level, and staff capable of analysing them. When used to their full potential, these data can provide answers to the key questions shown in Figure 5E and lead to better inventory management.

FIGURE 5E: KEY QUESTIONS IN MATCHING SUPPLY AND DEMAND/USAGE

How much stock of this product do we hold?
What is its shelf-life?
What is the rate of consumption for the product, and what seasonal factors might affect this?
Does the rate of consumption justify the amount of stock held?
What products are slow to move?
How much stock do we waste because its shelf-life has expired?
What is the optimum purchase quantity and cycle for the product, given the consumption rate and the cost of storage?
Should we hold the product in stock or should we order on a needs basis?
How long does it take to have an order for the product filled?
What is the risk if we run out of this product, and is that risk acceptable?

Source: Victorian Auditor-General's Office.

The ability to answer such questions is critical, particularly given the quantity, value and turnover of stock held on hand by individual hospitals in Victoria[3].

[3] The collective value of stock held on hand among the 10 hospitals we surveyed was equivalent to $25 million at June 2004.

Automated purchasing and stock control systems can provide answers to many of these questions, efficiently. All of the selected hospitals had purchasing and stock control systems in place, but only 4 (all of which were metropolitan hospitals) used the data to inform their purchasing and inventory management decisions.

The remaining hospitals largely relied on pre-set parameters within their stock control systems to dictate which products and quantities would be re-ordered and when. We saw little evidence that these parameters, often set by managers, were determined, periodically reviewed, or optimised through an evidence-based analysis of usage or demand. The most commonly cited reasons were the difficulty of extracting useful data from their systems and the lack of resources and skills to analyse them.

Among the hospitals that used data for making purchasing decisions, practices varied according to the maturity of the procurement function. For example, in the one hospital that had a mature procurement/supply management function, data was used comprehensively. Within the others, the emphasis was either on improving analytical skills and/or encouraging greater usage of data. Figure 5F outlines 2 different approaches.

FIGURE 5F: USING DATA TO INFORM PURCHASING DECISIONS: INITIATIVES IN SELECTED HOSPITALS

Melbourne Health

Melbourne Health's supply department produced a monthly report and trend analysis of supply chain activity over the past 4 financial years. It was used to manage and forecast inventory, infrastructure and labour resources, and for budgeting and materials forecasting. The report included data, key performance indicators and trends in the number and value of purchase requisitions/orders, receipts, back orders and stock lines ordered, as well as monthly tracking of inventory levels.

Bayside Health

Bayside Health conducted targeted training sessions with a range of internal staff including, nursing co-directors, nurse managers, business managers, management accountants and supply staff. The sessions aimed to give staff the skills to undertake targeted analysis of the expenditure and usage of consumables, and to make informed purchasing decisions. The initiative involved identifying the capabilities for conducting analyses, assessing skills gaps, developing and delivering training to identified staff, and an ongoing implementation plan. The initiative is aimed at improving the ability of purchasing and finance staff to identify trends and provide clinicians with appropriate data to improve their decisions in relation to choice of consumables.

Source: Victorian Auditor-General's Office.

5.4.5 Redesigning and improving supply management processes and inventory management practices

Six out of the 10 selected hospitals, most of them metropolitan hospitals, had implemented initiatives to improve their supply and inventory management. They were usually implemented following reviews of the effectiveness and efficiency of their supply management practices, or in response to identified opportunities for doing things better.

Hospital warehouse.

Most initiatives related to:

- restructuring the supply department to achieve improvements through:
  - better linkages with other internal business units, including finance
  - reorganising and/or refreshing staffing and management arrangements
- re-designing and improving the management of inventory and supplier deliveries.

Figure 5G provides examples of key initiatives.

FIGURE 5G: REDESIGNING AND IMPROVING SUPPLY MANAGEMENT: INITIATIVES: IN SELECTED HOSPITALS

Melbourne Health

In the mid-1990s, Melbourne Health reviewed its supply department and decided to market-test its effectiveness and efficiency through an open competitive tender process. This led to outsourcing of the service to a private sector operator for 5 years (1997-2002). During this time, processes significantly improved. In 2002, Melbourne Health decided to returned the service in-house under a new management team within the redeveloped Infrastructure Services Group.

Austin Health

As part of the recent redevelopment of the Austin Hospital, a review of ward ordering and stockholding practices was undertaken. This resulted in initiatives to reduce stock obsolescence by restructuring ordering and inventory management practices. Ongoing reviews focus on reducing wastage and unnecessary stockholdings.

Ballarat Health Services

Ballarat Base Hospital shared its supply function with the hospitals in Beaufort, Skipton and Hepburn. Ballarat maintained the warehousing facilities and charged a handling fee for distributing supplies. This arrangement increased the volumes purchased and enabled visiting clinicians between these services to use the same supplies and equipment.

South West Healthcare

South West Healthcare (SWH) based at Warrnambool coordinates the supply/purchasing function at for all its associated campuses, and for other south-west Victorian hospitals, including Port Fairy, Koroit, Cobden, Timboon, Terang and Mortlake. SWH introduced an initiative to expand the inventory function to achieve greater buying power and associated cost savings, and to enable better management of inventory for the region. It has commenced physical redevelopment of the supply department, which will include expanded general inventory storage facilities and sterile "clean store" facilities.

Source: Victorian Auditor-General's Office.

5.5 Conclusions

All 10 hospitals recognised the importance of procurement to their operations and had undertaken initiatives to achieve savings and efficiencies. The scale of the initiatives varied across the hospitals and, in part, reflected the maturity of the procurement systems within the hospitals, and the volume of procurement.

Initiatives were not confined to driving down prices by aggregating demand, but also focused on improving hospitals' internal processes, standardising product lines, improving controls over the products purchased, and improving inventory and supply management. These were areas where we observed earlier that had less focus from HPV.

Hospitals, both metropolitan and non-metropolitan, had worked together in their local areas to deliver savings and harness efficiencies. However, some non-metropolitan hospitals cited geographical isolation as a reason for concentrating on internal initiatives, instead of pursuing partnerships.

While all hospitals had introduced a range of initiatives, and savings had been achieved, hospitals in Victoria have a way to go before their procurement activities can be considered best practice. There is scope for HPV to assist the sector by developing a best practice model for logistics management in hospitals.

It is clear that IT systems and skills in hospitals need to be improved. While 3 metropolitan hospitals were capable of producing vital information for management purposes, most non-metropolitan hospitals thought that the limitations of systems were barriers to improving their procurement. HPV could play a role in facilitating training.

IT problems were not exclusive to non-metropolitan hospitals. They included a lack of automation surrounding manual ordering processes, antiquated stock control systems and the difficulty of extracting useful management information.

Recommendations

11. **That all hospitals develop procurement/supply management strategies derived through an evidence-based understanding of barriers and opportunities, and which identify key savings initiatives and targets.**
12. **That all hospitals develop their IT systems and staff skills to ensure that relevant and appropriate data are available for internal monitoring of procurement activities and the savings achieved, to inform their decision-making, and to provide to HPV to assist its central contracting and tendering activities.**
13. **That all hospitals identify a senior executive with overall responsibility for identifying, implementing and reporting on organisation-wide procurement initiatives and that hospital boards maintain a focus on procurement.**

Appendix A. About the audit

About the audit

Objective

To determine the extent to which the activities of public hospitals, health services and Health Purchasing Victoria (HPV) had delivered savings and other benefits in procuring health goods and services.

Scope and focus

We conducted examinations at HPV, and within the following selected metropolitan and non-metropolitan public hospitals and related health services:

Metropolitan

- Austin Health (comprising Austin Hospital, Heidelberg Repatriation Hospital and Royal Talbot Rehabilitation Centre)
- Bayside Health (comprising Caulfield General Medical Centre, Sandringham and District Memorial Hospital, and The Alfred)
- Melbourne Health (comprising Royal Melbourne Hospital City and Royal Melbourne Hospital, Royal Park campuses)
- Peter Mac (Peter MacCallum Cancer Centre)
- Southern Health (comprising Casey Hospital, Dandenong Hospital, Kingston Centre, and Monash Medical Centre Clayton and Moorabbin campuses).

Non-metropolitan

- Ballarat Health Services (comprising Ballarat Base Hospital and Queen Elizabeth Centre)
- Benalla and District Memorial Hospital
- Echuca Regional Health
- South West Healthcare (comprising Warrnambool, Lismore, Camperdown and Macarthur campuses)
- Swan Hill District Hospital.

The hospitals were selected on the basis of their volume of purchasing (quantity and cost), location (e.g. metropolitan, regional, rural) and diversity of operations (e.g. specialist hospitals).

We also contacted the following 4 small rural hospitals to obtain their views on HPV: Edenhope and District Memorial Hospital, Manangatang and District Hospital, Rural Northwest Health and Omeo District Health.

This audit focused on determining the extent to which the activities of HPV, and of the selected public hospitals, health services and HPV delivered savings and other benefits in procuring health goods and services.

Audit approach

In examining the activities of HPV, public hospitals and health services and determining whether they delivered savings and other benefits in procuring health goods and services, we asked the questions:

- What value of hospital spending was covered by HPV contracts and had HPV contracted the full range of goods and services purchased by hospitals?
- What savings had been delivered by HPV and had small hospitals achieved the same cost-benefits as larger metropolitan hospitals?
- Had HPV addressed the full range of sector support and practice improvement activities specified in its mandate?
- What factors had affected HPV's ability to deliver?
- Had selected hospitals recognised the importance of procurement?
- What initiatives had the selected hospitals introduced to deliver procurement savings and efficiencies, and what savings had they delivered?

To answer these questions, we:

- researched Australian and international literature and practice, and other state and national health bodies issues
- interviewed HPV's Chair and staff, and hospital CEOs and staff
- surveyed hospital CEOs and staff
- examined relevant documents, including guidelines, reports, plans and files
- collected analysed data from Department of Human Services (DHS), hospitals and HPV
- compared performance with other jurisdictions.

This was supplemented by assistance from our consultants: Kelly Enterprises, Logistics Bureau Pty Ltd and Logistics Consulting International Pty Ltd.

The audit was performed in accordance with the Australian auditing standards applicable to performance audits, and included tests and procedures necessary to conduct the audit.

Acknowledgments

We thank staff from HPV, DHS, the public hospitals and health services, and members of our steering committee for their assistance with the audit.

Cost of the audit

The cost of this audit was $560 000. This cost includes staff time, overheads, expert advice and printing.

Appendix B. Sampling methodology

Sampling methodology

We calculated the extent of savings in 10 hospitals using the following methodology.

Sample of hospitals

Ten hospitals participated in the audit. (Refer Appendix A.) While these hospitals include representatives of metropolitan and non-metropolitan hospitals, it was not a statistical sample of all hospitals. Hence, the data from this sample have not been used to estimate total savings to the state.

Sample of contracts

We tested the savings in 4 out of 17 Health Purchasing Victoria (HPV) contracts. The 4 contracts accounted for around $102 million (70 per cent) of the estimated $145.7 million annual expenditure on HPV contracts. One contract was the A-Z pharmaceutical contract. The 3 other contracts were continence management products, medical and surgical gloves, and needles and syringes.

Sample of items within the contracts

We selected 67 items out of 1 620 items covered by the 4 contracts. The 67 items represented $39.8 million (27 per cent) of the total annual expenditure by all hospitals in the state on the 4 HPV contracts sampled. The 67 items accounted for around $22 million in annual expenditure on HPV contracts for the 10 hospitals.

Our choice of items was based on the volume and cost of items purchased, and the reliability/comparability of data across hospitals for those items. The sample covered items with the greatest annual spend and the greatest savings opportunities from the 4 sampled contracts.

Data obtained from hospitals

We asked 10 hospitals for information about each of the selected items, specifically:

- the quantity purchased in 2004

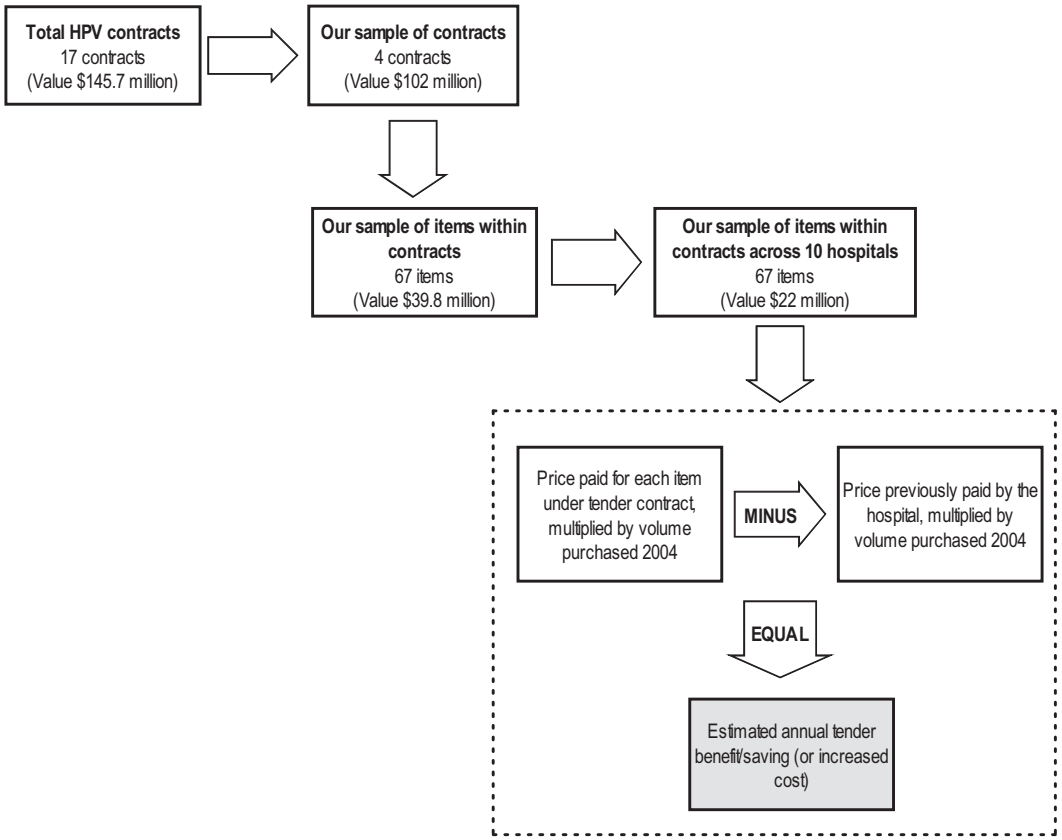
- the price paid pre-HPV contract[1], excluding items such as freight, rebates, storage costs and special deals
- the price paid under the HPV contract.

We verified the data supplied by hospitals.

Methodology for calculating savings

The methodology we used to calculate savings is shown in Figure B1.

FIGURE B1: METHODOLOGY FOR CALCULATING SAVINGS



Source: Victorian Auditor-General's Office.

Given our sampling methodology of selecting only 67 items in 10 hospitals, we have not extrapolated our results to estimate statewide savings for the 4 contracts.

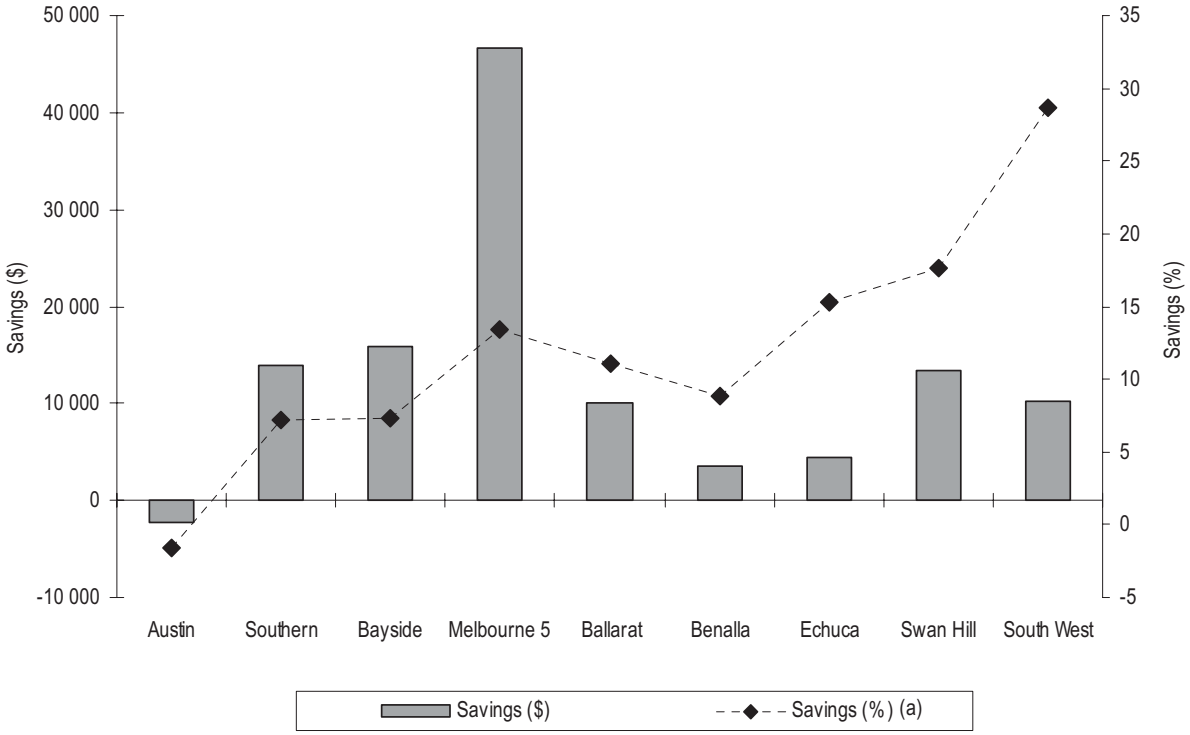
[1] For the A-Z pharmaceutical contract we obtained prices delivered under the pre-existing M-Z pharmaceutical contract (negotiated by HPV) and the A-L pharmaceutical contract (negotiated by HSA). We did not compare current prices with the previous M-Z pharmaceutical contract negotiated by HSA pre-2001.

Appendix C. Estimated savings on the basket of items for 3 contracts

Estimated savings on the basket of items for 3 contracts

We selected a basket of 67 items for the 10 selected hospitals. Thirty-three of these related to continence management products, medical and surgical gloves and needles and syringes. Savings on the 33 items for those 3 contracts are presented in the following Figures.

FIGURE C1: CONTINENCE MANAGEMENT PRODUCTS: ESTIMATED SAVINGS PER SELECTED HOSPITAL, 2004

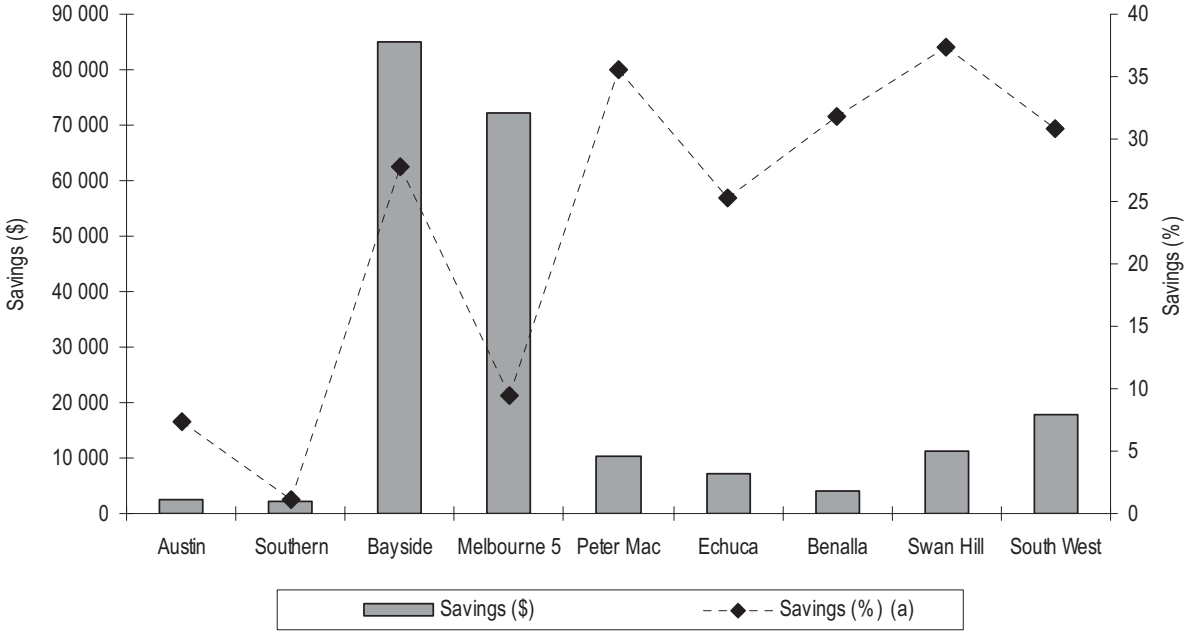


(a) The savings from the HPV contract as a percentage of the price previously paid by the hospital, using the volume purchased in 2004.

Note: Peter Mac did not use continence management products in our sample.

Source: Victorian Auditor-General's Office.

FIGURE C2: MEDICAL AND SURGICAL GLOVES: ESTIMATED SAVINGS PER SELECTED HOSPITAL, 2004

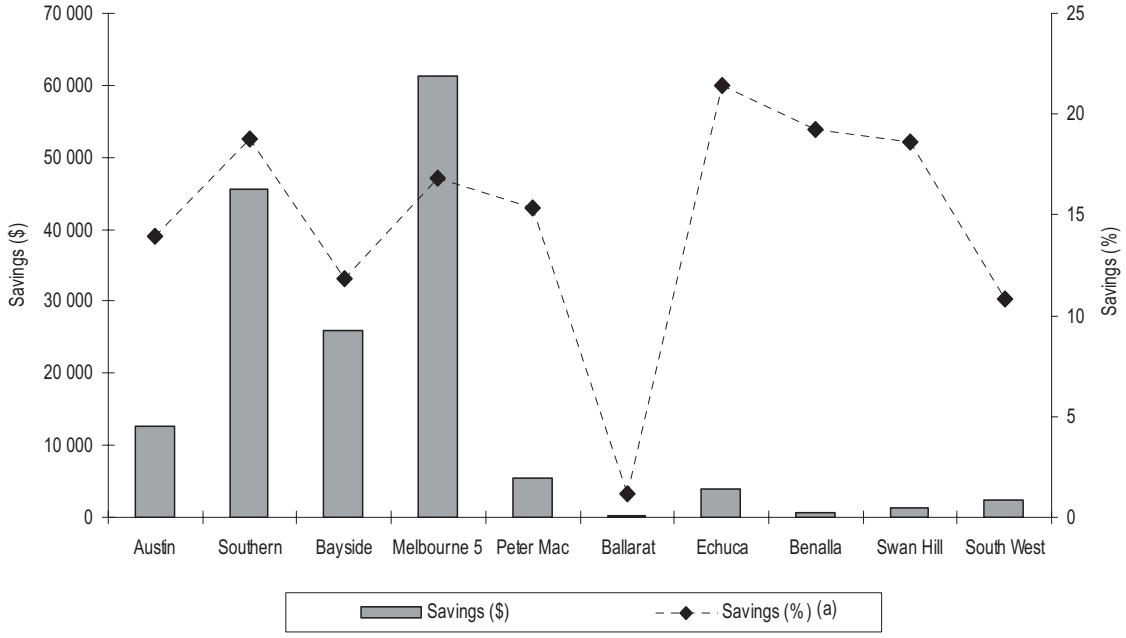


(a) The savings from the HPV contract as a percentage of the price previously paid by the hospital, using the volume purchased in 2004.

Note: Ballarat Health Services did not use gloves in our sample.

Source: Victorian Auditor-General's Office.

FIGURE C3: NEEDLES AND SYRINGES: ESTIMATED SAVINGS PER SELECTED HOSPITAL, 2004



(a) The savings from the HPV contract as a percentage of the price previously paid by the hospital, using the volume purchased in 2004.

Source: Victorian Auditor-General's Office.

Appendix D. Benchmarking results

Benchmarking results

How to read the results

Figures D1 to D4 show the incidence of lowest price by HPV and the difference between the lowest and highest purchase price for each of the 67 items benchmarked. For example, for Item 2 in Figure D1, HPV achieved the lowest price of all the benchmarked entities. The difference between the HPV's price for that item and the highest price for the same item in the benchmarked entities was 7 per cent.

Items have not been identified due to the confidentiality of the data.

Results

FIGURE D1: CONTINENCE MANAGEMENT PRODUCTS: INCIDENCE OF LOWEST PRICE BY HPV AND PERCENTAGE DIFFERENCE BETWEEN LOWEST AND HIGHEST SELLING PRICE

Item	Incidence of lowest price by HPV	Difference between highest and lowest price
		(%)
1		7
2	✓	7
3		9
4		16
5	✓	35
6	✓	36
7		50
8	✓	53
9		56
10	✓	57
11		60
12		84
13	✓	86
14	✓	97
15	✓	155

Source: Victorian Auditor-General's Office.

FIGURE D2: MEDICAL AND SURGICAL GLOVES: INCIDENCE OF LOWEST PRICE BY HPV AND PERCENTAGE DIFFERENCE BETWEEN LOWEST AND HIGHEST SELLING PRICE

Item	Incidence of lowest price by HPV	Difference between highest and lowest price
		(%)
1		8
2		10
3		10
4		10
5		10
6		10
7	✓	80
8		110
9		133
10		133

Source: Victorian Auditor-General's Office.

FIGURE D3: NEEDLES AND SYRINGES: INCIDENCE OF LOWEST PRICE BY HPV AND PERCENTAGE DIFFERENCE BETWEEN LOWEST AND HIGHEST SELLING PRICE

Item	Incidence of lowest price by HPV	Difference between highest and lowest price
		(%)
1	✓	36
2	✓	44
3	✓	46
4		56
5		63
6		75
7		80
8		90

Source: Victorian Auditor-General's Office.

FIGURE D4: A-Z PHARMACEUTICAL: INCIDENCE OF LOWEST PRICE BY HPV AND PERCENTAGE DIFFERENCE BETWEEN LOWEST AND HIGHEST SELLING PRICE

Item	Incidence of lowest price by HPV	Difference between highest and lowest price
		(%)
1	✓	0
2		(a) 0
3	✓	0
4	✓	0
5	✓	0
6	✓	0
7	✓	0
8	✓	0
9		(b) 0
10	✓	1
11	✓	1
12		2
13		2
14	✓	2
15		4
16		5
17		5
18		6
19		6
20		7
21	✓	7
22	✓	7
23		10
24	✓	10
25	✓	10
26		16
27		16
28		19
29	✓	19
30		38
31	✓	65
32		68
33		77
34	✓	96

(a) No comparative price was provided so no lowest price was recognised.
(b) The difference is not evident due to rounding.
Source: Victorian Auditor-General's Office.

Appendix E. Agency responses

Department of Human Services

Overall the report is balanced and effectively identifies areas for improvement in procurement practices.

It is expected that a service level agreement would address many of the issues raised and DHS will take steps to ensure that this is implemented.

We welcome the report on procurement practices in the Victorian public health sector, which identifies the importance that procurement practices play in achieving supply chain efficiencies and reduced costs for the sector.

We note the positive impact by HPV and we look forward to the implementation of improvement initiatives that align with the Auditor-General's recommendations, and that will allow HPV to demonstrate even more significant achievements in centralised procurement in the future.

DHS recognises the importance of best practice by all supply chain participants, including hospitals and HPV, to enable streamlined and efficient procurement processes.

Recommendation 1

Agree. It is considered that HPV should consult with DHS and hospitals to determine and prioritise goods and services to be subject to central procurement as part of the HPV strategic planning process. DHS will continue to support HPV in pursuit of best practice procurement.

Recommendation 3

Agree. DHS will review the current procurement model and related policies in order to support best practice in tendering and contracting.

Recommendation 4

Agree. In order to achieve better procurement outcomes DHS recognises that a formal agreement (service level agreement) between DHS and HPV would provide a framework to articulate responsibilities and address many of the issues raised in the report. The service level agreement would provide an objective basis for monitoring and measuring HPV performance.

DHS and HPV have been working closely together since inception. Where major issues have arisen in terms of HPV operations or initiatives, or where HPV has approached DHS for assistance and support, DHS has taken steps to provide solutions, through ongoing communications between DHS staff with HPV staff and the Minister.

Department of Human Services - continued

The agreement would recognise the need for:

- *quantitative performance targets to be articulated in HPV objectives (specific, measurable, achievable, realistic and time-based).*
- *an improved methodology for measuring the impact of HPV contracts.*
- *HPV tenders and contracts to be implemented on a priority basis.*
- *DHS, hospitals and HPV to continue to work closely together, for instance to identify the most suitable areas for tendering.*
- *continued support for HPV.*

Health Purchasing Victoria

The report provides a fair, balanced and independent assessment of the procurement practices within the Victorian public hospital sector. It also raises a number of issues regarding HPV's involvement in reforming procurement and supply chain operations in the public health sector.

HPV accepts the Auditor-General's report as a further milestone in its evolution. As with all organisations and sectors, there is always an opportunity for improvement and we are pleased to be able to use this document to guide our future strategic directions. Our current review of the HPV Strategic Directions Statement (2002-05) provides an opportunity to consider the inclusion of the report's recommendations as part of our action plan for the future. It is also a timely and useful reminder to all stakeholders of the complexity involved and the buy-in required by all parties to achieve the desired outcomes.

HPV is developing a number of business cases to assign effective allocation of resources to deliver the full impact of the HPV charter.

Recommendation 1

Agree. HPV supports this recommendation.

HPV engaged in extensive consultation with both DHS and hospitals and health services to determine both the initial tender program and the 2004-2006 tender program established by the purchasing policy of 1 July 2004 and 21 July 2005.

Health Purchasing Victoria - continued

HPV welcomes the continuing active involvement of DHS in this process to ensure best outcomes are delivered for the sector, eliminate duplication of effort, improve stakeholder acceptability; and encourage corporate ownership of the outcomes.

HPV believes that this should be interdependent with recommendation 2, i.e. a robust evidence-based methodology.

Recommendation 2

Agree. HPV believes that recommendations 1, 5, 11, 12 and 13 are prerequisites to achieving success in this area.

HPV supports the concept of a robust evidenced-based methodology and notes that HPV past tenders have utilised this approach. However, HPV recognises that although some data may not be perfect, a thorough competitive tender process can be expected to produce potential returns.

A business case is in preparation that will enable HPV to analyse information provided by health services (e.g. purchase volume, price, deal information) to:

- *develop tender plans that focus on areas of greatest benefit*
- *assist tender evaluation*
- *measure benefits from contracts let*
- *monitor contract take-up*
- *monitor supplier compliance.*
- *automate data from health services (e.g. data extracts from pharmacy and supply systems).*

Recommendation 3

Agree. HPV supports this recommendation, and acknowledges DHS's role in the determination of policy and funding.

HPV notes the Auditor-General's recognition of the cultural and regulatory constraints affecting HPV in connection with the implementation of centralised procurement. HPV is a public authority with a specific expertise in conducting tenders and awarding contracts in-line with government policy and philosophy meeting openness, transparency and probity.

HPV notes there is an inherent tension between "best price" for hospitals and "best value" for the sector.

HPV continually seeks best opportunity for its efforts and will not reject the use of any appropriate procurement model that will deliver stakeholders' expectations.

Health Purchasing Victoria - continued

HPV welcomes a review of the funding model that will provide resources sufficient to meet the expectations of stakeholders and permit HPV to meet its legislative and regulatory responsibilities.

Recommendation 4

Agree. HPV supports this recommendation. A communication strategy has been developed and applied (including targeted forums) to provide information to all levels of the sector, including DHS (metropolitan, and rural and regional), hospital and health service chief executives, chief financial officers, corporate services, supply management, pharmacists, clinicians, professional and supplier associations and industry as well as other interested government stakeholders.

HPV notes that recommendations 8 and 13 will assist in this area.

Recommendation 5

Agree. HPV supports this recommendation, and believes that recommendations 12 and 13 are integral to the success of this recommendation.

HPV is dependent upon the availability of data and market intelligence from hospitals and health services for the development of the tender programs. HPV contracts establish common unique identifiers for that range of products and the consistent data housekeeping practices in hospitals is encouraged.

HPV recently secured the cooperation of all major pharmaceutical departments and coordinated the electronic extraction of data from these systems with a minimum of effort or inconvenience to the ongoing functioning of these departments. By this method, HPV increased the sample size from 2003 to include all 41 hospital pharmaceutical departments which represented the state consumption of pharmaceutical products. Electronic retrieval of this hospital data through the use of PharmHos and iSOFT extraction programs resulted in approximately 82 000 pharmaceutical lines at a value greater than $300 million being identified for analysis. Notwithstanding these improvements, issues with data integrity continually exist throughout the tender process. After contract award, it is anticipated that the automatic uploading of contract data will yield further intangible savings through avoided labour costs.

In the absence of a unique product identifier or a product/device catalogue, HPV believes this area will continue to be challenging. This is a global challenge for procurement and is unlikely to be solved unilaterally.

Health Purchasing Victoria - continued

HPV notes that the current HealthSMART initiatives may provide further opportunities to extend these practices to non-pharmacy procurement systems and the appointment of the Director, Office of Health Information Systems, DHS as a member of HPV provides further opportunities for HPV involvement.

HPV notes that the business case discussed in recommendation 2 will contribute to this recommendation.

Recommendation 6

Agree. HPV notes the opportunity to consolidate the differential approach of IT development with respect to procurement, and emphasises the importance of a systemic IT procurement infrastructure and skills development of hospital personnel to facilitate the timely and accurate provision of information to HPV on request.

The data supplied to DHS and reviewed by HPV is from hospital finance systems that can only provide generalised information from a chart of accounts. HPV is keen to collaborate with HealthSMART, DHS, hospitals and health services to achieve improvements in this area.

The automated data extraction process during the A-Z pharmaceutical tender demonstrated the use of various naming conventions, product identifiers and variations to accepted industry resources such as the MIMS categorisation of classes of drugs. This highlights the individual ways in which hospitals may install, manage, maintain and track data in pharmaceuticals.

Recommendation 7

Agree. HPV welcomes this recommendation, whilst acknowledging the significant challenges that lie ahead that are dependent upon a coordinated response across the sector and are not necessarily restricted to the activities or influence of HPV.

HPV notes that cross-sectoral collaboration and consensus is required to address obstacles such as workforce capacity building, information technology within the supply chain and appropriate management of regulation of the market place for medical and surgical goods.

Despite its current limited resources, HPV has actively participated in its own right and encouraged participation in a number of national forums by interested parties from within the Victorian health sector. HPV chairs a number of working parties in the National Supply Chain Reform Taskforce and provides a communication channel through the maintenance and in some regions establishment of hospital supply management forums.

Health Purchasing Victoria - continued

HPV has contributed to Standards Australia in the development of a number of e-Commerce standards, which provides messaging guidelines to support the formal collection, storage, and transmission of data within hospital electronic supply chains (AS5023 series).

The Chief Executive of HPV now chairs the National Health Benchmarking Forum (NHBF) with active participation of all state, commonwealth and territory health departments. The departments of Veterans' Affairs and Defence are also participants working towards a common national approach.

HPV has championed the development and implementation of an electronic tendering solution (TenderMax) and chairs the Four State Health Networking Group (Qld, NSW, Vic and SA). This software is available for use by any Victorian public hospital or health service through a corporate licensing agreement brokered by HPV and is currently being rolled out.

HPV has been instrumental in the installation of the Clinical Advisors Group which has developed a number of best practice initiatives including the structure and functionality of the product evaluation database to assist hospitals in the avoidance of duplication of effort, costs and products and to provide a central repository to assist in assessment and networking on results.

HPV actively interacts through the Association of Hospital Supply and Purchasing Officers (AHSPO) to promote both the profile and initiatives that the various supply organisations and to provide a conduit by which the HPV charter is communicated.

The Monash Pharmacy Project is another area which HPV not only chairs but aligns current and future strategies for the development of policies and the facilitation of e-Commerce within the Victorian health sector. Overall, the project demonstrates the value of e-Commerce in the pharmaceutical supply chain and the next phase is to convince more manufacturers and key wholesalers to introduce a standardised bar-coding system and start applying EAN•UCC bar codes to their products. A standardised supply message chain is the key to tracking product from manufacturer to patient. The Monash Pharmaceutical Project adopted the EAN•UCC Standards and Australian Standard (AS 5023) to standardise the content of the supply message chain, which may be expanded in the future to include additional elements such as batch numbers and expiry dates.

Health Purchasing Victoria - continued

HPV assisted Bendigo Health Care Group in receiving a grant under the Victorian government's Supply Chain Collaboration Project which allowed Bendigo through a robust benchmarking project the opportunity to fully assess its supply department's current position measured against industry best practice modelling and is now well placed to implement the Oracle financial management information system.

HPV has sponsored a research project through Latrobe University School of Public Health that identifies best practice in prosthesis data capture and will provide recommendations to further enhance not only patient safety through coordinated data management practices, but also provide hospitals and health services with the ability to review, manage and plan their prosthetic expenditure and income through compensable sources.

HPV notes in the report the points raised in regards to equipment and has had both input and is a clear recommendation in the recently released Victorian Healthcare Association's Health Service Capital Expenditure and Management Review (Non-Major Infrastructure and Equipment).

Recommendation 8

Agree. HPV acknowledges that this area needs to be refined and modified to meet the changing needs of the sector. An integral part of this will be consultation with all stakeholders to maximise impact.

HPV would be pleased to tailor a communication program so that the appropriate person is contacted in each entity. However, as hospitals and health services are all independent there is a wide variation in the internal organisational structures of each entity. HPV is very keen to explore potential improvements with hospitals and health services. HPV resources should be noted; and with the need to communicate with >70 statutory entities HPV will always be dependent upon the proactive input from hospitals regarding changes of staff etc.

It is agreed that current arrangements are not the most effective approach to maximise the resources of all parties. Consequently, HPV plans to engage expert advice to review and develop its communication and marketing strategy for all stakeholders. Ideally, HPV would prefer to streamline its communications to maximise greatest effect with the least disruption, i.e. communicate with pharmacies, materials management and the chief executives where appropriate.

HPV notes that recommendation 13 will assist in this area.

Health Purchasing Victoria - continued

Recommendation 9

Agree. HPV recognises the need to recruit a data/business analyst resource to improve its current practices and skill base. HPV will continue to explore methods and models for the extraction, manipulation, analysis, and extrapolation of outcomes to support informed decision-making and to quantify opportunity for attainment of "best value".

Best value is defined as being informed evidence-based procurement decisions that encourage and support the uptake of useful, safe, and where appropriate innovative goods and services used in health or social care at the lowest total delivered cost, and is implicit in section 133 of the Health Services Act 1988.

HPV acknowledges gaps in data management and is actively working towards remedying this and a business case is in development which is expected to provide the necessary improvements

All hospitals and health services are separate entities and whilst most agree in principle to a common catalogue, every hospital is currently able to apply other practices. This impacts on the ability of HPV to provide an opportunity for future data mining as evidenced in the recent A-Z pharmaceutical tender.

Nevertheless, the progressive establishment of HPV contracts serves towards the establishment of common standards in cataloguing. HPV has found that returning to market with data based upon previous quarterly contract sales reports has been invaluable.

HPV provides a "before and after" result for each tender based upon the procurement information available from hospitals. HPV also requested information from a variety of sources including the aggregated data collected by DHS from hospital financial systems. Other methods are employed such as comparison with other entities interstate or modelling on a "basket of goods". At the conclusion of the tender the system always requires a concise dollar effect.

Recommendation 10

Agree. HPV established its strategic directions based upon the section 131 of the Health Services Act 1988, which in turn was influenced by the final report of the Procurement Strategy Group and clearly enunciated in the document Future Procurement Arrangements in Victoria.

Health Purchasing Victoria - continued

With respect to internal performance indicators, in common with any new organisation HPV has established internal systems and structures where none previously existed. In the last 12 months HPV has codified its operational procedures with a view to providing a framework for evidence-based decision-making, and has a robust internal reporting and review process established.

HPV has also identified an opportunity to take a lead role in the development of a best value *measurement model. On adoption, it is envisaged that hospitals will benchmark and develop networks to identify further opportunities for the implementation of change programs. Outcomes are likely to include the identification and achievement of quick fixes, tactical improvements and strategic opportunities contributing to best practice in procurement.*

HPV is dependent upon data sourcing and management methodologies, particularly in relation to process, and is still working upon auditable targets in relation to best value in procured goods. This challenge is not unique and faces procurement agencies on a world-wide basis and is dependent upon the validity of the data obtained and or provided.

Recommendation 11

Agree. HPV supports this recommendation.

To assist this recommendation HPV is currently developing a number of business cases that will in part contribute by:

1. *developing procurement policies, recommended best practice procedures, templates and other tools that can be used to improve purchasing throughout the health sector (to both HPV and non-HPV contracts)*
2. *driving ongoing improvement in effectiveness and efficiency of the supply chain*
3. *identifying best supply chain practices and facilitate their implementation across the health sector*
4. *promoting improved supply chain practices, such as:*
   - *sourcing strategies*
   - *extended supplier relationships*
   - *standardisation and rationalisation of products*
   - *purchasing intelligence.*

Health Purchasing Victoria - continued

5. *providing resources to identify best practices, develop templates, user guides, purchasing manuals, libraries of case studies etc that can be applied at health service level (based upon existing materials developed by HPV and the VGPB), for example:*
    - *contracting*
    - *tender management*
    - *terms of trade*
    - *disaster recovery/contingency planning*
    - *purchasing procedure manuals*
    - *application of international and Australian Standards*
    - *handling of dangerous goods.*

Recommendation 12.

Agree. HPV supports this recommendation.

To assist in this recommendation HPV is developing a number of business cases that will in part facilitate the identification of minimum standards and educational opportunities to assist hospitals and health services to progress this recommendation.

This will improve the skills of procurement/purchasing officers throughout the Victorian public health system and enable health services to take advantage of deals negotiated by HPV and encourage improved purchasing practices throughout the sector for all purchases (i.e. both HPV and non-HPV contracts).

The business case envisages the:

1. *engagement of a short term resource (e.g. 6 months) to conduct a training needs analysis of health service supply personnel*
2. *development of a competency framework linked to career development for supply personnel*
3. *accreditation of courses for training of health services employees. Example areas of training could include:*
    - *i. basic purchasing*
    - *ii. basic negotiation skills*
    - *iii. contract management*
4. *identification of funding sources for staff to attend training courses (e.g. state/commonwealth grants).*

Health Purchasing Victoria - continued

This project would identify potential e-Procurement strategies including the development of electronic catalogues maintained /hosted by key suppliers and the implementation of standardised electronic transactions (requisitions, orders) between health services and key suppliers. Development of an e-Procurement strategy for the Victorian health sector in accordance with the following methodology including:

- *Environmental scan of current and planned health service e-Procurement initiatives specifically considering the role of this initiative in relation to the state-wide HealthSMART implementation and enhanced by current interstate and overseas initiatives*
- *Develop a vision for health sector e-Procurement*
- *Develop strategic options to bridge and navigate the gap between current state and desired state in relation to e-Procurement*
- *Develop a detailed business case to support the recommended strategy.*

Recommendation 13

Agree. HPV supports this recommendation to place an appropriate focus on procurement.

HPV notes that this recommendation will assist in facilitating recommendation 8.

HPV also notes that targeted communication and or engagement strategies would be required for the differing stakeholders, i.e. DHS, health service boards, health service managements, supply departments, pharmacies, and suppliers.

General comments:

Strategic directions

HPV established its strategic directions based upon the enabling legislation, which in turn was influenced by the final report of the Procurement Reference Group and clearly enunciated in the document Future Procurement Arrangements in Victoria.

HPV concurs with the observation of the Auditor-General that a significant portion of non-salary and wages expenditure arises from the purchasing of some service functions across the sector such as cleaning, catering etc.

Health Purchasing Victoria - continued

To achieve tenders in this area is challenging as many of the largest potential users may have already entered into service agreements that include the provision of goods and services that may otherwise have been subject to HPV contracts.

Environment

HPV suggests that the report falls short of adequately representing the role of external factors, such as the enormity of the inherent problems of information communication technology and the infrastructure, skills and commitment that are the cornerstones to the effective delivery of HPV objectives.

Timeline of significant milestones

HPV believes that a summary of organisational milestones is helpful in establishing the context of HPV's development and the environmental challenges it has experienced during its initial years and is summarised below.

Date	No. of staff	Significant event
July 2001	3	HPV established
August 2001	3	Members appointed, first meeting of HPV members.
October 2001	3	Tender program developed in close consultation with the materials managers throughout the sector.
		HPV's assistance sought in relation to the nurse agency crisis.
December 2001	3	General agreement with tender program, tender managers from hospitals appointed to conduct tenders on behalf of HPV
		HPV sought an exemption from Section 7 of the Commonwealth *Trade Practices Act 1974* from the Australian Consumer and Competition Council (ACCC) to conduct a tender in partnership with St Vincent's Hospital Melbourne Ltd.
January 2002	7	Chief Executive and Manager Strategic Procurement, office manager and temporary project worker appointed.
February 2002	7	Permanent Chief Executive commences.
March 2002	7	Secretary of the Department of Human Services issues a direction pursuant to section 42 of the *Health Services Act 1988* regarding the terms in which nurses may be employed through agencies.
May 2002	7	Members resolve to request the Secretary of the Department of Human Services to issue a *direction* in accordance with Section 42 of the *Health Services Act 1988* for hospitals to appoint HPV as their sole agent for the purpose of procuring goods and services listed in the tender program. Members advised to seek to achieve a collaborative model with voluntary appointment by hospitals. Hospitals refuse, citing a possible breach of the Commonwealth *Trade Practices Act 1974*.
June 2002	7	Resignation of HPV member (metropolitan health service CEO), not replaced until July 2004.
August 2002	7	"Research" officer appointed (later redesignated as a contract officer), project officer ceases.

Health Purchasing Victoria - continued

Date	No. of staff	Significant event
December 2002	7	ACCC grants permission for HPV to tender for nursing agencies
		Interested parties mount challenge to ACCC determination in the Australian Competition Tribunal.
August 2003	7	Operating model drafted by a representative of the Metropolitan Chief Executive's Forum, changes status of HPV from coordination of tendering activity to sole responsibility for conducting tenders.
September 2003	9	Additional staff members appointed, data analyst and further contract officer.
September 2003	9	HPV instructed to implement the operating model drafted by a representative of the Metropolitan Chief Executive's Forum, a condition of which is that all communication between HPV and the hospital is to be via the hospital's CEO.
September 2003	9	Review of governance arrangements of the health sector published.
December 2003	9	*Health Services Act 1988* amended (section 134O) to provide protection from the *Commonwealth Trade Practices Act 1974*.
December 2003	9	Litigation commenced against HPV (contrast media).
April/May 2004	9	Review of operating model and further legal advice received perceives a legal risk.
June 2004	9	HPV issues a *direction* pursuant to section 132 of the *Health Services Act 1988* for all contracts currently in force, and proposes a tender program (2004 – 2006) to receive force of law via a mechanism known as a *purchasing policy i*n accordance with section 134 of the *Health Services Act 1988*.
July 1 2004	9	Purchasing Policy made.
		Increased funding to expand services based upon needs of the tender program expressed by the *purchasing policy*.
		Term of appointment of original HPV members expires.
July 2004	9	New HPV members appointed.
August 2004	11	Additional contract officers appointed.
July 2005	11	Litigation settled out of court (contrast media).

Austin Health

We consider the report provides a fair and balanced account of the matters subject to investigation. Austin Health hereby accepts the recommendations made in the report.

Bayside Health

The report is fair and provides a balanced and professional analysis of the history, problems and achievements of HPV. In particular, the lack of definition of 'best value' has made it difficult to assess HPV's performance and make decisions about its direction. The data in relation to Bayside Health that is included in the report is accurate.

The report makes specific recommendations that when acted upon will assist all parties realise greater value. It is essential that these recommendations be implemented in a timely fashion to assist HPV to plan its future and to maximise the benefits that be gained commencing in the current financial year. All 13 recommendations in some way relate to Bayside Health.

Recommendation 1

Agree. Bayside Health would be a willing participant in this process.

Recommendation 2

Agree. It is imperative that hospitals are consulted to ensure that hospital needs are met.

Recommendation 3

Agree. Bayside Health would participate in any review of the current procurement model.

Recommendation 4

Agree.

Recommendation 5

Agree

Recommendation 6

Agree. It is my expectation that the results of this analysis would be shared with hospitals.

Recommendation 7

Agree.

Recommendation 8

Agree.

Recommendation 9

Agree.

Bayside Health - continued

Recommendation 10

Agree. It is my expectation that hospitals be consulted during this process and that the results were shared with the hospitals.

Recommendation 11

Agree.

Recommendation 12

Agree. I agree that this is an important requirement, but the lack of resources and differing clinical priorities may make it difficult to achieve in the short-term. DHS, hospitals and HPV will need to work together to develop the IT systems. If you consider pharmacy systems as an example, there are primarily 2 pharmacy systems in Victoria for procurement in public hospitals. In implementing your recommendation, any software changes must be developed centrally rather than expecting individual hospitals to implement such changes. This is not in the scope of the current HealthSMART initiatives and would need to be a DHS supported initiative otherwise achievement at the local level would be problematic.

Recommendation 13

Agree.

Benalla and District Memorial Hospital

In my view, the report is fair and balanced.

In terms of conclusions and recommendations, I accept these as being valid.

We appreciated the opportunity to be part of the audit.

Melbourne Health

Melbourne Health believes the report provides a fair and balanced assessment of current procurement practices in relation to this organisation and its dealings with HPV.

In relation to Part 5 of your report regarding hospital procurement, Melbourne Health agrees with recommendations 11, 12 and 13 and advises that we currently have systems in place covering these recommendations.

Peter MacCallum Cancer Centre

Peter MacCallum Cancer Centre is satisfied that the performance audit report for Health Procurement Practices presents a fair and balanced view of all the issues raised and that I agree with all the recommendations.

Southern Health

We acknowledge that this report is a thorough and complex document that addresses a number of topics across the sector. Generally speaking, it is our opinion that the proposed report is a fair, reasonable and balanced assessment of the current situation within the sector. There are, however, significant sections of the proposed report that we cannot comment on, due to non-relevance to Southern Health. These sections of the proposed report specifically relate to HPV.

For example:

- *Clause 4.3.4 Funding model - Whilst health services may have knowledge of HPV's funding model, they cannot influence it or influence how any funding model is tied to any incentive mechanism.*
- *Clause 4.3.9 Measuring performance - We are not aware of HPV's performance indicators or targets. We do, however, agree that the level of performance needed to achieve HPV's desired outcomes is unclear.*

Our statement above on the proposed report's fairness and balance is therefore limited to the areas of the proposed report that are relevant to Southern Health or where we have knowledge of activity or information.

We offer the following additional comments:

- *The report states, on a number of occasions, that HPV has focused on tendering and contracting as its primary activity. In so doing, you have stated that HPV has not achieved all its activities within its mandate. Whilst this is not in dispute, we feel it appropriate to advise that, in our opinion, the procurement and contracting function is the function we wish HPV to focus on as its priority. This function delivers the most desirable outcomes for Southern Health. The other functions within HPV's mandate, we feel, we are better placed and resourced to achieve the required outcomes.*

Southern Health - continued

- *Clause 4.3.2 states (in part) "HPV considers that June 2005 revisions to the purchasing policy have addressed the outstanding issues and that the new policy replaces the need for the tender operating model". Our opinion is that an operating model is required as a support mechanism to ensure the success of the policy. Your recommendation number 3 appears to further support our opinion, in that the model is recommended to be reviewed by DHS. It is therefore not intended to be replaced with the most recent purchasing policy as HPV understand the situation.*
- *Clause 3.3.2 Tender program - The proposed report states (in part) "We saw no evidence that HPV and the hospitals took the opportunity to strategically re-position the tender program…" Southern Health has, on a number of occasions, provided advice and feedback to HPV with regards to the tender program composition. Examples of our previous specific advice relate to the requirement for the need for HPV to include prosthetics and medical gases, both of which are major expense items for hospitals and difficult contracts to execute.*
- *You refer to the composition of HPV's board in the report. This board does not currently have, nor has it had previously, a member with a hospital supply or logistics background. Perhaps the addition of such an individual could assist HPV with the strategic direction of the organisation that the proposed report highlights as a current deficiency.*

Recommendation 1

Agree.

Recommendation 2

Agree.

Recommendation 3

Agree.

Recommendation 4

Agree.

Southern Health - continued

Recommendation 5

Partially agree. We recommend that HPV investigate the merits of developing their own data extraction system that would eliminate the need for health services to extract and communicate detailed data for HPV's purposes and activities. This in turn would provide HPV with an increased level of comfort in the accuracy of the data received from hospitals. Data integrity and accuracy has been identified as an issue in the proposed report. This would rectify that situation in our opinion.

Recommendation 6

Agree.

Recommendation 7

Partially agree. At this time HPV is not resourced to complete these tasks. We feel HPV is better suited to focusing on its main role of tendering and contracting.

Recommendation 8

Agree.

Recommendation 9

Agree.

Recommendation 10

Agree. However, this is a management issue, not an operational one for health services.

Recommendation 11

Agree.

Recommendation 12

Agree.

Recommendation 13

Agree.

Southern Health - continued

Southern Health is a leader in the sector in its cooperation level afforded to HPV. Our Materials Management department invests a significant proportion of its time in ensuring all required data is collated and submitted to HPV, HPV contracts are engaged, relevant feedback is provided and that appropriate Southern Health representation on HPV committees is secured. We support HPV in a significant manner and we look forward to their continued delivery of attractive tender outcomes for the state.

Auditor-General's Reports

2004-05

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Results of special reviews and other studies	August 2004
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Meeting our future Victorian Public Service workforce needs	December 2004
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Regulating operational rail safety (2005:1)	February 2005
Managing patient safety in public hospitals (2005:2)	March 2005
Management of occupational health and safety in local government (2005:3)	April 2005
Results of special reviews and other investigations (2005:4)	May 2005
Results of financial statement audits for agencies with other than 30 June 2004 balance dates, and other audits (2005:5)	May 2005
Our children are our future: Improving outcomes for children and young people in Out of Home Care (2005:6)	June 2005
In good hands: Smart recruiting for a capable public sector (2005:7)	June 2005
Managing stormwater flooding risks in Melbourne (2005:8)	July 2005
Managing intellectual property in government agencies (2005:9)	July 2005
East Gippsland Shire Council: Proposed sale of Lakes Entrance property (2005:10)	July 2005
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