# A REVIEW OF CURRENT PROCUREMENT PRACTICES IN IRELAND

AUTHOR
DR. PAUL DAVIS



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# EXECUTIVE SUMMARY

**The objective of the study was to carry out a review of current procurement practices and to make recommendations for best practices in the procurement of medical devices in Ireland. The review of current procurement practices was based on two approaches, an overview of the current literature and international practice of procurement and a review of current practices in Ireland.**

Procurement within the public sector is seen as more a traditional tendering role rather than a set of activities that can contribute more than the tender itself. The full range of the procurement process is not being utilised. In many cases of procurement in the public sector, engagement with suppliers either through pre-market engagement or through ongoing contract evaluation does not take place. In the case of medical device procurement, it was found that the procurement is being focused on a category management approach.

The Irish health sector itself is formally moving to a more centralised approach. Yet research shows that centralised state procurement of medical technology can lead to a stifling of innovation and a reduction in competition and does not allow for local needs in relation to specific patients.

Furthermore there seems at a national level in Ireland to be a move towards framework agreements focused primarily on price. International research findings conclude that a singular focus on procurement price reduction can result in a failure to reduce total healthcare costs.

The approach of Irish public procurement is to deal with the tactical issues of price and delivery and to forgo investment in strategic activities. Medical technology procurement needs to be seen as a strategic activity in order to focus on total healthcare costs.

In reviewing approaches being adopted internationally, Ireland is still struggling to move procurement to a strategic activity that encompasses new methodologies such as commissioning. Whereas in the UK this model has been widely adopted, in Ireland this is still in its infancy.

In looking at the Health Technology Assessment (HTA) approach, it was found that there was little or no involvement of the procurement function. Currently there is not even a formal review process of existing HTAs on medical devices to realise the cost benefits available. Where the procurement takes a lead on the purchase of medical technology it is just as critical that clinical and biomedical engineering input be obtained for evaluation and subsequent procurement.

There is a growing use of standards across Europe and procurement professionals need to understand and have access to these. It is critical that a national access point be set up for the sharing of these standards with procurement. Consultation with industry can drive a better understanding of the market, which leads to increased access/utilisation of innovation and more cost-effective solutions to key healthcare issues. Consultation with industry also will ensure that procurement professionals are up to date with current standards and practices in this fast developing field.

As previously mentioned there is an overemphasis on price within many of the procurement practices. There is a need for the public sector to work closely with industry to develop total cost of ownership models. Market engagement should not involve the use of tenders to gain market knowledge but rather to enhance the opportunity for innovative products and services to be delivered. Public procurement should enable market access for local indigenous companies and SMEs, both manufacturers/developers and suppliers. This report can be used as a stimulus for a wider and deeper engagement between the policy makers, the procurement professionals and the medical device industry in Ireland.

# 1.0 CHAPTER 1

## 1.1 STUDY GOALS AND OBJECTIVES

The objective of the study was to carry out a review of current procurement practices and to make recommendations for best practices in the procurement of medical devices in Ireland. The review of current procurement practices was based on two approaches, an overview of the current literature and international practice of procurement and a review of current practices in Ireland.

The output from the review was a review outlining the current practices in Ireland, a review of practices in other jurisdictions, and a set of recommendations for adopting best practice in Ireland.

## 1.2 REASONS FOR DOING THE STUDY

The medical device sector provides over 30,000 jobs in Ireland, comprises more than 160 companies and generates sales of in excess of €6 billion. In a review recently carried out by the European Enterprise Network two findings stand out.

Firstly there is a relatively low overall level of engagement by clinicians in research. The report concluded that this stood as a challenge for the future of medical devices research in Ireland as significant medical devices innovations frequently emerge informally from the application of engineering principles to clinician insights.

Secondly the sector owed much of its growth to overseas investment. The report concluded that rising costs, unfavourable exchange rates and the improving manufacturing capabilities of competing low-cost economics are now challenging this record of growth.

Against this background IMSTA and Enterprise Ireland requested that a review take place of procurement practices by the Health Sector in Ireland and that recommendations should be sought to ensure best practice procurement is adopted.

## 1.3 INTENDED AUDIENCE

The report is aimed primarily at procurement professionals who work in the health sector on the purchase of medical and associated devices. It should act as a guide for procurement professionals on current practices available for the procurement of medical devices. It is also aimed at government policy makers as well as relevant Government Departments to ensure that best practice procurement is adopted so that both value for money and patient outcomes are balanced.

## 1.4 SCOPE AND FORMAT

The study took place over the period August 2011 to November 2011. It involved an extensive academic and practitioner based literature review, two surveys, a series of interviews and a focus group. The format of the report is firstly to give a broad overview of the current literature and findings from the research. Secondly the report will outline future trends from the literature and the research for medical device procurement. Thirdly the report outlines the key recommendations for procurement of medical devices in Ireland.

## 1.5 LIMITATIONS OF STUDY

The study was limited on two fronts, firstly time and secondly response and access. On the aspect of time, the study is bounded by the fact that it was conducted over a three-month timeframe, so any findings are based on information available during this time frame. Secondly, access to the public procurers was limited and the response rate was low.

## 1.6 INFORMATION SOURCES AND METHODOLOGY

All information provided for the report is grounded through the literature, surveys, interviews and focus group.

In carrying out the review the following steps were taken

- An extensive literature review of current practices in the procurement of medical devices.
- A survey of IMSTA members to establish current practices in Ireland (a summary of the survey is attached in Appendix 3, all replies were confidential).
- A focus group of IMSTA members to assess findings of the survey and establish common grounds for building best practices (an outline of the approach to the discussion is given in Appendix 1, all replies were confidential).
- A number of interviews with representatives of both procurement functions and manufacturers to ground out recommendations (an outline of the interview approach is given in Appendix 2, all replies were confidential).

## 1.7 ANALYST CREDENTIALS

Dr. Davis is Programme Director for the MBS in Strategic Procurement and the MSc in International Management. He has been a guest lecturer at UCSC, Cremona, Italy and ESB, Reutlingen Germany. He is currently President for the Irish Institute of Purchasing and Materials Management. He has been on the Procurement for Innovation working group and was responsible for the delivery of the research that led to the publication of the 10 Step Guide to Smarter Procurement. He is currently on the Advisory Board to the National Procurement Service at the OPW.

DCU in partnership with Bangor University and the Irish Institute of Purchasing and Materials Management has been successful in winning approval for their project "Winning in Tendering" under the Ireland Wales Interreg 4A scheme. The project has a budget of €4.2 million. Dr. Davis will be heading up the DCU elements and will co-ordinate the partners in Ireland. The project is a strategic project aimed at transforming the public tendering experience of Small Indigenous Suppliers (SIS) in the Ireland / Wales region. The project will address skills gaps of SISs and Public Procurers, which inhibit the regions competiveness and sustainable development. This work builds on the successful MBS in Strategic Procurement in DCUBS which has been endorsed by the public sector in Ireland, in particular the National Procurement Service of the OPW, and the National Public Procurement Policy Unit of the Department of Finance.

# 2.0 CHAPTER 2

## 2.1 INTRODUCTION

The approach to the literature review was to look at the academic literature to establish initially a common definition for procurement. From this the various methods of procurement used were examined and these are then briefly outlined. The background to how procurement uses the advice of experts is then examined. Following on from this the ramifications of the current legislative regime that is in place for procurement are discussed. In these four sections a general approach is taken with recommendations being made in areas that have not been addressed within the remit of public procurement to date. In the final section, building on these reviews, the case of medical device procurement specifically is addressed, and recommendations are made based on the findings of the survey, focus groups and interviews which apply specifically to medical device procurement.

## 2.2 GENERAL PROCUREMENT

Traditionally purchasing was managed as a three-stage process (Lysons and Farrington, 2006). This was the Identification Phase, the Ordering Phase and the Post-ordering Phase. The inefficiencies of these traditional procedures included

- A sequence of non-value adding clerical activities
- Excessive documentation
- Excessive time in processing orders both internally and externally
- Excessive cost on purely clerical work
  *(Lysons and Farrington, 2006, p.184).*

With Porter's (1985) Value Chain came a questioning of what value-adding activities needed to be accomplished and more importantly how they needed to be done. Reck and Long's (1988) purchasing development model suggested that this traditional three-step model of purchasing was in what they defined as the passive phase. Yet the development of supplier relationships and the movement of focus to external performance indicators (Harwick, 1997) suggested that a more process-oriented view of purchasing needed to be adopted.

Broadening out the traditional role of purchasing meant adopting new terms. Procurement is now seen as the process that includes all activities required to get an item (be it a product or service) from the supplier to the final destination (Brenner and Hamm, 1996, p.212; Van Weele, 2004). This encompasses the traditional purchasing steps but also very clearly encompasses the roles of supply management.

Van Weele (2004, p.12), defines it specifically as "…obtaining from external sources all goods, services, capabilities and knowledge where necessary for running, maintaining and managing the company's primary and support activities at the most favorable conditions."

Further definitions can be found in the literature, and the papers by Novak and Simco, 1990; Archer and Yuan, 1995 ; Gershon, 1999; Van Weele, 2004; Caldwell, Bakker, and Read, 2007 demonstrate some commonality.

Procurement then (as defined by the literature to date) is seen as including all the activities required in order to get the product from the supplier to the final destination. It encompasses the purchasing function, stores, traffic and transportation, incoming inspection and quality control and invoicing. Some organisations would also include salvage and environmental issues. Procurement spans the supply chain as defined and the management of procurement in a modern organisation

encompasses logistics management as well. It is important when drawing up guidance to have a clear view of what procurement is. Traditionally procurement in the public sector would have been seen as starting at the tendering stage but this is not the case (See 10 Step Guide to Smarter Procurement, July 2009, Ireland Government Policy).

For example, allowing the suppliers to offer enhancements over and above what is specified in the tender might be very good for innovation, in particular with medical devices. However, currently the Remedies Directive means that procurers may take the cheapest bid that meets the minimum standards of the tender (otherwise if they choose one with enhancements there is a fear that the other suppliers will object), the approach thus being a risk adverse approach.

There is scope to develop guidance here, which could relate to how a procurer steers through this particular difficulty. They should define the need for enhancements up front, and publish weightings for enhancements versus standard elements (where there are already standards/ guidelines).

### 2.2.1 RECOMMENDATIONS

- Ensure the full procurement process is being used and not focus on tendering alone.
- Develop guidance for procurement professionals on how to interact with the medical device industry.
- Develop guidance for procurement professionals on how to develop pilot schemes for new medical technology.
- Ensure structured inputs for clinical, scientific and biomedical engineering are put in place as part of the procurement process.

## 2.3 SELECTING METHOD FOR PROCUREMENT

Services are now seen as the driving force of the EU economy. The structural reforms required to create a genuine Single Market for services are at the heart of the "Europe 2020" strategy, which highlighted that "an open single market for services must be created on the basis of the Services Directive". The recently adopted "Single Market Act" (SMA) put forward a set of concrete actions to further deepen the Single Market for services and underlined the need to build on the results of the "mutual evaluation" process provided for in the Services Directive (Barnier, 2011).

The SMA objectives are :

- Smart, sustainable and inclusive growth.
- Public procurement as a market-based instrument.
- Improvement of framework conditions for innovation.
- Resource efficiency and low-carbon economy.
- Development of the business environment with a focus on SMEs.
- Efficient use of public funds through open procurement markets.

However, the need for products remains. In medical devices, there is a linkage between the products being provided and the services required. However, the processes for procuring medical devices remain linked to the standard processes defined for public procurement, these being

- Open competitive tender
- Restricted Procedure
- Negotiated Procedure
- Competitive Dialogue

which, in the main, are still primarily managed as if products alone were being bought.

## 2.0 CHAPTER 2 CONTINUED

There is currently no grounded data for the amount spent on medical devices within the HSE but there is an estimate that "there are three major buying categories that each involve expenditure of over €100 million per annum". One of these categories involves medical equipment. What is interesting to note is that due to the absence of a single system with a single national catalogue, there are multiple systems in place so that it is not possible to have a spend analysis grounded for each category, let alone each procurement approach.

Where any or all of these have been used, there are quite often further procedures such as the use of framework contracts, and in some cases, as for example with below threshold purchasing, there is a just a request for quotation.

### 2.3.1 RECOMMENDATIONS

- Ensure appropriate tender process is employed for the products or services being procured – the focus on open competitive tenders may not be conducive to good market development.
- Ensure that the appropriate criteria are applied to tenders, for example promoting technical expertise or improvements in technology. The use of Most Economically Advantageous Tender (MEAT) is often seen as promoting good market development as outlined under the Single Market Act.

## 2.4 ENSURING ADEQUATE EXPERTISE IS AVAILABLE

Procurers should ensure that the procurement team has or has access to expertise in evaluating the tenders. There has been no research to date in Ireland on the level of expertise needed to carry out procurement. In researching this area it was felt that the research carried out in other jurisdictions was equally relevant to Ireland.

Thai (2001) examined six common challenges that public procurement practitioners face in the developed and developing world:-

First, the sheer magnitude of procurement expenditure has a great impact on the economy and needs to be well managed. Thai claims that handling and managing the colossal sums of money involved in public procurement efficiently has been a policy and management concern, as well as a challenge for public procurement practitioners.

Second, public procurement has been used as an important tool for achieving economic, social and other objectives (Arrowsmith, 1997; Thai, 2001). Public procurement has to ensure that the money is spent only on the projects and that the procurements are conducted in an open, equal and transparent manner while encouraging local indigenous suppliers to bid.

Third, for many reasons (including greater scrutiny of taxpayers and competing vendors), public procurement has been perceived as an area of waste and corruption. Overcoming the negative perception - which is, to some extent, an objective reality – is one of the biggest challenges in public procurement.

Fourth, as many countries have moved to a regional and or global economy, public procurement practitioners face the challenge of complying with their government's procurement regulations and social and economic procurement goals without violating regional or international trade agreements.

Fifth, public practitioners face the challenge of disregarding their economic, social, and political environment.

Sixth, Thai claims that a sound procurement system has to accomplish two sets of requirements, management requirements and policy requirements. The procurement management requirements normally include quality, timeliness, cost (more than just the price), minimising business, financial and technical risks and maximising competition

### 2.4.1 RECOMMENDATIONS

- Medical technology procurement by its very nature requires specialist procurement skills not identical to those that apply to procuring commodities.
- Specialist skills should be available for input into the procurement process for medical technologies.
- A broader set of skills is required for strategic procurement than for category management. Because medical technologies involve risk assessment and long term impact, it would be appropriate for the skills of current category managers to be broadened.

## 2.5 LEGAL FRAMEWORKS

The legal framework at different levels (EU; national; sector) can influence the procurement process.

The European public procurement market is currently regulated by directives 2004/18/EC and 2004/17/EC for procurement of classic public purchases as well as purchases in the area of utilities in the water, energy and transport sectors. Directives 2004/17/EC and 2004/18/EC lay down rules governing the procedure for public procurement above certain EU thresholds. These two directives are accompanied by a Remedies Directive 2007/66/EC stipulating the right of a bidder to ask for effective remedies in case of an infringement of the provisions regarding the procurement procedure as established by directives 2004/18/EC and 2004/17/EC. The public procurement directives stress the equal treatment of the participants to the tender and the objective assessment of the tenders to determine which one offers the best value for money. However, it leaves the choice to the Member States whether they want to exclude or include third countries in the tender, subject of course to commitments in the GPA or FTAs. To the extent that Member States tend not to exclude third-country entities, the European public procurement market is among the most open in the world. The TFEU allows the institutions to create new laws to complement the objectives of the TFEU. These laws are called secondary legislation, as the TFEU is the primary legislation. There are two types of secondary legislation, directives and regulations. The EU public procurement rules are laid down in directives.

Each member state can decide the precise form and method of implementation of the directives. They are a form of legal tool used by the European Union rather than a regulation. A directive allows a member state a period to align itself with the goals of the directive. In Ireland we transpose the directives straight into law, while in the UK a regulatory framework is created to manage the implementation of the directives. There may be merit in debating which is more appropriate for the Irish economy in the future.

Within the directives themselves there are provisions that procurers seek to address. In many cases these may be seen as "constraints". Procurers must work their way down the constraints. This could be part of the objectives (e.g. value for money within the legal constraints).

The cost of the procurement process may represent quite a high percentage of the total value of a contract, particularly at the lower end. In an EU wide review it was found that at the lowest threshold in the directives, €125,000, total costs can amount to between 18 and 29 % of the contract value. At €390, 000, the median contract value, costs reach between 6 and 9 %. Although the cost for each participant is lower than this total (about 1/6), these shares are significant.

However these findings are influenced by the fact that many of the contracts published are well below the thresholds. Work has not been done in an Irish context to date to establish the costs of procurement.

### 2.5.1 RECOMMENDATIONS

Value for money mechanisms currently being used should be modified to take into account wider sets of evaluation criteria.

Following the directives literally leads to a risk adverse culture and inefficiencies in tendering – therefore procurers should be encouraged to take a more commercial aspect to the procurement process

## 2.6 MEDICAL DEVICE PROCUREMENT

In most European countries, medical device procurement applies to both public and private sectors and across products used in inpatient and outpatient settings. Sorenson and Kanavos examined medical device procurement across five European Countries (England, France, Germany, Italy and Spain), identifying key similarities and differences between systems. They assessed the key procurement mechanisms, actors and processes and presented them in tabular form. As part of this review a similar analysis was taken, see Table 1 below.

Compared to other European countries, Ireland has followed a familiar pattern. However due to fragmented nature of the sector there is not a coherent policy for medical device procurement across the range of organisations involved.

With the establishment of the Health Services Executive there was a move towards centralisation of procurement. However this has taken some years and is still not complete. Thus within the sector there are differences between procurement practices and duplication of responsibilities for procurement, with both the HSE and HPSG and some voluntary hospitals pursuing parallel procurements.

Increasingly the move to open tenders has led to a focus on price rather than quality, innovation or other factors. Where tenders have gone out on the basis of MEAT criteria, the weighting for price has been such that the tenders have been price based rather than the most economically advantageous.

In July 2009, the Department of Enterprise, Trade and Innovation published its 10 Step Guide to Smarter Procurement. The Steps involved are

- Identify the Need
- Define and Refine User Requirements
- Ascertain the budget available
- Engage with the market prior to tendering
- Decide the best process for procurement
- Design the tender
- Tender exercise
- Contract award
- Contract management, review and evaluation
- Record lessons for the future

Building on these steps were a series of recommendations including pre-market engagement with suppliers as well as market analysis. Although there is some engagement currently within the public health sector marketplace there is an increasing use of the tender process itself to seek market information. This is through the use of qualification criteria such as current sales and product

## 2.0 CHAPTER 2 CONTINUED

information (this being the volumes, prices, product listing being currently supplied to the procurer) being requested as part of the tender process.

| | |
|---|---|
| Principal regulatory / policy mechanisms influencing or guiding procurement | The IMB is responsible for the regulation of medical devices on the Irish market.†<br>Health Funding (Department of Health)<br>See also note on Austerity Measures -<br>Price referencing (within and across countries)<br>National and cross-border price comparisons increasingly made by governments, payers, hospitals, purchasers and the media<br>(UK, Greece, NL, etc.) |
| Key Procurement Actors | Department of Health<br>Health Service Executive<br>Hospital Procurement Services Group<br>Voluntary Hospitals<br>Private Hospitals<br>Independent units – e.g. IBTS |
| Degree of Procurement Centralisation | Traditionally decentralised – but moving to centralised structures with implementation of category management |
| Criteria used to make procurement decisions | Price<br>MEAT – most economically advantageous tender – can include price, quality, volume |

The move to category management within the HSE has led to tenders being managed by staff with little knowledge of the products or services that are being bought. Where there has been engagement with suppliers for pre-tendering, there seems to have been a greater awareness of the issues with the procurement process. An example of this type of engagement was with the da Vinci Surgical System case study outlined in the 10 Step Guide for Smarter Procurement.

Research findings reveal five keys to establishing objective, efficient, and flexible medical technology procurement strategies.

> *Hurdles to successful system development: The use of tenders is a conceptually straightforward attempt to achieve advantageous medical device pricing. A recognition and understanding of these issues can help to shape best practices for success.*
>
> *Increasing total episodic costs limits access to high-quality care: A singular focus on procurement price reduction can result in a failure to reduce total healthcare costs. A number of studies document that high-quality and innovative products that carry a higher procurement price (initial cost) can often generate improvements in patient care over alternative practices.*
>
> *Restricting competition: Some tendering systems have used "all-or-nothing" purchasing, which can inadvertently harm competition in the long term, as the loss in demand for excluded suppliers may force them to exit the market altogether. Less competition also reduces the procurer's negotiation leverage in future rounds of purchasing, ultimately resulting in higher long-term procurement costs.*
>
> *Limiting inefficiency and potential corruption: The processes and institutions used to operate tendering systems can become unwieldy and opaque, creating extra costs and opportunities for corruption.*

These findings are based on a global perspective and indicate perhaps where the market is likely to develop in Ireland.

What is clear from both the secondary research and the primary research is the conclusion that, when poorly designed, tendering systems may inadvertently result in higher total costs of care, restricted clinical access, reduced competition and higher costs due to inefficiency.

Research into Group Purchasing Organisations suggests that the initial ambition of securing the best prices for medical devices for their member hospitals has not necessarily been achieved. The research shows that the results are inconsistent with the hypothesis that GPO's secure the best prices for their member hospitals.

The survey findings here suggest that there is a dominant trend towards price and sole contracting. Out of 24 responses to the question of why organisations were unsuccessful in winning tenders, 54% organisations responded that price was the criterion used.

There is also evidence of increasing use of framework contracts and that these are not being used consistently throughout the sector. In the survey carried out with Medical Device companies it was found that between open tenders and frameworks, medical device organisations are submitting up to 60 or so tenders, with in the case of one organisation in excess of 200+ quotes being submitted in a single year. The recent Comptrollers report suggested that there was scope for extending the use of frameworks. In particular it was noted as part of the report that in two local health areas reviewed, four companies made up 58% of the purchases under the frameworks and that these purchases were mainly incontinence products, bedding and mobility aids.

In a recent resolution passed at the European Parliament , MEPs voted to simplify the process for procurement for SMEs. Over 60% of the companies surveyed were classified as SMEs. The problems identified in previous work - over-onerous paperwork, lack of engagement with the public buyer and rigidity of the rules - also applied in the case of medical devices.

### 2.6.1 RECOMMENDATIONS

- Simplification of the tendering process is required for greater participation of local indigenous companies.
- Price should not be the dominant criteria and procurers should use a wider range of award criteria.
- There should be a central database for suppliers to enter information (see Europass recommendations, footnote 31).
- A single price regime for contracts involving different logistics is not applicable and pricing should be set so as to help deliver best-cost logistics and materials management
- There should be greater engagement between industry and the health procurers – see the survey summary in appendix 3.
- A review of the approach of group purchasing should be undertaken to establish if best value is being achieved for medical device procurement.

# 3.0 CHAPTER 3

The term 'medical device' covers all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. Medical devices range from diagnostic imaging and life support equipment, infusion pumps and syringes to incontinence wear and wound care products.

With such a vast range of items there is a variety of approaches to procurement.

With very specific medical devices there may be advantages in undertaking prior market engagement to develop the specifications and ensure maximum innovation.

## 3.1 COMMISSIONING

One such approach has been the adoption of commissioning as highlighted in current research. Murray et al (2008) recognises that commissioning has now become an important term in the lexicon of UK public policy but asks whether it is just a further stage of the evolution from "purchasing" to "procurement". Are "commissioning" and "procurement" synonymous? Anecdotal evidence suggests that practitioners are confused in answering this question. Therefore there is an opportunity for the academic community to help practitioners understand the answer and its implications. A document analysis of various UK central Government departments' commissioning frameworks was used to establish the key themes and compare commissioning, procurement and purchasing. This paper discusses the similarities and differences, and argues that commissioning is different from procurement, but that commissioning offers major opportunities for procurement practitioners to make a strategic contribution.

Murray (2009), in a second article, investigates third sector commissioning policy commitments and their relevance to English local government procurement. The conclusion is that there is confusion regarding the differences between commissioning and procurement. Policy commitments are not properly embedded in procurement policy, strategy, procedures and performance management. Other countries with an interest in these policy developments should take note of the issues regarding embedding in order to improve service delivery and commissioning decisions.

### 3.1.1 RECOMMENDATIONS

- The Health sector should examine the role of commissioning and how procurement can actively support its introduction.
- Up-skilling of personnel involved in medical device procurement (including clinicians and biomedical engineers, for example) on how procurement and commissioning can deliver greater value should be put in place.

## 3.2 STANDARDS

Procurers at times may use standards that have the unknown effect of limiting the number of eligible suppliers and thus restricting competition (e.g. AMD in ICT), but for the procurement of medical devices the use of standards can ensure consistency between different organisations. The adoption of global standards (eg: GS1 standards, which are the most widely adopted standards globally) should be recommended in order to bring about synergies between organisations in the HSE and the wider health sector that currently use a number of different materials management systems to gain visibility over the procurement of products. Furthermore such adoption would support the accurate handling of product related financial transactions and claims as well as supporting the regulatory requirements for additional data to enable traceability.

Guijarro (2009) remarks that most governments have regarded interoperability as one of the key enablers of e-government. If interoperability was achieved, the vision of an integrated provision of public services to both citizens and businesses by means of information and communications technologies (ICT), regardless of the number and type of departments involved in the provision, could be realised. This type of thinking, which is occurring at European Commission level, needs to be adopted at a national level, and can be led through initiatives that are focused within a given sector. One example would be the adoption of a single materials master using common barcodes as the product identifier for all medical devices supplied to the health sector.

### 3.2.1 RECOMMENDATIONS

- A database of standards should be made available so that all procurers can access them. Although the NSAI is responsible for maintaining a database of standards, in many cases procurement professionals do not have access to it nor know of what is available. In making such a database available there should be a body responsible for ensuring that these standards are properly communicated to procurers.
- The adoption of global standards (eg: GS1 standards, which are the most widely adopted standards globally) should be recommended in order to bring about synergies between organisations in the HSE and the wider health sector that currently use a number of different materials management systems to gain visibility over the procurement of products.
- Global Standards should also be developed between the health sector and the medical device sector and not driven by industry alone – this would include a consultative process between industry and the health sector.
- Consultation on the adoption of appropriate categories should include consideration of new EU medical devices regulations.
- Consideration could be given to working with agencies involved in product identifiers to increase traceability e.g. GS1 (40 years experience in idenification and tracking of goods and services).

## 3.3 MARKET ASSESSMENT

Research has shown that an assessment of the supplier market, to be aware of how competitive it is, or whether certain suppliers may gain monopoly power, or the risks associated with the supply market, is critical in managing the marketplace itself. The interviews done for this paper indicated that this was not being done systematically or consistently across the public health sector.

### 3.3.1 RECOMMENDATIONS

- Market analysis should be performed on an ongoing basis, and criteria for the establishment of a database of new technologies should be built into the practice.
- Engagement with suppliers should be at pre-tendering and post-contract and should form part of market assessment. It was clear from previous research carried out for the 10 Step Guide to Smarter Procurement that early engagement with suppliers not only led to innovation but also to greater market awareness. Current research on the Winning in Tendering project is also confirming this.

## 3.4 TOTAL COST OF OWNERSHIP (TCO)

One of the major considerations for procurers in examining best practice is how to evaluate the costs associated with the procurement of medical devices. This has been dealt with in other sectors and Irish health sector organisations should adopt similar approaches.

## 3.0 CHAPTER 3 CONTINUED

Consideration of life cycle costs is relevant here – ensuring that the procurer investigates the total life cycle costs of the procurement and takes into account the need to change the technology in the future. There is a wide variety of models available for life cycle costing and the selection of an appropriate model requires development and consultation not just internally between stakeholders but also with industry sectors that have developed such models. In a paper on TCO and its use for ICT, for example, it was found that public procurement is neither a fully documented nor an agreed process. From state to state and jurisdiction to jurisdiction there are a number of models of procurement. Coming from the first IRSPP, Caldwell et al (2007) outlined a procurement process based on the model in Van Weeles (2004). The model broke the process down into six direct steps – specification, supplier selection, contracting, ordering, expediting and follow-up/evaluation.

In carrying out the specification and supplier selection there are a number of issues that can arise. Again from previous cases, specifications are easier to achieve when procurement is rule driven but more difficult when innovative solutions are required. Having the evaluation criteria agreed upfront for example is critical within the EU, as publication of tender documents must indicate criteria for evaluation.

The procurement of medical devices and associated technologies is quite complex. There are many issues to consider. These can include the existing medical support infrastructure, the supply of services, for example utilities such as electricity, and staff training. To procure medical devices could be seen in certain instances as being a strategic activity. It generally involves a medium- to long-term perspective. The Total Cost of Ownership (TCO) is a tool that can serve to analyse indirect costs (Hurkens and Wynstra, 2006) and many organisations are trying to achieve the lowest TCO with their suppliers in supporting their strategy, which in turn is seen as integrating purchasing into company policy (Van Weele 2004).

Three levels, operational, tactical and strategic, of TCO analysis supporting cost management have been identified by Ellram and Siferd (1998). TCO models generally attempt to determine all the cost elements, thereby revealing opportunities for cost reduction or cost avoidance for each cost element, rather than merely analysing or comparing prices. The difficulty lies in identifying and tracking these cost elements and using the information to compare different suppliers. The comparison of each of the suppliers relies heavily on having access to accurate and up to date cost information.

The concept of TCO acknowledges that acquisition price is merely one part of the costs associated with owning a good or procuring a service. Interestingly, when examining the procurement of medical devices, this can often involve the procurement of both products and services. While the most obvious reason for using TCO is to identify the actual cost of the supply decision (Leenders et al, 2006). TCO can also be used for a number of other reasons:

- To highlight cost reduction opportunities.
- To aid supplier evaluation and selection.
- To provide data for negotiations.
- To focus suppliers on cost reduction opportunities.
- To highlight the advantage of expensive, high quality items.
- To clarify and define supplier performance expectations.
- To create a long-term supply perspective.
- To forecast future performance.

There are a number of methods for estimating total cost of ownership. Each organisation must develop or adopt a method of cost modelling that best fits its needs. There are many approaches to cost modelling from informal ones to highly sophisticated complex computer models. Organisations may use either standard cost models which are applied to a variety of situations or unique cost models which are developed for a specific item or situation.Hurkens et al (2006) identified a number of methods of examining costs. The first was known as the monetary based method, which allocated the costs of purchasing an offering to the different cost components based on true costs.

The second method described by Hurkens was the cost-ratio or value-based method (Carr and Ittner, 1992; Ellram 1995 cited, Hurkens et al.). This method combined monetary with qualitative performance information, which was found to be more difficult to express in monetary terms. On the basis of the non-monetary, historical information, for instance supplier-rating scores of several suppliers, a total cost factor is calculated (Wynstra and Hurkens, 2006).

As a third method, Benton and Shin (2007) described a model for supplier selection and evaluation. This included five performance factors, quality, delivery, technology, price and service. A perfect supplier would receive a score of 1.0. The idea is to give a simple numeric rating to the hidden cost of ownership – the additional product lifetime cost to the organisation in question.

Although there has been considerable research carried out on life cycle costing and total cost of ownership in other jurisdictions and within other product categories, there is little evidence of this being done in Ireland within the medical devices sector. There is scope here for further research and collaboration between the public sector and industry to develop these models.

### 3.4.1 RECOMMENDATIONS

- Total Cost of Ownership Tools should be developed in conjunction with industry.
- Total Cost of Ownership should be developed as a key award criterion for medical device procurement. This would allow decisions to be based on long-term considerations rather than short-term price considerations.

## 3.5 AGGREGATION

If a procurer finds out that other organisations are also trying to procure the same medical devices then savings could be made. Guidelines could suggest that procurers look across their "level" (e.g. not just public health but also the private health sector) and even across the EU (for example, buying with health agencies from other jurisdictions), to increase the opportunities for joint bidding.

Coulthard and Castleman (2001) debate issues of aggregation for electronic procurement in a paper that allows us to explore the issues of aggregation within an ICT context. Although focused on ICT procurement, the applicability to the buying of medical devices is also noted.

There is also the possibility of aggregation by demand and not supply. This would have procurers pool their medical device needs, but then split tenders into a number of lots to increase the number of suppliers. In Ireland, published in July 2009, the 10 Step Guide to Smarter Procurement outlines the Irish Government's position of aggregating by demand and not by supply.

However it is necessary to beware of the "tyranny of small decisions". The individual decisions taken by small procurers that are optimal for them may be sub-optimal on a larger scale. For example, (optimal) small decisions by individual procurers may lead to lock-in for an entire network. Suppliers could take advantage of this and prefer lots of small decision makers who are unaware of what the rest of the network is doing.

There is also a question of on what level of aggregation could be recommended. Should the recommendation then be many individual decision makers that closely represent a competitive market, or large centralised decision makers to ensure more socially optimal procurement decisions are taken? Or should it be a combination? There is again a lack of grounded data in Ireland on procurement spend and the effects of different approaches, which makes it difficult to assess what is the right course of action. The recommendations are based on best practice from the literature reviewed.

### 3.5.1 RECOMMENDATIONS

- Aggregation should be by demand and not by supply.
- Aggregation should not be driven by price but rather efficiency and effectiveness of process.

## 3.6 COLLABORATIVE PROCUREMENT

Racca and Albano try in their paper "Collaborative Public Procurement and Supply in the EU experience" to better understand the relation between national, European and international policies associated with purchasing and purchasing strategy and performance. They consider (1) purchasing or contracting as strategy and (2) strategies associated with effective purchasing by focusing on the current European experience as a result of European Union policy and its interaction with national and local policies

### 3.6.1 RECOMMENDATIONS

- The health sector should benchmark with other jurisdictions.
- Collaborative procurement should not be limited to within the public health sector but should encompass both public and private domains.
- Collaborative procurement should be sought across jurisdictions where value for money is a priority.

## 3.7 STRUCTURE OF PROCUREMENT ORGANISATIONS

Lawrence and Lorsch (1967) argue that the organisation should be structured in such a way that it can respond to pressures for change from its environment and pursue any appropriate opportunities that are spotted. Given that strategies are concerned with relating the organisation's resources and value within the environment, it follows that strategy and structure are linked.

There is however no one right way to structure an organisation. The degree of devolution should for example be matched to choice of strategies. So a highly centralised regime (a well functioning bureaucracy) may be well matched to the delivery of a no-frills cost efficient service. In centralised regimes, the corporate centre is expected to add value through efficiency/leverage, expertise, investment, competence building, fostering innovation, mitigating risk, collaboration, and standardisation. In devolved regimes the corporate centre mainly adds value through its parenting skills and perhaps its ability to create synergy. There is a strong relationship between structure and controls in organisations and the culture they create over many years. So there is a need to consider how culture will need to be changed alongside structural changes, which are deemed necessary to support new strategies. This is why many public services have found it difficult to rise to the opportunity of a less regulated world (Scholes, 2001).

Centralised and decentralised are concepts commonly used in dealing with the relationship between the corporate centre and the organisational divisions. Decentralisation is often associated with a pluralistic and loosely coupled organisation with a portfolio of autonomous business units (Jarzabkowksi, 2002). Greater centralisation is associated with the view of the organisation as an overarching carapace of core competences and identity, under which a set of synergistic departments are managed.

Competitive environments increase centralisation as organisations resort to management controls in order to improve co-ordination, monitor quality, and reduce costs (Khandwalla, 1973). This is particularly true in pluralistic organisations, where management controls improve standardisation and create a unitary image (Khandwalla, 1973; Mintzberg, 1979). In the public sector, in particular in

Europe, the term New Public Sector management has dominated public sector management in the last few years (Flynn and Strehl, 1996, Pollitt and Summa, 1997). There are, however, three key dimensions (Bach and Della Rocca, 2000) underlying these management practices. The first concerns the extent to which a stronger management function, held accountable for performance, has emerged.

The second issue concerns changes in the organisational structures and the extent to which monolithic public service organisations are broken into separate units with more devolved management practices. The third element they draw attention to is the development of a market orientation, whereby public sector management practice has shifted from management by hierarchy to management by contract. These changes in environment and managerial practice have not, to date, been debated as part of the centralisation and decentralisation of procurement within the public sector.

Most organisations that operate several different business units adapt between buying everything centrally and buying everything locally, aiming to balance the advantages of strength with those of flexibility. Basically there are three alternatives (Bailey et al, 2005): complete decentralisation, complete centralisation or a combination of the two. Centralised purchasing has gradually become common in the United States. However, the centralisation trend has been challenged in recent years. Many practitioners and researchers have contended that purchasing authority, especially in government, must be decentralised in order to provide more responsive support to end users, eliminate bureaucratic obstacles to programme accomplishment, improve inter-departmental coordination, and empower service delivery managers to procure what they need without impediment by a centralised organisation (Thai, 2001).

In setting objectives for the procurement of medical devices it is clear that there is a debate to be had about the issue of centralisation and decentralisation from the perspective of fit. We need to ask in proposing the use of procurement from the centre, what approaches should be taken and if the theoretical concepts and approach of centralisation and decentralisation of the purchasing function are appropriate for public sector. There is a traditional analysis of centralisation and decentralisation of purchasing, but with the development of new technologies and the adoption of more innovative approaches to procurement we must ask is the centralisation approach contrary to new public management approach such as commissioning and is the traditional view of purchasing still relevant? In setting the objectives of procurement, traditional approaches based on specifications that were technical and standards-based may be more appropriate to be enforced centrally for standardised systems such as commodity-based products, whereas decentralised systems and use of commissioning may be more relevant where innovation and patient-centered delivery systems are involved.

### 3.7.1 RECOMMENDATIONS

- Centralised procurement systems should be developed for transactional procurement.
- Decentralised or strategic procurement models should be developed around patient outcomes.

## 3.8 TECHNOLOGY ASSESSMENT

Technology Assessment arose in the mid-1960s from an appreciation of the critical role of technology in modern society and its potential for unintended and sometimes harmful consequences. Health technology assessment considers the effectiveness, appropriateness and cost of technologies. It does this by asking four fundamental questions. Does the technology work, for whom and at what cost and how does it compare with alternatives? It is a structured analysis of health technology, a set of related technologies, or a technology-related issue that is performed for providing input to a policy decision. It is a multidisciplinary field policy analysis, and encompasses medical, social, ethical and economic implications of development, diffusion and use of health technology.

Work carried out in other jurisdictions, such as the UK, was reviewed. Although there was anecdotal evidence that procurement was being involved in the HTA in the UK, when the implementation documents were reviewed there was only one reference to purchasing in the NHS "Guide to the multiple technology appraisal process" published in October 2009.

In Ireland HTA is governed by HIQA. Similar to the UK documentation, in all of HIQA's 3 recent publications the role of procurement in helping to examine the cost benefits or the economic evaluation is not mentioned. Procurement as such is not seen as having a role to play in the engagement with suppliers of medical devices, rather the role falls to clinicians and specialist staff. This lack of linkage between the early involvement of procurement and the development of innovation goes counter to previous government recommendations for the procurement of innovation. This approach may indicate a lack of consistency between government policy and actual implementation.

In both surveys of public procurers and IMSTA members there were clear recommendations from both buyers and suppliers for early engagement in product and service development.

### 3.8.1 RECOMMENDATIONS

- Procurement should play a key role in the development of economic models for health technology assessment.
- Procurement should be involved in the pre-commercial engagement of organisations where health technology assessment is being carried out.
- The HIQA health technology assessment guidelines should be updated to include a direct role for procurement.

# 4.0 CHAPTER 4

## 4.1 RECOMMENDATIONS FOR MEDICAL DEVICE PROCUREMENT

The recommendations are broken down into two categories. The first category consists of those recommendations that can be applied generically to public procurement in Ireland. IMSTA should work along with other industry bodies to ensure that there is a consistent approach taken with policy makers to public procurement. These recommendations could help IMSTA have a common ground for this discussion. The second category consists of those recommendations that are specific to the Medical Device Sector and should form a basis for opening dialogue between the HSE and IMSTA.

### General Procurement Recommendations

- Ensure the full procurement process is being used and not focus on Tendering alone
- Ensure appropriate tender process is employed for products and services being procured – the focus on open competitive tenders may not be conducive to good market development.
- Ensure that the appropriate criteria are applied to tenders for example promoting technical expertise or improvements in technology. The use of Most Economically Advantageous Tender (MEAT) is often seen as promoting good market development as outlined under the Single Market Act.
- Value for money mechanisms currently being used should be modified to take into account wider sets of evaluation criteria.
- Following the directives literally leads to a risk adverse culture and inefficiencies in tendering – procurers should be encouraged to take a more commercial aspect to the procurement process.
- Simplification of the tendering process is required for greater participation of local indigenous companies.
- Price should not be the dominant criterion and procurers should use a wider range of award criteria.
- There should be a central database for suppliers to enter information (see Europass recommendations, footnote 31).
- A single price regime for contracts involving different logistics is not applicable and pricing should be set so as to help deliver best-cost logistics and materials management.
- A database of standards should be made available so that all procurers can access them. Although the NSAI are responsible for maintaining a database of standards, in many cases procurement professionals do not have access nor know of what is available. In making such a database available there should be a body responsible for ensuring proper communication of these standards is given to the procurement functions.
- Market analysis should be performed on an ongoing basis, and criteria for the establishment of a database of new technologies should be built into the practice.
- Engagement with suppliers should be at pre-tendering and post-contract and should form part of market assessment. It was clear form previous research carried out for the 10 Step Guide to Smarter Procurement that early engagement with suppliers not only led to innovation but also to greater market awareness. Current research on the "Winning in Tendering" project is also confirming this.
- Total Cost of Ownership Tools should be developed in conjunction with industry.
- Aggregation should be by demand and not by supply.
- Aggregation should not be driven by price but rather efficiency and effectiveness of process.
- Collaborative procurement should be sought across jurisdictions where value for money is a priority.
- Centralised procurement systems should be developed for transactional procurement.
- Consideration should be given to the fact that on a global level, GS1 is the most widely adopted standard within procurement systems in healthcare and other industry sectors.

The above recommendations should be prioritized by IMSTA in conjunction with other representative bodies. These same findings are occurring in multiple areas of research and should be approached rather than on a sectoral level (such as just medical devices) but at a national level. Responsibility for implementation of the recommendations should be identified and actioned. This again could be done in conjunction not just with other representative bodies but also the public sector itself.

### Medical Device Sector Specific Recommendations

- Develop guidance for procurement professionals on how to interact with medical device industry.
- Develop guidance for procurement professionals on how to develop pilot schemes for new medical technology.
- Ensure structured inputs for clinical, scientific and biomedical engineering are put in place as part of the procurement process.
- Medical technology procurement by its very nature requires specialist procurement skills and cannot effectively be procured in the same way as commodities.
- Specialist skills should be available for input into the procurement process for medical technologies.
- A broader set of skills are required for strategic procurement than for category management. Because medical technologies involve risk assessment and long-term impact, it would be appropriate for the skills of category managers to be broadened.
- There should be greater engagement between industry and health procurers – see survey summary in appendix 3.
- A review of the approach of group purchasing should be undertaken to establish whether best value is being achieved for medical device procurement.
- The Health sector should examine the role of commissioning and how procurement can actively support the role out of the practice.
- Up-skilling of personnel involved in medical device procurement (this includes clinicians and biomedical engineers, for example) on how procurement and commissioning can deliver greater value should be put in place.
- Standards should be developed between the health sector and the medical device sector and not driven by industry alone – this would include a consultative process between industry and the health sector– see GS1 whitepaper on UDI (Unique Device Identification)
- Consultation on the adoption of appropriate categories should include consideration of new EU medical devices regulations.
- Consideration could be given to working with agencies involved in product identifiers to increase traceability e.g. GS1.
- Total Cost of Ownership should be developed as a key award criterion for medical device procurement. This would allow decisions to be based on long-term considerations rather than short-term price considerations.
- The health sector should benchmark with other jurisdictions.
- Collaborative procurement should not be limited to within the public health sector but should encompass both public and private domains.
- Decentralised and strategic procurement models should be developed around patient outcomes.
- Procurement should play a key role in the development of economic models for health technology assessment.
- Procurement should be involved in the pre-commercial engagement of organisations where health technology assessment is being carried out.
- The HIQA health technology assessment guidelines should be updated to include a direct role for procurement.

There are quite a lot of recommendations that are specific to the medical device sector. One approach for establishing priorities here would be for a number of stakeholders in IMSTA to establish a working group to prioritise the recommendations. A second approach is for independent organisations to examine the recommendations and to work with agencies such as the HSE to see how they could be implemented.

# 5.0 CHAPTER 5

## 5.1 SUMMARY AND CONCLUSIONS

**The objective of the study was to carry out a review of current procurement practices and to make recommendations for best practices in the procurement of medical devices in Ireland. These have been made in Chapter 4. Although there are over 37 recommendations, it would be of benefit for IMSTA to prioritise a number of these for action with stakeholders.**

The output from the review is this report, which reviewed current practices in Ireland, and examined current practices elsewhere. The report also highlighted areas that both procurement and the medical technology supply industry could better co-ordinate to improve the outcomes of current processes.

There is a current trend in public sector procurement to focus on short term wins with price, but risk attaches to this approach and the practices outlined in this report are about building sustainable long-term procurement practices that will best serve both patients and the economy.

The recommendations are meant to act as an impetus for discussion for IMSTA, the agencies within the Health Sector and Government and policy makers. The approach taken was not to set priorities but set out a list of markers that could form the basis of a policy document for IMSTA.

# APPENDICES

## APPENDIX 1 FOCUS GROUP OUTLINE

A focus group was held with members of IMSTA.
The objectives of the focus group was to

- Involve the users in the key data gathering phase
- The collection of information relevant to the primary objective of identifying best practice procurement
- To analyze the information collected to explore and obtain findings to support best practice procurement

The focus group took place over a single morning and the agenda for the focus group was

- Background to the Study
- A review of the Survey Data
- A review of the Interview Data
- Key Findings to Date

The outcomes of the focus group were a consolidation of the data gathered from the previous work.

## APPENDIX 2 INTERVIEWS

A number of interviews were carried out with both IMSTA members and Public Procurement Buyers. The purpose of the interviews was to discuss some of the findings from the surveys in greater detail. The interviews were carried out over the period October to November 2011.

Notes were taken from the interviews and these were used to support the literature review and survey results in making the recommendations in this report.

## APPENDIX 3 RESULTS OF IMSTA SURVEY

### Q1. Location of Your Organisation

There were
17 Companies from Dublin
8 from Galway / Limerick
1 from Cork
1 from the UK
1 from the USA

### Q2. Type of Organisation e.g. Manufacturing, Distribution, Wholesale, etc

There were
16 companies classified as Distribution / Sales / Wholesale
6 companies classified as Manufacturing
3 companies classified as Research / testing / development
5 others, which would include consultancy and services, provision

### Q3. Size of Organisation e.g. Multinational, SME, Subsidiary etc

There were
15 companies classified as SME
6 companies classified as subsidiary
8 companies classified as Multinational
1 classified as other

## APPENDICES CONTINUED

**Q4. Please list the types of products / services provided**
The range of products / services provided included

Mobility equipment, Pressure Care, Seating
Supply and service of medical equipment and consumables to hospitals in the island of Ireland
Product & Packaging testing service
Single Use Sterile Medical Devices
Decontamination
IVD equipment, reagents, service & maintenance
Healthcare products including pharmaceutical, medical devices and OTC items
Mobility, Rehabilitation Equipment and Medical Consumables
X-Ray - Radiology Products and IT Solutions
Single Use Disposables
Respiratory therapies and respiratory equipment
Medical device distribution
Wide range of medical devices for lesser-invasive treatments
Patient administration and electronic patient record (PAS/EPR) systems, A&E, Maternity, child health, business intelligence, PACS, Cardiology, adult and children's social care systems, workforce management solutions and services, and a variety of clinical and commissioning applications.
Manufacture medical devices that are used for the treatment of complex Coronary Artery Disease
Product testing & consultancy, reliability testing & consultancy, Medical Device testing.
Medical Devices
Medical, Surgical and Primary care consumables and equipment
PTA Catheters
Medical Devices
Patient Positioners
Monitoring, Project management,
Diagnostics equipment. (1) Research reagents and instruments, (2) Molecular Diagnostics reagents and instruments, (3) Biochemistry, Immunoassay, Serology instrument platforms & reagents, (4) Point of Care POC testing equipment, (5) Tissue Diagnostics equipment & reagents
Pharma, Medical Devices, Diagnostics and Services
Incontinence wear (Prescription Management, Clinical support & home delivery), risk prevention products and wound care,
Orthopedic medical devices
Coronary stents and catheter delivery systems
Product and Process Design and Development

**Q5. Does your organisation have a dedicated person or team focused on tendering submissions?**
Please explain briefly their role if the answer is yes.

Included below are the answers supplied

1 No. Usually carried out by owner.
2 Yes- this team usually includes (depending on the type of product tendered) members of our product specialist team, sales administration, sales management, and technical support teams who would each have an input in compiling the overall submission
3 No
4 No
5 No
6 Yes. To lead the complete process from announcement of procurement through to contract award, including advert response, PQQ, tender submission, contract management.
7 Not a dedicated resource - submissions are prepared by an experienced team
8 Yes, it's a part of their overall role which includes marketing and business development
9 Yes
10 1 person co-coordinating all submissions
11 Yes, contracts manager leads a selected team for each tender
12 4 people would spend part of their time working on tenders but not fully dedicated

APPENDICES CONTINUED

13 Most countries do have such a function. They scan OJEU and work with Divisions to manage responses to customers
14 Yes - Teams are split between UK and Vancouver. The Vancouver team provides technical and functional response and UK manage the administration side of the response
15 No
16 No
17 Yes
18 Yes - Commercial Team of 3 looking after all pricing, quotations, tenders and framework agreements
19 No
20 No
21 No. We sell to Distributors and they would put in tenders
22 No
23 Yes. Team focused on screening tenders as published on platforms such as etenders as well as final collation of tender submissions
24 No
25 Yes we quote on a weekly basis. RFQ's are received and detail quotations 3:40 PM provided back to customer.
26 Yes Trawl of OJEC or alternatives, Compilation and Submission of bids
27 Team approach
28 Yes - we have Business Unit Managers who are responsible for tender submissions
29 No
30 No

**Q6. Have you bid for Public Sector Contracts: specifically in Ireland within the last three years?**

21 companies have bid for business within the last three years. 9 companies had not.

**Q7. If Yes to Question 6: Please list out the frequency of the tenders e.g. how many times have you tendered in the last 3 years?**

The answers given where applicable were included here.

1 Approx 63 tenders were submitted
2 More than 10
3 2
4 5 times in the last 2 years, prior to that business was with a distributor.
5 1
6 Seven
7 12 Times
8 30
9 10 to 20 per annum
10 Any time a tender for medical equipment comes out
11 Don't have a definitive number. We will have responded to all public tenders where our products would be appropriate
12 This team manages a number of tenders for our international business. However Ireland specific = 1
14 1
15 Multiple - constantly completing tenders/frameworks on weekly basis
16 No
17 approx 20-30 times
18 At least six times
19 On average 200+ quotes per year. (600+)
20 >100
21 Infrequent as papers not issued.

## APPENDICES CONTINUED

**Q8. How many tenders have been successful for you?**

1 0
2 Approx 30
3 Partially in most
4 2
5 0
6 Results pending
7 Three
8 TWO - One (in Northern Ireland)
9 20
10 80%
11 hard to say, 65%
12 N/K
13 1
14 N/A
15 1
16 Successful on a number but limited new business gained
17 3-4 per year
18 None
19 -
20 N/A
21 2
22 Between 10-14%
23 Many successful but partially
24 3

**Q9. How many tenders were unsuccessful?**

1 0
2 Approx 33
3 Usually Partially Successful
4 0
5 3, 2 still not awarded.
6 see 10
7 Four
8 Ten
9 10
10 20%
11 35%
12 N/K
13 0
15 0
16 Large number based on the volume of tenders submitted
17 10-15 per year
18 None
19 -
21 4
22 80 +%
23 as per 10
24 1
25 none

## APPENDICES CONTINUED

### Q10. What were the reasons for the unsuccessful tenders?

1 Mainly due to lower cost competitor tender bids being awarded
2 Sometimes Price, Sometimes User Preference
3 existing supplier preferred
4 Predominantly price
5 Price
6 Sometimes cancelled and other not successful on price or experience
7 Equipment spec not ideal Price
8 Pricing
9 Variety of reasons - usually simple as price
13 The Products Didn't Met the Specifications
14 HSE only considering lowest price Award to multiple suppliers - exercise reduce pricing and remain with existing supplier to avoid any disruption for HSE. Tender/Framework cancelled. Framework awarded but no subsequent action taken
15 Price
18 Technical specification/solution, price,
19 No reason given
20 Major reason was pricing. 2nd reason was delivery time.
21 Price
22 Always price!
23 Not applicable

### Q11. Did you request or receive feedback from the public sector bodies for the unsuccessful tenders?

In only 10 cases feedback was given by the Public Sector.

### Q12. If you have not engaged in public sector tendering within the last three years please list your reasons why?

*There were a number of reasons given here, these included*

- Private company, not part of business plan or scope of company
- Not used in our business area
- Not a sector we have been have been targeting
- There have been no formal tenders in this area as yet
- We work with medical device companies - not finished medical devices

### Q13. Do you engage with the public sector other than through tendering? Examples of the type of engagement that might have occurred is collaboration, research, below threshold purchasing

*Where positive answers and an explanation was given, these have been included below. Of the responding companies 21 companies were engaged with the public sector in areas other than tendering.*

We engage on a day to day basis in the supply of consumable products and spare parts - some of which are not on contract - and on other equipment that is acquired on a below threshold purchase basis

Distribute to them on an ongoing basis outside of the tender arena

Yes, our biggest customer is the HSE for mobility / rehabilitation equipment sold via HSE Occupational Therapists. Hospital consumables sold via HSE procurement / hospital stores buyers and infection control.

## APPENDICES CONTINUED

Yes, on Servicing, Pricing and Cost Saving Proposals

Yes we have many smaller supply arrangements with hospitals or clinics. In addition we have on R&D project on going

At strategic level via IMSTA. Operationally we will have some discussions around new products, contract performance but not around research

Collaboration, R&D, future needs analysis, BTP

Yes. HSE operate 3 quotation process for goods over €5k (seems to operate the 3 quotation process for equipment under €5k also). Local price agreements - pricing agreements with individual hospitals areas

Yes, in research

Yes - individual hospital negotiations are a daily occurrence. We are also engaged actively with stock management solutions in a number of HSE units

**Q14. If you answered yes, please describe how? If you answered no, please describe why not?**

*Samples of the answers are given to this question here.*

We carry out assessments with Public sector employees for the provision of aids and appliances

Purchases are often made on the basis of three quotations being sought from suppliers routines Sales Activity

Below threshold purchasing

Both face to face and via written correspondence

Through either local contracts or through sales people selling to end users

Service level agreements, pilot projects, and framework agreements

Pricing

On a Governmental level through our solicitors and on HSE executive level through direct request

Work together with patient organisations, government

Business below threshold not tendered

Multifaceted, Trials, Research, Joint Initiatives, Recalls, Debtors

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