Health ClusterNET Report 1

How the Health Sector can contribute to regional development: the example of local procurement
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Many thanks are given to all the participants and organisers (Margit Ohr - Network Coordinator, Igor Krampac – Regional Public Health Institute, Maribor; Nekane Astigarraga – Universidad de Deusto) of the Maribor Workshop and Bilbao Policy Forum for the knowledge and experiences shared, the issues debated and their contributions to shaping both the content of this report and the policy recommendations in The Bilbao Agenda. Thanks also to Justin Sacks (formerly with the new economics foundation and now K2A) who together with Adam Wilkinson gave an inspired masterclass on LM3.

The opinions and recommendations contained in this report represent the collective view of Health ClusterNET partners. They should not be taken to represent the views of individual partner organisations, ONE North East (the lead partner) or the Interreg IIIC Programme.

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Executive summary

Introduction

The purpose of this report is to present the knowledge and experiences shared by partners that explored how the health sector can contribute to regional development through its procurement activities.

Who should read this report

- For health service decision makers this agenda supports the development of the corporate social responsibility role of their organisations and also shows their commitment to the health inequalities and health improvement agenda.

- For local health organisations such as acute hospitals and primary care organisations, this agenda helps show commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels.

- For SMEs, the adoption of this agenda in a region or community, offers a clear basis for lobbying for simpler, more transparent procurement processes with less bureaucracy and the development of an enterprise aware culture in health service organisations.

- For relevant directorates within the European Commission (DG Enterprise, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for an approach that cuts across individual DG competencies in order to achieve European added value.

Key messages

- Procurement by health service organisations at regional and local levels has the potential to improve health and develop human capital by
  - Stimulating the development of capable local businesses
  - Strengthening their competitiveness in wider markets
  - Supporting a positive drive to achieve the goals of the Lisbon Agenda.

- In addition, enabling local businesses to compete for public procurement contracts has other proven benefits to local economies and regional development including
  - Increasing local employment
  - Increasing the skills base in local labour markets
  - Enhancing community wellbeing and social cohesion
  - Protecting the environment by decreasing transport miles.

- Procurement can be done in ways that are both creative and that fit within current EC and national legislation

- It is important to incentivise understanding of and support for sustainable approaches to procurement by creating processes that benefit health sector organisations and SMEs at the same time

- However, in many partner regions health sector procurement is becoming increasingly centralised in order to promote greater efficiencies and manage risks associated with procurement decisions; this may work against local suppliers in regions where local procurement in some commodity areas is not already established

- To overcome the potential pitfalls of this development, there needs to be a willingness among purchasers and suppliers to
  - Simplify complicated public sector procurement procedures
  - Raise awareness of procurement opportunities in the local supply chain
  - Identify commodity areas that are easier to open-up to local procurement
  - Set organisational targets e.g. increase the value of local spend by 10% that would result in monetary gains to local economies and significant efficiency gains to those organisations
  - Work with local business support organisations to ensure SMEs are able to deal with e-procurement, e-commerce, e-trading, e-auctions.
Case studies

North East (England) – Measuring local economic impact of procurement decisions.

In 2004, Northumbria County Council used the LM3 (Local Multiplier 3) tool to benchmark the impact of council procurement on the local economy before the council’s existing €4.3m annual food contract came up for renewal. The benchmarking process found that local suppliers re-spent on average 76% of their contracts with local people and businesses. Non-local suppliers only spent 36% of contracts locally. This information encouraged the council to reach out to businesses and their support organisations in the area ensuring that the former were better informed about the food procurement process and the latter were able to assist local businesses to put tender submissions together. The new contract was split into seven smaller lots facilitating local businesses to compete. As a result, four of the seven product categories were awarded to local suppliers.

North West (England) – Opening up the health supply chain to SMEs

In 2003, the North West Regional Development Agency commissioned Groundwork North West, a leading environmental regeneration organisation, to develop and deliver a programme to open up the NHS supply chain to local SMEs. The rationale for this is that the estimated €3.2bn regional spend by the NHS on goods and services can be a prime motivator to influence regeneration, improve health and reduce environmental impact. This is done by developing the skills of the supplier base to compete for contracts in exchange for improved technical compliance with health & safety and environmental standards, identifying product areas that are most appropriate for local procurement, engaging NHS Trusts in this process while raising awareness of sustainable procurement. A full evaluation of the economic impact of the project will be ready in December 2006. Part of the evaluation will include an LM3 analysis.

Etelä Suomi (Finland) – Developing the potential of social enterprise in service provision

In 1998, the costs of primary health care and elderly care in Karis Municipality were 20% higher than the national average. Relatedly, a local district hospital was judged too expensive to continue running. The underlying reason for these two challenges was the growing elderly population. At that time a decision was made to outsource these services. The municipality sought a partner from the social enterprise sector. Folkhälsan, a Swedish speaking but Finnish NGO was appointed because the majority of the Karis population are Swedish speaking. Both primary and elderly care were outsourced to Folkhälsan and coverage eventually extended beyond Karis due to other local government reorganisation and allowing private customers to buy services. To reassure public concern, STAKES were commissioned to track costs and cost-efficiency. By 2003, the needs-adjusted costs of primary health care and elderly care were lower in Karis than other Finnish municipalities, who averaged a 12.6% increase in costs in the same period.

Brandenburg (Germany) - Facilitating local SME competitiveness by developing a marketing network

The scientific and market potential within the Berlin-Brandenburg region is considerable with Berlin having a high concentration of leading-edge health providers and related R&D. The medical technology element of the Berlin health care market was worth around €1.3bn in 2000. Within this market segment there are around 150 companies. Of these, 36% are fast growing companies over 3 years old, 55% are traditional companies, 6% are part of larger international companies and 3% are start-up companies. Between 1999 and 2003, this market sector has seen more growth in smaller companies. In part, this dynamism is supported by key cooperation structures that provide a platform for SMEs to compete effectively against larger suppliers, especially in niche markets. One of these structures is medtecnet-BB. This managed network acts as a bridge between SMEs and health procurement managers. The network facilitates closer cooperation at all levels of the supply chain and coordinates shared systems solutions and demand-oriented R&D strategies among SME members. Evaluation is ongoing but the goal is to generate medium-term growth and employment and longer-term strength of regional innovation potential.
The Bilbao Policy Agenda

Policy recommendations for health sector procurement are contained in The Bilbao Agenda available at www.healthclusternet.org and included in the final section of this report. This Agenda provides a practical response to the ‘health equals wealth’ challenge first set out at the European Health Policy Forum in October 2003.

The aims of the agenda are to:

- To enable regional health systems to more positively engage with regional development through procurement practices that contribute to dynamic local enterprise cultures.
- To redefine ‘value for money’ (or national equivalent term¹) to include outcomes that connect public sector procurement to the achievement of regional development priorities.
- To reshape public procurement practice with and by regional health systems so that it contributes to the revised concept of ‘value for money’.

The Bilbao Agenda puts forward a range of immediate and longer-term procurement policy actions for localities, regions, and the European Commission. The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in HealthClusterNET.

A key element to the success of the Bilbao Agenda will be the creation of “enlightened” public sector purchasers, who with the right communication tools could fairly help to develop the capabilities of businesses wishing to compete for health sector contracts.

¹ Other words used across partner regions that are equivalent to ‘value for money’ are: best value, total economic benefit, best offer.
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1 Introduction

1.1 The purpose of this report is to present the knowledge and experiences shared by partners that explore how the health sector can contribute to regional development through its procurement activities. This paper includes material presented by and discussions between partners at a three-day workshop in Maribor (June 2005) and subsequent policy forum in Bilbao (October 2005). The paper is posted on the HealthClusterNET Website (www.healthclusternet.org) to provide an opportunity for wider consultation on its content and recommendations.

1.2 As described by INTERREG IIIC, "HealthClusterNET is intended as a lasting interregional network of 13 regions from across the EU that will build and share knowledge and experience among regional policy makers in order to find out how they can more effectively engage their health sector within the regional development agenda". The four themes that are identified by partners as key interfaces between the health sector and regional policies on social cohesion, and economic competitiveness are: employment, procurement, capital investment, and innovation.

1.3 The purpose of knowledge sharing and development through each of these four themes is to focus on how the health sector can contribute to regional development and how other regional stakeholders can support this engagement.

1.4 In summary, the purpose of this paper is to show that the health sector can contribute to the dynamism of regional & local economies and communities by:

- Understanding that there is significant scope through health sector procurement of goods and services to identify possibilities for encouraging local business dynamism in selected commodity areas
- Procuring in a way that is creative but also fits within current EC legislation
- Incentivising support for local procurement (where appropriate) by creating win-win situations for both health sector organisations and local small and medium size enterprises (SMEs).
2 Definitions\(^2\)

**Procurement**

2.1 Procurement means *getting something*. A basic challenge for the health sector is to consider this: what are we trying to obtain? The obvious answer is that the health sector needs to obtain supplies (clinical and non-clinical) and services (such as cleaning, consulting, financial services). For example, a hospital says that what they want is to obtain an outcome such as waste minimisation. It is up to the contractor to suggest how. For the partners in HealthClusterNET, when we refer to procurement, we mean all the ways the health sector obtains goods and services for itself and the constituency it serves.

2.2 Other words that are sometimes used instead of procurement include purchasing, public service delivery, back office spending, and frontline services. Finally, it is important to remember that procurement should not be confused with ‘spending’.

**Sustainable development**

2.3 What does this paper mean by sustainable development? This refers to activity by organisations and communities that are sustainable in economic, social and environmental terms. In the context of procurement, that means maintaining a full and healthy local economy without relying on external grants, such as Objective 1 funding, for the long-term. We refer to economic sustainability to make the point that communities can regenerate themselves using the money that is already circulating within them.

**‘Value for money’**

2.4 ‘Value for money’, is a phrase that has been widely adopted as part of the public sector procurement process across Europe. It means assessing tenders for goods or services in terms of a combination of cost and quality. This means that tenders for contracts are not just judged simply in terms of the lowest cost bid. However, the term is still legally ambiguous. A clearer legal term in the UK is ‘Best Value’. This refers specifically to a legal framework developed under the UK Local Government Act 1999 and defined under *Government Accounting* as "the optimum combination of whole-life cost and quality (or fitness for purpose) to meet the user’s requirement". Only local government is currently required to use Best Value to assess contract bids. In short, the Best Value process requires local government to consult with others on how to design and implement services, review how to make improvements, and develop targets to evaluate progress. Other terms used include ‘best offer’ and ‘total economic value’.

\(^2\) These definitions are adapted from Sacks J (2005) *Public Spending for Public Benefit*, New Economics Foundation - a HealthClusterNET supported publication.
Efficiency

2.5 Efficiency is another term with multiple and often conflicting interpretations. Efficiency can only be defined with reference to what we are trying to conserve or to better achieve. Technically, efficiency generally refers to the ratio between what we put in and what we get out. We are more familiar with, for example, fuel-efficient cars that use less fuel to travel more kilometres with less harmful emissions. When it comes to public procurement, we often talk about efficiency in terms of short-term economic costs – the price of a contract and per unit price. This paper does, however, extend that definition to consider the long-term and other economic factors beyond the price of a contract. In addition, in our discussions, efficiency was frequently used to describe a process of rationalisation and centralisation that health sector procurement systems are now facing in many partner regions. An objective here is to achieve economies of scale through purchasing fewer larger contracts, thus managing risk better. It is an open question whether this approach really does promote efficiencies: witness problems around major IT procurement projects in the UK NHS compared to alternative project management approaches in the Netherlands.

Local

2.6 What is local? It is a question that troubles anyone dealing with regeneration. We all define local for ourselves. The easiest answer is whatever you consider to be your local area is your local area. For the case studies in this paper, local refers to their region and the communities within that region. We do not seek to challenge what truly constitutes local or not, but rather how to let people use whatever definition inspires them to take action.

Regeneration

2.7 Regeneration is a short word for ‘improving a community’. Regeneration literally refers to the process of giving new life or energy and is commonly used with reference to disadvantaged communities. You may see words like economic development, revitalisation, or renewal. They all have the same meaning.
3 The health sector as an economic actor

3.1 The potential dividend from health sector investment at regional and local levels is twofold. First, it can be used to improve health services efficiency in terms of: improved health care services, better access, enhanced productivity and more cost-effective use of resources. These goals of health policy and the broad thrust of public sector spending represent conventional policy wisdom since the 1990s. However, there is a more compelling set of policy goals. These relate to the potential contribution of health sector investment to economic regeneration. In this scenario:

- targeted investment in deprived areas or those with relatively low economic output contributes to economic regeneration,
- helps provide social cohesion in disadvantaged communities,
- increases employment prospects where matched by inclusive employment policies,
- raises the skill base in the regional and local labour markets.

3.2 Overall, the combination of social, educational and economic gains, together with improved access to health care for disadvantaged communities, will itself contribute to health gain, which in turn acts as a further economic investment (a spiralling up in economic competitiveness). However, a question for national and local stakeholders is where and how such investment returns can be actually realised. Figure 1 summarises where we might look at leveraging health assets in favour of sustainable development by mapping the operational responsibilities of health services against the principles of sustainable development.

3.3 The point is that in regions with low economic activity and poor health, using health sector investment as an economic and social catalyst has the potential to impact on the wider determinants of health (jobs, income, social networks, environment) and on the levers for economic development (education & training, R&D, procurement, capital investment, employment). That said, we are at the start of a process of developing and using model policies, good practice examples, economic modelling and scenario planning that will give decision makers whether in Finance, Health or other public policy sectors the confidence and capability to shift their sense of what is possible.

3.4 In thinking about the challenges of health care sector investment, this paper suggests that we could all benefit from a shift in perspective regarding what the business of the health sector is. If national policy makers, health care providers and regional government engaged with some of the ideas presented here, then the argument shifts from health care spend as a burden on national and local economies to health care spend as a lever for the sustainable economic development of regional and local economies and subsequent health and social gain in local communities. This is about doing differently what we are already doing.
**Figure 1: Sustainable development and health framework (Source: adapted from CPS and Nuffield Institute for Health, 2003)**

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<tr>
<th>Principles of sustainable development</th>
<th>Operational responsibilities</th>
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<td>• Improving community well being by taking account of the effect of health sector decision making on production, supply and employment in regional and local economies</td>
<td>Service provision</td>
</tr>
<tr>
<td>• Ensuring health sector organisations have the capacity, skills and intellectual capital to deliver sustainable services with funding and resources to provide continuity, security and long term planning</td>
<td>Employment</td>
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<td>• Promoting health, tackling health inequalities, ensuring equitable sharing of resources in regeneration and development plans</td>
<td>Procurement of goods and services</td>
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<td>• Strengthening democratic accountability in the planning, design and delivery of health care</td>
<td>Planning and managing infrastructure</td>
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<tr>
<td>• Taking account of direct and indirect social, economic and environmental costs and benefits in the planning, building and procurement of goods and services based on recycling and resource minimisation strategies</td>
<td>Capital investment</td>
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<tr>
<td>• Integrating health care planning and provision with housing, education, business, social facilities and employment in regional regeneration and growth</td>
<td>Tackling health inequalities</td>
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<tr>
<td>• Valuing natural resources and taking account of environmental and ecological issues in planning and development.</td>
<td>Management and capacity building</td>
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<td>Planning and assessing impact</td>
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**Targets and achievements**
North East England: health spend and economic development

3.5 This case focuses on understanding the potential contribution of health service spending in an English region (the North East) to the regional economy and placing this contribution in the context of the Regional Economic Strategy. In this context, The North East is a diverse region, culturally and economically. 70% of its 2.6 million population live in urban conurbations along the Tees, Tyne and Wear Rivers. Yet, the North East is a mainly rural region. No less than 68% of the region is categorised as rural according to the Council for the Protection of Rural England.

3.6 As with several of the HealthClusterNET partner regions, in recent memory the economic base of the region has been severely affected by the decline of traditional mining, shipbuilding and heavy engineering. The loss of many thousands of jobs in these industries has been felt most in urban areas and in the smaller communities in Northumberland, around Durham and East Cleveland who were very dependent on mining or heavy industry. These areas now include some of the most deprived communities in the UK. Changes in agriculture combined with restructuring of the labour market have also had a dramatic impact on rural communities.

3.7 Regional strategies and reports acknowledge the consequences of these changes in showing that compared to other English regions:

- GDP per head is lower
- Unemployment is higher
- A higher proportion of the population claim income support (except for Northern Ireland)
- Educational attainment at 14 and 16 is well below UK averages
- 12 local authorities are on the list of the 50 most deprived
- The health status of the North East is the poorest in the UK

3.8 Economic data on the [www.n-e-region.com](http://www.n-e-region.com) website provides some clues about how and where the NHS could utilise its economic leverage (Figure 2 below).

*Figure 2: A picture of the North East economy*

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4 [www.culturenortheast.org/strategy](http://www.culturenortheast.org/strategy)
• The North East has a greater reliance on manufacturing than all but two other English regions. 27% of regional GDP is created in manufacturing compared to 20% for the UK. Combined, the public sector accounts for 22.8% of regional GDP.

• Compared to the UK, the North East has fewer self-employed (10% compared to 12.4%), more female employees (51.5% compared to 49%) and more part-time employees (30.4% compared to 28.5%). Mirroring the decline in fulltime jobs, there has been an increase in people in part-time jobs and self-employment since 1979

• In 1998, 0.8% of NE establishments employed 200+ people. Small enterprises (employing up to 10 people) constitute 80% of enterprises in the NE

• In relation to population, the business base is over 40% smaller than the UK average at 203 businesses for every 10,000 adults. The UK figure is 354 per 10,000.

• Since 1993 employment growth in the region as been poor (0.3%) compared to the UK (9%)

• The North East’s low economic activity is mainly due to older people leaving the labour force. Between the ages of 45 and 65, 28.8% of all NE men were neither in work nor seeking work; 2.5 times the UK rate. Most describe their state as ‘permanently sick’ but many have probably left the labour market due to a lack of suitable job opportunities.

• Pronounced population changes (fewer children, working age adults and more older people) will exacerbate these factors.

The regional economic strategy

3.9 One North East is the Regional Development Agency and, in consultation with other organisations in the region, has been responsible for developing a framework around which energy and resources can be released and used to promote ‘a more prosperous and inclusive’ region. The regional economic strategy Realising our Potential outlined six interdependent strategic objectives. Responsibility for realising these objectives lay with a range of partners, not least the health service. The potential contribution of the health service in the region to this agenda is summarised in Figure 3.

Figure 3: Key findings from economic impact study (2002)

• In 2001, NHS spend in the North East accounted for about 6.8% of regional GDP
  ➢ The NHS employed 51100 staff in the North East, enabling these staff and their families to potentially spend £1.23 billion in the region.
  ➢ When health and social care are combined they accounted for the employment of over 130000 employees, financially enabling over 400 000 of our population.
  ➢ By 2002-2003 NHS was predicted to account for 8.4% of regional GDP
• The £1.73 billion NHS operating cost exceeded for example the GVA of the Construction Industry (£1.3 billion), and the £70 million NHS spend on Utilities equated to approximately 9% of the GVA of the Utility Industry in the North East.
• Approximately 40% of direct NHS external expenditure was on non-clinical items and services)
  ➢ This equated to a minimum of £182 million in the North East.
  ➢ Extending this purchasing power to clinical supplies/services can include an extra £228 million
  ➢ All of which can be explored for their potential catalysing role in local economies
• The April 2002 UK Budget included a commitment to increase the level of NHS funding by an average of 7.5% in real terms between 2002 and 2008. Even if the real increase in spending is a more modest 3.2% work elsewhere has demonstrated that this is likely to result in more jobs (direct NHS employ and indirect employ) in the regional economy

3.10 This scoping study showed the considerable contribution that NHS employment and procurement could have in a local area. The former would require inclusive employment practices. The latter would require investment in developing local SME/supplier capability and capacity combined with action to make procurement opportunities more accessible and visible for local suppliers.

3.11 If we look at the big picture provided by this study it shows that:
• The NHS is one of the very few industry sectors in the North East that was predicted to experience a significant increase in spending power.
• Its year on year growth compared to other sectors would increase its significance as an economic catalyst.
• However, this potential would only be realised if its external purchasing activity, its employment practices and capital/ICT investments are directed and developed to meet such a challenge.

3.12 As a result, ONE funded a new position at a senior level to coordinate and stimulate action among regional partners in the areas of procurement, employment, capital investment and innovation.
4 The potential for local procurement: two case studies

4.1 In this section we present three case studies from Spain and Poland that quantify health sector spending on procurement of goods and services. They also show that local procurement is happening and that there is potential to increase the proportion of goods and services bought locally (within the region), where this encourages local business dynamism within wider markets.

Case 1: The Basque Health Service\(^6\)

4.2 The Basque Country (Euskadi) has had its own Government and parliament since the arrival of democracy in Spain in the late 1970s. In particular, the regional government has competency for sectors such as health, education, culture and housing. The Gross Domestic Product (GDP) of Euskadi at 2002 market process was 44,995m euros (6.5% of the national state total). Of this, sectors received the following: agriculture and fishing (1.5%); Industry (32.7%); Construction (7.7%) and Services (58.1%). Other sectors, including research, industrial policy, transport and communications have a higher degree of autonomy, financed by an Economic Agreement with the Central Spanish Government.

4.3 The Basque Government manages all publicly funded health care in the Basque Country through the Basque public health service. This comprises 51 hospitals, 442 outpatients centres and more than 24,000 health care professionals, a number that ensures 4.5 doctors per 1,000 population. According to figures for 1999, the Basque Country set aside 2.215m euros for expenditure on health care related goods and services, equivalent to 6.1% of regional GDP in that year.

4.4 Public institutions such as the Basque health service and Basque Government health department were responsible for 76% of all expenditure on health in the region, with the private sector financing 24%. Expenditure per inhabitant came to 1,342 units of purchasing power parity (ppp), putting the region ahead of Spain (1,194) and of countries like Portugal (1,203), Greece (1,198) but behind countries like Germany (2,361). In other OECD countries, public expenditure accounts for an average of 74% of expenditure.

4.5 In 2004, the Basque Government Health Department undertook a study to measure the relationship between publicly funded health sector expenditure and the regional economy. The method for doing this was to use impact analysis based on input-output methodology (Figure 4).

\(^{6}\) The source of this case study is an English language summary of a report commissioned by the Basque Country Health Department. The reference for the summary is Vitorica Leoz, AI (2004) Impact of Public Health Care on the Basque Country Economy: methodological concepts and conclusions based on given results. Vitoria: Basque Regional Health Department.
Figure 4: Description of the impact model on the Basque Country economy

<table>
<thead>
<tr>
<th>DIRECT EFFECT</th>
<th>INDIRECT EFFECT</th>
<th>ECONOMIC IMPACT ON REGIONAL ECONOMY</th>
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<tbody>
<tr>
<td>Cost of health service</td>
<td>INDIRECT EFFECT</td>
<td>GDP GENERATION</td>
</tr>
<tr>
<td>• workforce costs</td>
<td>INPUT-OUTPUT MULTIPLIER</td>
<td>EMPLOYMENT</td>
</tr>
<tr>
<td>• pharmaceuticals/other medical goods</td>
<td>TECHNICAL COEFFICIENTS</td>
<td>PUBLIC TAXES GENERATION</td>
</tr>
<tr>
<td>• others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of private service</td>
<td>as for health service above</td>
<td></td>
</tr>
<tr>
<td>Cost of pharmaceutical products financed by public sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs of other agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• public health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• users and companions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• medical conventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 5: Description of direct effects

<table>
<thead>
<tr>
<th>Suppliers</th>
<th>Destination</th>
<th>Origin: Basque Country %</th>
<th>Origin: External %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service (68%)</td>
<td>Employment cost+ excedent (61%)</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Private suppliers (6%)</td>
<td>Pharma products (18%)</td>
<td>1.33</td>
<td>98.66</td>
</tr>
<tr>
<td>Chemist shops (20%)</td>
<td>Health material (6%)</td>
<td>0.93</td>
<td>99.07</td>
</tr>
<tr>
<td>Others (6%)</td>
<td>Transport (2.4%)</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>• health department (public health services)</td>
<td>Cleaning (1.7%)</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>• transport (patients and companions)</td>
<td>Repairs and maintenance (1.2%)</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>• medical conventions</td>
<td>Other costs (9.7%)</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 6: Basic results

<table>
<thead>
<tr>
<th>Publicly funded health care</th>
<th>Economic impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health department spends: 1,797m euros</td>
<td>Impact on GDP: 1,505m euros</td>
</tr>
<tr>
<td>Spends of other agents: 150m euros</td>
<td>Impact on employment: 34,018 workers</td>
</tr>
<tr>
<td>Total: 1,947m euros</td>
<td>Impact on public taxes: 330m euros</td>
</tr>
</tbody>
</table>

4.6 Figure 5 clearly shows a pattern of procurement activity that may be familiar to other European regions. Non-clinical and support services are purchased within the region while medical supplies and drug products are largely sourced from outside the region. However, the impact of this pattern of procurement on the regional economy is not quantified in the current study in
terms of impact on indirect employment and money flows in the local economy. Figure 6 clearly shows that this spending activity has a positive economic impact on the regional economy in terms of direct impact on GDP, employment and tax remittances.

**Case 2: The John Paul II Hospital, Krakow**

4.7 The John Paul II Hospital is a public health care institution. The mission of the Hospital is to fight against the major epidemic and chronic diseases in society induced by factors related to the environment, civilization, and psychological and socio-economic impact. The hospital guarantees highest quality specialist services to treat cardiovascular, respiratory and infectious diseases using the most up-to-date equipment and technology. The hospital co-operates with the Jagiellonian University in carrying out top-class scientific research, clinical research, and teaching activities. The John Paul II Hospital is located in Malopolska Voivodship in the city of Krakow, in southern Poland. The Hospital is the largest heart and lung centre in Poland. According to its statute, and in compliance with the fundamental patient’s right of having free access to medical services, it is open to all people in need. As one of the best-equipped hospitals with the highest qualified medical personnel it offers 550 beds for treatment of a spectrum of diseases. John Paul II Hospital is also actively involved and interested in research studies on new drugs and new medical technologies. Physicians at JPII Hospital are involved in many research studies of medications, devices and diagnostic methods. So, patients often gain access to new treatments only available through carefully monitored clinical trial protocols and not available at other hospitals.

*Figure 7: Key figures about the John Paul II Hospital*

| Admits over 100 000 patients annually |
| Provides 70 000 ambulatory consultations annually |
| Performs about 60 000 imaging examinations, functional tests and endoscopies annually |
| Performs about 8 000 procedures in interventional cardiology annually |
| Performs about 2 500 open-heart operations and about 20 heart transplantations annually |
| Performs 1 300 thoracic procedures and operations annually |
| Implants over 1 000 cardiac pacemakers and defibrillators annually |
| Performs almost 970 000 laboratory tests annually |
| Employs 200 physicians including 4 professors, 7 associate professors, 40 physicians with PhD, 530 nurses, 111 technicians |
| Has 15 wards with 550 beds and 40 specialized laboratories |

4.8 The structure of goods by costs is medical costs (62%), other costs (32%) and extramedical costs (6%). The items included in each cost category are set out in the following table. The largest cost category is medical costs. The number of suppliers for selected types of goods varies as is shown in Figures 7-9 below. None of the cost items are associated with a single supplier. Most

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7 This study was undertaken by the Department of Social Policy of the Marshal’s Office of the Malopolskie Voivodship for HealthClusterNET and presented at the Maribor Workshop in June 2005.
numerous are suppliers of small medical instruments, drugs, other chemical products, food products, equipment (not durable resources) and professional books & journals.

Figure 8: Detail of cost categories

<table>
<thead>
<tr>
<th>Medical goods</th>
<th>Other costs</th>
<th>Extramedical costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• drugs,</td>
<td>• vaccines,</td>
<td>• paper and office materials,</td>
</tr>
<tr>
<td>• dressings,</td>
<td>• contrast agents,</td>
<td>• food products,</td>
</tr>
<tr>
<td>• medical gases,</td>
<td>• surgical threads,</td>
<td>• hygiene products,</td>
</tr>
<tr>
<td>• small medical</td>
<td>• radiological material,</td>
<td>• individual protection means,</td>
</tr>
<tr>
<td>instruments which</td>
<td>• irradiation materials,</td>
<td>• textiles (protective clothes,</td>
</tr>
<tr>
<td>are not durable</td>
<td>• blood and plasma,</td>
<td>bed-linen),</td>
</tr>
<tr>
<td>resources,</td>
<td>• books, journals,</td>
<td>• coke, oil products,</td>
</tr>
<tr>
<td>• pharmaceuticals,</td>
<td>• technical gases,</td>
<td>• equipment (not durable resources).</td>
</tr>
<tr>
<td>• other chemical</td>
<td>• fuel and car accessories,</td>
<td></td>
</tr>
<tr>
<td>products (e.g.</td>
<td>• energy materials.</td>
<td></td>
</tr>
<tr>
<td>reagents),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• gum products (pro-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tective gloves, clothes)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 9 Goods - number of suppliers: MEDICAL costs

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Dressings</th>
<th>Medical Gases</th>
<th>Small medical instruments</th>
<th>Pharmaceuticals</th>
<th>Other chemical products</th>
<th>Gum products</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>4</td>
<td>2</td>
<td>52</td>
<td>16</td>
<td>20</td>
<td>4</td>
</tr>
</tbody>
</table>
Figure 10 Goods - number of suppliers: EXTRAMEDICAL costs

Figure 9 Goods - number of suppliers: OTHER costs
4.9 Firms from the Malopolska region supply most goods—about 40%. Many suppliers i.e. 38% come from the Mazowieckie Voivodship for a simple reason, the companies supplying their medical materials or equipment are located in Warsaw—the capital of Poland and the Mazowieckie Voivodship; it would be unreasonable to buy from agents.

4.10 The diversity of suppliers is mainly a result of the specific activities of the Hospital, which offers services in the following areas:

1. Lung diseases (I Ward of Lung Diseases, II Ward of Lung Diseases with Chemotherapy Unit, Ward of Thoracic Surgery)
2. Cardiology (Clinical Ward of Cardiovascular Surgery and Transplantation, Clinical Ward of Cardiovascular Diseases, Clinical Ward of Coronary Heart Disease, Clinical Ward of Electrocardiology)
3. Contagious and infectious diseases (Ward of Paediatric Infectious Diseases and Hepatology, Ward of Paediatric Neuroinfection and Neurology, Ward of Viral Hepatitis and Hepatology)
4. State-of-the-art diagnostic imaging (Centre for Interventional treatment of Cardiovascular Diseases, Subunit of Interventional Cardiology, Centre for Diagnosis and Rehabilitation of Heart and Lung Diseases with Subunit of Quick Diagnostics, central Clinical Laboratory, Malopolskie Central Laboratory of Tubercle Bacillus Diagnosis, department of Pathomorhology and Independent Laboratory of Molecular Biology and Research)
5. The Hospital also offers consultations and diagnostic services on an outpatient basis.
4.11 Figure 13 below provides a breakdown of service costs by main categories. Figure 14 provides details of items within each service. In almost half of the items there is only one supplier. Technical maintenance and repairs of medical equipment are provided by several dozen suppliers – this is a result of the diversity of Hospital’s services entailing the diversity of suppliers of medical equipment – it is not possible to have only or several suppliers for technical maintenance.

**Figure 13 SERVICES: structure of costs (%)**

<table>
<thead>
<tr>
<th>Auxiliary services</th>
<th>Other costs</th>
<th>Energy, waste &amp; sewage</th>
<th>Specialist services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Laundry</td>
<td>• maintenance and repair of medical equipment, telephone services, waste removal, maintenance of hospital area, property tax, insurance costs, maintenance of heating systems</td>
<td>• electrical energy, heat energy, water and sewage.</td>
<td>• complementary health services, laboratory diagnostics, IT services, technical maintenance, advisory services (including legal consulting), protection of property.</td>
</tr>
<tr>
<td>• Cleaning</td>
<td>• maintenance and repair of medical equipment, telephone services, waste removal, maintenance of hospital area, property tax, insurance costs, maintenance of heating systems</td>
<td>• electrical energy, heat energy, water and sewage.</td>
<td>• complementary health services, laboratory diagnostics, IT services, technical maintenance, advisory services (including legal consulting), protection of property.</td>
</tr>
<tr>
<td>• Waste utilisation</td>
<td>• maintenance and repair of medical equipment, telephone services, waste removal, maintenance of hospital area, property tax, insurance costs, maintenance of heating systems</td>
<td>• electrical energy, heat energy, water and sewage.</td>
<td>• complementary health services, laboratory diagnostics, IT services, technical maintenance, advisory services (including legal consulting), protection of property.</td>
</tr>
<tr>
<td>• Medical transport</td>
<td>• maintenance and repair of medical equipment, telephone services, waste removal, maintenance of hospital area, property tax, insurance costs, maintenance of heating systems</td>
<td>• electrical energy, heat energy, water and sewage.</td>
<td>• complementary health services, laboratory diagnostics, IT services, technical maintenance, advisory services (including legal consulting), protection of property.</td>
</tr>
</tbody>
</table>

**Figure 14: Details of service items by cost category**
### Figure 15: Service suppliers by main cost categories

**SERVICES - number of suppliers:**

- **ENERGY, WATER, and SEWAGE**
  - Electrical energy: 1
  - Heat energy: 1
  - Water and sewage: 1

- **AUXILIARY SERVICES**
  - Laundry: 1
  - Cleaning: 1
  - Utilization of waste: 1
  - Medical transport: 2

- **SPECIALIST SERVICES**
  - Complementary health services: 1
  - Laboratory diagnostics: 6
  - IT services: 3
  - Technical maintenance: 39
  - Advisory services (including legal consulting): 2
  - Protection of property: 1

- **OTHER COSTS**
  - Maintenance and repair of medical equipment: 55
  - Telephone services: 2
  - Waste removal: 1
  - Maintenance and hospital area: 1
  - Maintenance of heating systems: 1
  - Insurance costs: 1
4.11 As Figure 16 shows, 71% of suppliers come from the Malopolska region, almost 13% from the Malopolskie Voivodship, and 6% from the Silesian Voivodship; the remaining suppliers make up almost 10%.

4.12 In summary, this case shows that 40% of goods and 71% of services are supplied by regional businesses. For the former, small medical supplies, food and books & journals are the main regional sourced commodities. For the latter, technical maintenance is the most frequently sourced service regionally. As with the Basque example, most pharmaceutical products are sourced outside the region.
5 Issues shaping procurement practice in partner regions

Values in procurement

5.1 The procurement process can seem quite rational. However, decision-making is loaded with unspoken values. Purchasing organisations can explicitly state certain values e.g. cost, quality, value for money. The HCN partners have reflected on the values that inform procurement in their organisations (Figure 17). In general, most partners agreed that the traditional values of “Cost” and “Quality” remain these days and are the basic values of the purchasing process. However, there has been an evolution over the last decade from purchasing “the cheapest” to looking for “value for money”. In addition, other non-monetary values such as environmental protection, innovation, local procurement, workplace health & safety may be considered in procurement decisions. However, there can be tension in procurement decision-making between what are seen as ‘harder’ economic (and to a growing extent, environmental) values and ‘softer’ (social, moral) values.

Figure 17: Values in procurement

<table>
<thead>
<tr>
<th>Economic</th>
<th>Environmental</th>
<th>Social</th>
<th>Moral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>Protection</td>
<td>Customer benefit</td>
<td>Protecting vulnerable groups</td>
</tr>
<tr>
<td>Quality</td>
<td>Sustainability</td>
<td>Local employment</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Quality</td>
<td>Regeneration</td>
<td></td>
</tr>
<tr>
<td>Managing risk</td>
<td></td>
<td>Innovation</td>
<td></td>
</tr>
<tr>
<td>Value for money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local focus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountability</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2 In a sense, economic values are more valued and social/moral values are less valued in decision-making. In turn, certain values are legitimised because they reflect and support other factors that can be important in procurement including: political interests, the needs of health care organisations, the operational processes of procurement and regional competitiveness.

5.3 However, two complimentary developments in the public and private sectors are starting to legitimise the softer values and encouraging organisations to define their ‘values set’. These developments are corporate social responsibility (business sector) and corporate citizenship (public sector). Both developments are about getting organisations to look beyond core business perspectives and to recognise that their actions and activities have a wider impact on local communities, the environment and economies.
Rationalisation and centralisation

5.4 Despite this diverse range of values, most partners note that health sector procurement systems are becoming increasingly centralised in a drive to promote greater efficiencies from procurement decisions. There is real concern that the drive for efficiencies may occur at the expense of facilitating local procurement in certain commodity areas (as demonstrated in the Basque and Malopolska case studies in chapter 4).

5.5 For example, in two partner regions - Alentejo and Pais Vasco - rationalisation is driven by several factors. These include: a desire to ensure that procurement is properly regulated; the opportunities for centralisation afforded by IT developments; and the use of both to manage risk in the public sector procurement process.

National Programme for Electronic Purchases, Portugal

5.6 In Portugal in recent years the enlarged acquisition systems have become generalized or, at least, the suppliers’ qualification has. These systems speed up procedures on acquisition time and are considered to be an advantage in large-scale acquisition contracts by reducing prices and minimizing transaction costs. They are seen as powerful tools for the defence of Public Administration Efficiency and the guarantee of transparency and equality in its relations with the private sector.

5.7 An example of this process is the National Program for Electronic Purchases (PNCE). UMIC- the Knowledge Society Agency⁸, has implemented the public e-procurement initiative, defending, in its targets, the promotion of efficiency of the public acquisition process, generating structural gains and savings, making easier and enlarging business access to market and public acquisitions. Assessment shows that this is raising the quality and transparency of the services. Moreover, it creates a modernization dynamic close to economic agents, promoting competitiveness and productivity and inducing new electronic commerce practices, at national level.

5.8 Briefly, this project⁹, involves:

- the creation of a unit which ensures the whole PNCE management and updating, with responsibility for monitoring and defining politics, on sourcing (purchases strategic management), regulating, normalizing and promoting, as well as developing integrated information systems management.

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⁹ see annex slides and leaflet [Prog_Nac_Compras_Elec.pdf]
the initial UCN focus on centralized negotiating processes in order to obtain a more substantial initial impact on savings level

following an international trend in this matter although PNCE is a minimalist model in terms of dimensions. Thus, the UNC will be supported by UMC (Unidades Ministeriais de Compra – Ministry Units for Purchasing) following of shared services logic. These will ensure an additional impact in savings through the rationalization, at ministerial level as well as the decentralized management of sector categories.

Pais Vasco – the ALDABIDE purchasing process

5.9 Procurement in the Basque Health System is based on the ALDABIDE purchasing Process, which is an information system model based on SAP (Systems, Applications, and Goods). This purchasing process is premised on the characteristics below:

- Best prices and highest efficiency throughout the system
- Purchasing process relies mainly on the purchasing departments of the organisation which offer the services
- Osakidetza’s purchasing department focuses on the strategic planning, items standardisation, integration with other purchasing centres, as well as purchasing process and providers’ assessment
- Master goods and providers in the organisation are unique and centralised.
- Focus on the end user when planning purchasing needs and technical requirements that lead to the purchasing decision.

5.10 The purchasing process is integrated with the warehouse operations and planning. The cycle starts after detecting a need, which is followed by the cost estimation. Afterwards, the offer request is given and analysed, and the contract is agreed. Orders are placed following this agreement. After receiving the invoice and verifying it, the payment is made. There is no need to go through the whole cycle if desired not to. For instance, we can order an item without previously requesting the offer. There is a specific document for every purchasing step: offer request and orders. All documents are integrated as a whole and each one refers to the other.

Promoting local economic linkages

5.11 The idea of promoting local economic linkages through procurement activity seems to run against the trend towards centralisation and rationalisation. However, several partners representing different economic sectors identified this linkage as important for local economies whether motivated by purely economic interest or other such as environmental and social concerns:
North East: environmental issues, and social values such as buying goods from companies with active healthy/safety programmes should be taken into account. Also, economic development of the region is an important factor at the time of the purchasing process. Procurement nowadays is about purchasing efficiently and health sectors are not making the best of the purchasing process. Perhaps, instead of meeting status obligations, there is a need to take risks at the purchasing process.

North West: emphasised that the health sector consists of large organisations with lots of rules and that it is important to educate local providers, so they can compete with foreign and larger sellers. They also highlighted the importance of Corporate Social Responsibility at the time of making purchasing decisions.

Berlin-Brandenburg: the old health system is changing and there is a need for “Innovation”. The importance of bringing technology into hospitals and producing a better image of the health sector was stressed. Also emphasised was the importance of cooperation between Berlin and the surrounding region. One focus has been to develop a network as a support mechanism for local medical technology SMEs.

Slovenia: Gave the example of food procurement. This has involved the coordination of many partners from many different sectors. Key aims are the stress on environmental impact through ecological production. Essentially, environmental concerns have given an opportunity to develop local procurement. The main barrier is the ability of smaller suppliers to compete with larger companies.

Basque Country: described the goals of procurement as, first having a strategic mission and second, drawing an operational description of procedures. Some factors that affect the purchasing process, such as, economic pressure, political interests, needs of health care, regional productivity, and operational process of buying were identified.

5.12 For regions seeking to become more competitive, a solution for regenerating urban and rural areas has been to attract more money into them, whether it is in the form of tourism, agriculture, corporate relocations, and other forms of inward investment. Work by the new economics foundation shows that there is a different approach that can have an even greater, more sustainable, impact: regenerating the local economy from within by taking advantage of the resources that communities already possess.

The perspective of a regional health fund Finance Director (Steiermark)

To support local businesses and not offend against the law we could (i) change the law, since we are not allowed to take “the support of local small and medium size enterprises” as selection criteria directly into account (ii) indirectly we can choose selection criteria which can help local small and medium size enterprises to get the contract - for example to emphazise delivery services which should be better within nearer-by enterprises - but this will not take place in the KAGes if there is not a countable economical benefit.

5.13 In many areas, the issue is not that too little money comes in but that most of the money that does enter the local economy flows right out again in the form of spending on and contracts to non-local businesses and labour. In the cases (Basque Health Department and John Paul II

18 Steiermärkische Krankenanstaltengesellschaft mbh. – KAGes)
Hospital) presented in chapter 4 preliminary analysis shows that certain goods and services are sourced from their surrounding region. However, it is not clear how much of the revenue generated for local businesses remains in the region to stimulate local economies. Research by the Countryside Agency has shown that on average upwards of 40 percent of business turnover ‘leaks’ outside of the local economy. By finding ways to ‘plug the leaks’ by creating economic linkages between local businesses, labour, and public bodies, poorer communities can build a healthy local economy that can stand on its own long after regeneration funding dries up.

Opportunities and barriers to increasing local procurement

Figure 18: Summary of opportunities and barriers to local procurement

5.14 On the whole, participants agreed that the Health System should also include “Innovation” in its procurement agenda and look into ways to innovate the Health sector. Computerising the health system and educating the users as well as providers can change the system. It was found that there is also a need to take risks and instead of following the traditional view of meeting purchasing process expectations, we should take risks and find new ways to improve the Health System and its contribution to other sectors. Figure 18 summarises opportunities and barriers (identified by workshop participants) that are (i) affecting the ability of regional and local health service organisations to extend local procurement opportunities (ii) affecting the ability of SMEs to compete for health service contracts (iii) affecting the ability of purchasers and SMEs to work collaboratively to extend local procurement.
A SME perspective: GALEX Pharmaceuticals, Slovenia

5.15 Galex was founded in 1991 as a limited liability company by its employees and the Pharmacies of the Pomurie Region in Slovenia. At the start, the function of Galex was to perform as a galenical laboratory for the pharmacies of the region. However, the company expanded its activities to become a producer of medicines for other pharmacies in Slovenia. In 1994, Galex was reformed as a joint-stock company and expanded its activity into the area of wholesale medicines. In 1997, the Slovenia Ministry of Health issued Galex with a license for the production of medicants and trade. In 2000, the company moved into new premises in Murska Sobota. The premises and organisation of the company meet the demands

5.16 Now the company employs 32 people and has an annual turnover of 10 million €. Its main activities are:

- production of ‘over the counter’ medicines
- production of galenical products
- production of generic medicines
- wholesale of medicines.

5.17 As a joint-stock company the owners expect to get a profit. By contrast, the consumer and the health service in Slovenia expect quality, safety and efficiency while keeping products and services affordable. Galex seeks to ensure quality and innovation. Products and services meet standards for good manufacturing practice and ISO 9001:2000. The company offers a wide range of products and has produced lower-cost generic medicines since 2002. The company has also sought to improve its corporate responsibility profile by becoming active in the development and dissemination of information for consumers and schoolchildren about the proper use of OTC and other products.

5.18 However, Galex faces problems in maintaining a position in the health sector supply chain. Slovenia is itself a very small market with many producers. Some producers sell spurious OTC products and the level of inspection by public authorities can vary. Producers can find themselves producing competing products and there is not much incentive for them to cooperate. This is particularly the case with OTC and galenical products. The situation with generic medicines is different. Here the company seeks to develop niche products. This is based on quality and optimizing production i.e. having the flexibility to produce small batches. This is a general characteristic of SMEs. They tend to be able to identify needs, innovate and respond more quickly to demand than larger companies.
6 Connecting health procurement and local economies

6.1 In this chapter four case studies are presented from the UK, Germany and Sweden that provide practical examples of how health sector procurement can contribute to building more dynamic local businesses. These cases offer different but complimentary approaches to connecting health sector procurement to local economies:

- Measuring the local impact of procurement decisions using LM3 (North East England)
- Promoting social value by outsourcing to social enterprises (West Sweden)
- Opening up the health sector supply chain to local SMEs (North West England)
- A managed network to support SME competitiveness in medical technology (Brandenburg).

Case 1: Measuring the local economic impact of procurement

Introduction

6.2 The Local Multiplier 3 (LM3) tool has been developed by nef (the new economics foundation) to help communities tackle issues of deprivation from within. LM3 enables organisations to measure the impact they have on a local economy by tracking where the money they receive is then spent and re-spent. The purpose of tracking and measuring this spending is to identify opportunities to get more money circulating locally. Deprived communities can achieve more local circulation of money by strengthening linkages in their local economies.

6.3 The name ‘Local Multiplier 3’ indicates how the tool works. The multiplier is an economic tool, usually applied at the national or regional level, to measure how income into an area circulates, and hence multiplies, within the economy. nef has adapted the multiplier for use at the local level. Since the multiplier measures how money is spent and re-spent, we stop after three ‘rounds’ of spending rather than continue onwards. This is where the bulk of spending takes place, and it also becomes uneconomic to keep tracking beyond this point.

How LM3 works:

- Measure an organisation’s income, which may be a combination of public and private funds (Round 1);
- Then look at how that organisation spends its income in a defined local area (i.e. parish, ward, district, or 30 mile radius) – suppliers, staff, subcontractors, and overhead are typically the principal expenditures (Round 2);
- Then look at how the local people and local businesses who received money from that organisation – the suppliers, staff, etc. – spend their money (Round 3);
- Finally, run through some quick maths to arrive at the LM3, which tells you how much spending by the organisation impacts the local economy.
6.4 LM3 therefore gives a clear figure, which is an indicator for how the organisation is impacting on the local economy. Moreover, the LM3 process enables those involved in the analysis to determine how to increase their local economic impact. In this case Northumberland County Council decided to measure and improve its local economic impact, and used its supply contracts, and initially its food supply contracts, as an opportunity to focus efforts.

**Benchmarking local economic impact using LM3**

6.5 The project started with a benchmarking of the council's current economic impact using LM3. In spring of 2004, the council's food contract, for which the council contracted for food on behalf of all schools, care and civic catering facilities in Northumberland came up for renewal. The council decided to use the opportunity of this £3 million per annum contract to make some changes.

6.6 The first step was to reach out to the businesses and support organisations in the area. A seminar was organised aimed at communicating the contract needs to all the small and local food suppliers, together with those food and transport suppliers already supplying the council. Delegates were taken through the food tender process and a lot of the second tier suppliers were encouraged to complete the exercise to achieve approved supplier list status, even if they might not compete and win the full tender. The council hadn't previously contracted for bread - so regional bread suppliers were alerted to the contract.

6.7 The second step was to get the regional Business Link and local umbrella organisation, Northumbria Larder, on board. Close liaison resulted in a number of businesses being provided with advice and help, including business and technical assistance by Business Link and Northumbria Larder in order to put submissions together and complete the required tender documentation.

6.8 The third step was to alter the specifications in the upcoming tender to open up the playing field to all types of businesses. The tender was split into lots allowing businesses to bid on any combination of seven food categories and for the majority of categories in four geographic areas of the county. This system in fact gave Northumberland County Council the most competitive total service because it could combine tenders in a number of ways. The procurement team also used Best Value criteria with the award evaluation criteria focused predominantly on quality; the quality / price ratio weighted 60:40. Especially included in the quality criteria was the requirement that the contractor must be prepared to assist the councils Catering Services Department in pursuing a sustainable food procurement strategy, which could include supplying locally grown or organic produce when specified by the schools and other establishments.
Types of services involved in the project

6.9 Services supplied are: Food supplies including meat, milk, bread, and fruit and vegetables for the provision of school meals, social services residential and day care establishments and civic catering.

Outcomes of the project

6.10 Overall, there were several positive outcomes from this project:

- The investment yielded better relations with regional suppliers, a more responsive regional business support network, and more competitive and localised sourcing of food for the school food contract.
- The contract was split into lots allowing businesses to bid on any combination of seven food categories in four geographic areas of the county.
- The work on the food contract also increased the effectiveness of the council's links to business support organisations such as Business Link and Northumbria Larder.
- The council's profile has been increased with local businesses, who have appreciated the efforts made to increase the opportunities for them to compete for the business.
- The result of the food contract tendering process was that four of the seven product categories (meat, milk, bread, and fruit and vegetables) were awarded to local suppliers.

Lessons learned during implementation

6.11 The benchmarking process found that local suppliers on average re-spent 76% of their contracts with local people and businesses while non-local suppliers on average re-spent 36% of their contracts locally. The exercise produced an LM3 benchmark of 2.19: that means that for every 1 GBP spent locally, 2.19 GBP was generated for the local economy. In round terms, this shows that if the Council were to increase the proportion of local spend by 10% then this would result in an extra 34m GBP to the local economy & community and incorporate a 9.5m GBP annual efficiency gain by the Council.

6.12 Breaking a contract into smaller ones gives the contracting organisation a more competitive service overall. There is more administrative work involved with Northumberland County Council now managing several rather than a few contracts. But the additional time investment was deemed to be offset by the quantity and quality of the tenders received.

6.13 The effect of increasing awareness of the council food tender process and encouraging local and small suppliers was evident in both the expressions of interest made and also the tenders received. A five-fold increase in local supplier expressions of interest was the result.
Case 2: Promoting social value by outsourcing to social enterprises

Introduction

6.14 In 1998 when the services in Karis, Finland were outsourced the costs of primary health care and elderly care were 20% bigger than the nation’s average. In 2003, the need-adjusted costs of the same services were lower in Karis than in other Finnish municipalities in general. In Karis, the need-adjusted costs of health care and elderly care were clearly under the national average (-5%). During the same period, the costs showed a 12.6% increase in other municipalities.

6.15 The hospital district of Uusimaa did not want to maintain special health care at the Meltola hospital because it had become too expensive. Instead of closing down the hospital, the municipality of Karis made assessments to find a new purpose for the hospital. Originally the Meltola hospital was built for tuberculosis patients, but it had been transformed into a district hospital with inpatient departments of the medical health centre. The municipality of Karis maintained Meltola hospital and had noted high costs. The reason behind these costs was an asymmetrical population structure in Karis with a high percent of elderly needing primary care and elderly care.

The decision to outsource services

6.16 A nurturing firm from Sweden contacted Karis wanting to buy Meltola and transform it into an elderly home. Instead of accepting this offer, Karis decided to have a domestic partner and started thus negotiating with Folkhålsan. Folkhålsan is a Swedish-speaking NGO in the social welfare and health care sector in Finland that carries out scientific research that provides social welfare and health care services as well as information and counselling. Because the majority of population in Karis are Swedish speaking, it became clear that also the health care provider should have special knowledge on the special characteristics of the population as well as be able to give services in Swedish.

6.17 The negotiations finished in 1998 with the municipality of Karis outsourcing primary health care and elderly care by giving the task to Folkhålsan on a multi-year contract. According to the contract Folkhålsan was responsible for producing the health care service. In the beginning the service was limited only to Karis, but after re-organisation also other municipalities and private customers could buy services from Folkhålsan Raseborg that was founded for this purpose.

Managing reaction to the decision

6.18 Large publicity followed the contract with a focus on the high price of outsourced services. It was said that the municipality is deprived of all its money. Also the general opinion considered the contract too expensive. All this led to an independent survey and development work. For this
purpose the municipality of Karis asked STAKES (National Research and Development Centre for Welfare and Health) to do research on actual costs. Results of the research were clear: expenses were under control; production of services was on average level compared to use. The main problem however was inadequate public revenues (tax income) used to finance health care services.

**Outcomes**

6.19 STAKES does follow-up research every year to see how the cost-efficiency has developed. These results show that towards the year 2003 open care had substituted a part of the services in institutional care. The strategy of Folkhälsan Raseborg from 2002 included new measures for primary and elderly care. The main calculation of the strategy was to show that beds in institutions should diminish by the year 2010 from 608 to 450. During the same period the amount of personnel should reduce from 166 to 120 employees. On the other hand, home care was not going to be increased.

**Case 3: Opening up the health sector supply chain to SMEs**

**Introduction**

6.20 On behalf of the North West Regional Development Agency (NWRDA), Groundwork has developed and is delivering a programme to open up the NHS supply chain to locally based small and medium-sized enterprises (SMEs). The rationale for this development is that the significant NHS regional spend on goods and services will be the prime motivator to influence regeneration, improve health and reduce environmental impact. This is being done through up-skilling the supplier base, identifying key areas of opportunity, engaging NHS trusts while raising awareness of sustainable procurement. The ultimate aim of the bureau is to increase the proportion of the estimated £2.2 billion NHS non-pay spend procured through North West suppliers.

6.21 This project has been developed from work carried out in the Merseyside region (Health Action Zone Employment Innovation project) that finished in March 2003. This focussed on existing suppliers to Wirral NHS Trust and looked at reviewing and improving their health and safety arrangements. Many issues from both suppliers and trusts came out of the evaluation. These issues are being addressed through the current NHS Suppliers Bureau Project that is directly funded through NWRDA and matched with Objective 1 funding.
Actions with SMEs

- Training workshops (including tender procedures, structure of NHS, understanding decision making process, developing a strategy to sell into this market). Eleven events have been delivered (up to May 2006) to 418 businesses
- Development of database of local suppliers on-line
- Awareness raising of IT supplier requirements and development essential to trade effectively with NHS (e-commerce, e-trading, e-auctions)
- Auditing supplier businesses to ensure effective control of health, safety and environment impact; highlighting areas of weakness or risk. A report and action plan is produced to assist improvement; 73 audits undertaken to date
- SME friendly health, safety and environmental manual/CD Rom has been developed to compliment the audit process. Developed in partnership with Health@Work
- Development of a NHS Passport scheme which will raise awareness and educate employees of NHS contractors on occupational health issues, risk specific to NHS sites, safety and the environmental impact of their work
- Setting up website (www.intend.org.uk) to effectively promote and communicate the work in progress with both supplier and NHS procurement departments. It will provide general NHS procurement information, a library of strategic documents specific to the health sector, NHS procurement opportunities, capturing supplier interest, (contact details). This is currently in the process of being updated with a more detailed supplier registration / supplier portal with tender opportunities, frequently asked questions, e-bulletins.
- One-to-one support for suppliers through Procurement Clinics which result in an action plan being produced that outlines a strategy and way forward on how to target key budget holders and access the NHS market
- Production of a SME booklet: ‘How to tender and sell to the NHS’.

Actions with NHS Trusts

- Involvement with procurement working group for Good Corporate Citizenship with representation from each of the three strategic health authorities
- Identifying existing suppliers within the region that would benefit from further support
- Identifying tender/quotation opportunities
- LM3 analysis (see Case 1 above)
- Joint working on food contracts through the Heart of Mersey Food Forum
- Joint working in Cumbria, linking the rural economies with NHS spend.

Other actions

- On-going engagement with North West business support organisations (Business Links, Chambers of Commerce, Training support)
- Potential focus on NHS Boardroom Roadshow ‘From Bilbao to Birkenhead’: a practical stepped approach to implementing the Bilbao Agenda
- Health is Wealth initiative in Merseyside
- Potential to explore development and guidance on approaches to ‘social clauses’ within public sector contracts.

Legality

6.22 At the moment the project is not challenging the legal processes involved in the tender process but is making the regional suppliers aware of this process. There are plenty of opportunities for trusts to initially obtain quotes and tenders for business under the European threshold (for areas such as building works, maintenance contracts, pest control, window cleaning, printing).
**Economic impact**

6.23 A full evaluation of the economic impact of the project will be ready December 2006, with on-going communication with the suppliers engaged to identify issues and identify successes. Part of the evaluation will include an LM3 analysis to establish the impact of local procurement within the whole local economy.

6.24 Specific case studies have been developed with companies in the IT, food and office furniture sectors – which have increased the level of business within the NHS and effectively tendered for further business.

**Additional impacts**

6.25 The project will help trusts to demonstrate their commitment to being a Good Corporate Citizen by communicating opportunities to local suppliers, supporting the NW NHS Supplier Bureau workshops, providing information and supporting their own local suppliers to improve health, safety and environmental control.

6.26 Through the project we are promoting other health initiatives, which could improve health in the workplace. Introducing the National Clean Air Award, encouraging companies to become smoke free organisations.

**Next steps**

6.27 With the project being funded up to January 2007 there will be on-going supplier support and development, strengthening communication links with the NHS and establishing a formal partnership with the NHS – encouraging innovation from both suppliers and the NHS.

6.28 There will be a formal evaluation of supplier success in terms of increased business within the NHS, impacts of reviewing health and safety practices. There is a wider project being proposed across the North West looking at the entire public sector.
Case 4: medtecnet – developing a marketing network for SMEs

Introduction
6.29 This case study shows how SMEs in the medical technology sector have been supported to compete for hospital procurement contracts in the German region ‘Berlin-Brandenburg’. The core feature of this approach has been the development of medtecnet-BB, a network of SMEs that can provide health technology products to the health care market in the region. This initiative itself has come from the Technology Foundation of Berlin and specifically from its TSBmedici programme.

6.30 The main focus of TSBmedici is to provide:

- Assistance in setting up innovative companies
- Consultation to innovative companies
- Technology transfer between science and industry
- A forum for dialogue between science and business
- A network of research, clinical development and production
- A platform for presenting regional medical technology to other regions in Germany and elsewhere.

Scientific and market potential in Berlin-Brandenburg
6.31 The scientific potential and market potential in the region is considerable. The University Hospital Berlin deals with about 125,000 in-patients and 900,000 ambulatory patients each year. Elsewhere in the city, the German Heart Centre Berlin is one of the leading transplantation Centre’s in the world. Meanwhile, UKB is the first fully digitalized hospital in Germany and Vivantes Klinikum Neukolln includes the world’s first laser clinic. Overall, the region has 136 hospitals and 45,000 beds.

6.32 Supporting this scientific potential are several leading research organisations including: the Academy for Cardiology Technology; the Max-Delbruck Centre for Molecular Medicine; the Max-Planck-Institute for Molecular Genetics; the German Research Centre for Rheumatism; the Laser and Medical Technology Company, Berlin. In addition a number of Public Authorities are based in the region.

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The health care market in Berlin-Brandenburg

6.33 Looking at the health care market in Berlin (Figure 19) we can see that the Medical Technology element was worth around 1.3 Mrd € in 2000. Within this segment of the market there are around 150 producing companies. Of these:

- 36% are fast growing companies over 3 years old
- 55% are traditional companies
- 6% are affiliates of international companies
- 3% are start-up companies less than 3 years old.

6.34 Between 1999 and 2003 this sector of the market has also seen more growth in the smaller companies with a smaller rate of growth in medium size companies. In part, the dynamism in this sector of the market is supported by key structures for cooperation in the region that provide a platform for SMEs to compete effectively against large companies, especially in niche product markets. This is where SMEs appear to be more adaptable and faster to respond to or innovate new products. The main structures for cooperation are:

- Network for Medical Microsystems Technology
- Network in Regenerative Medicine CellNet.Org
- EnForCe Research Centre for Endocrinology, Charite
- Medtecnet-BB network of companies in medical technology in Berlin-Brandenburg.
Medtecnet-BB: providing a platform for SMEs to compete

6.35 The last of these, medtecnet-BB was set up by the Technology Foundation Berlin to help regional SMEs take advantage of some market opportunities in the region and overcome important market barriers. The opportunities include:

- Excellent concentration of hospitals, resident physicians and research institutes
- Powerful and vibrant medical technology cluster (most are SMEs)
- One of the most important medical technology locations in Germany
- Strong international profile with high export volume.

The barriers include:

- Low-level sales in the region because of the existing supplier connections that act to exclude or shut out SMEs from local markets.

Goals of medtecnet-BB

1. Increase regional sales of companies in the Network
2. Facilitate closer cooperation at all levels of the supply chain (R&D, clinical testing, production, sales)
3. Supply coordinated systems solutions and demand-orientated R&D strategies
4. Generate medium term growth and employment effects
5. Contribute to the long-term strength of innovation potential in the regional medical technology sector.

6.36 To achieve these goals medtecnet-BB has adopted a two-phase development plan. Phase 1 involves data compilation of all hospitals in the region; expert interviews with a representative sample of hospital procurement managers; SWOT-analysis of the Network; developing a marketing concept for phase 2. Phase 2 involves: developing a Network website, brochure, product catalogue; forming strategic partnerships for target groups e.g. workshops for hospital procurement managers and organisation of business club events for hospital managers in cooperation with Gesundheitsstadt e.v.; mailings, sales fairs and public relations.

Achievements of medtecnet-BB to date

- 3 common R&D projects (2 current and 1 planned)
- 10 contacts with hospital procurement managers (generating sales of about 60,000€
- 10 contacts to hospital physicians
- Joint presentation of the network at sales fairs e.g. Arab health and the Moskow fair
- Information exchange to enable opening up of export markets
- Providing contact mediation for a sales distribution contract.
7 Towards a policy agenda for health sector procurement

7.1 The costs of publicly funded health services are pushing at the limits of affordability. This is a challenge shared by all European regional health systems. In this financial climate, health organisations need to be able to demonstrate the added value of investment and expenditure decisions.

7.2 Within partner regions, spending by health services on staff, goods & services, buildings, IT and equipment ranges from 6 to 9% of regional GDP. This is a significant level of economic activity. But it is not optimised to positively contribute to regional development agendas. Nor is it used to maximise the population health benefit of health care expenditure.

7.3 Procurement practices are one way of achieving these contributions. They should: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion. These are the kinds of added value that we should expect from public organisations spending public money.

Ensuring the relevance of a policy agenda

7.4 There are four main audiences for an agenda on health sector procurement:

- For health service decision makers this agenda supports the development of the corporate social responsibility role of their organisations and also shows their commitment to the health inequalities and health improvement agenda.

- For local health organisations such as acute hospitals and primary care organisations, this agenda helps show commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels.

- For SMEs, the adoption of this agenda in a region or community, offers a clear basis for lobbying for simpler, more transparent procurement processes with less bureaucracy and the development of an enterprise aware culture in health service organisations.

- For relevant directorates within the European Commission (DG Enterprise, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for an approach that cuts across individual DG competencies in order to achieve European added value.
The benefits of a policy agenda

7.5 Procurement by health service organisations has the potential to stimulate the development of capable local businesses, strengthening their competitiveness in wider markets and so supporting a positive drive to achieve the goals of the Lisbon Agenda (growth, competition, employment).

7.6 Specifically, increasing local procurement has proven benefits to local economies and regional development. These include:

- Increasing local employment
- Increasing the skills base in local labour markets
- Increasing wealth in the region
- Promoting business growth (SMEs) competitive in wider markets
- Contributing to health improvement
- Enhancing community well being and social cohesion
- Protecting the environment by decreasing transport miles.
8 The Bilbao Policy Agenda

8.1 This Agenda and the others that will follow it, provide a practical response to the ‘health equals wealth’ challenge first set out at the European Health Policy Forum in October 2003. The Bilbao Agenda puts forward a range of procurement policy actions for localities, regions, and the European Commission. The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in HealthClusterNET.

8.2 A key element to the success of the Bilbao Agenda will be the creation of “enlightened” public sector purchasers, who with the right communication tools could fairly help to develop the capabilities of businesses wishing to compete for health sector contracts.

Aims of the agenda

8.3 The aims of the agenda are to:

- To enable regional health systems to more positively engage with regional development through procurement practices that contribute to dynamic local enterprise cultures.

- To redefine ‘value for money’ (or national equivalent term1) to include outcomes that connect public sector procurement to the achievement of regional development priorities.

- To reshape public procurement practice with and by regional health systems so that it contributes to the revised concept of ‘value for money’.

Recommendations for early actions

Europe-wide actions

- Revise the definition of ‘Value for money’ so that it includes the following as legitimate evaluation factors: commitment to minimising environmental impact, improving workplace and population health, strengthening social cohesion, enhancing capability of local businesses and promoting community regeneration.

- Identify ‘communities of action’ in order to promote understanding (supported by evidence) about:

1 Other words used across partner regions that are equivalent to ‘value for money’ are: best value, total economic benefit, best offer.
o the contribution of health as a cross cutting driver of public policy
o the contribution of health sector procurement to regional/local competitiveness, health improvement and social inclusion
o using inter-regional benchmarking as a means of sharing good practice, promoting a cost effectiveness approach to procurement, learning and dissemination.

• Identify and develop metrics that allow us to operationalise the revised definition of ‘Value for money’.

Regional and local level actions
• Identify ‘regional communities of action’ in order to promote understanding (supported by evidence) about:
  o the contribution of health as a cross cutting driver of public policy
  o the contribution of health sector procurement to regional/local competitiveness, health improvement and social inclusion
  o using inter-regional benchmarking as a means of sharing good practice, promoting a cost effectiveness approach to procurement, learning and dissemination.

• Where not already in place, create regional centres of excellence in procurement and innovation. These will support public sector organisations and SMEs to engage with this agenda and ensure that relevant expertise is not duplicated across sectors.

• Undertake procurement spend analysis within regions to identify baseline and potential long-term benefits.

• Regional health systems should define their own ‘economic footprint’ as a basis for baselining and then monitoring the contribution of their procurement activity to regional economic development.

• Health sector procurement organisations should look at how they can simplify procurement processes by reducing bureaucracy and clarifying procedures.

• Develop and disseminate e-Procurement tools as a means of opening up competition and improving SME access.

• Develop training schemes that help local businesses develop the capacity and capability to comply with the requirements of public sector contracts
• Develop a database of accredited local suppliers who have participated in a public procurement training scheme

• Regional health systems should work with centres of excellence, business associations and economic development agencies to create managed SME networks in health market segments.\(^{11}\)

• Develop awareness and capability training schemes for health sector procurement staff, both senior management and operational, to allow the concept of appropriate local procurement to be broadly accepted.

• Regional health systems should be engaged to accept the concept of local and regional procurement gains as “acceptable currency” for procurement performance.

Recommendations for longer-term actions

Europe-wide actions

• Develop a single unified Pre-Qualification Questionnaire (possibly with ISO accreditation) that helps to simply the procurement process for SMEs when they compete for public sector contracts.

• Establish a system within the regions to open up access by SMEs to tenders under the EU directive.

• Explore opportunities to maximise competition by dividing large procurement exercises (e.g. information technology), into a portfolio of medium and smaller size contracts with successful delivery ensured by effective project management capabilities within procurement organisations.

• Contracts and service level agreements for health care providers should include the revised definition of ‘Value for money’.

• There is a need for local businesses to be provided with the ability to compete for public sector contracts on a fair and open basis. Changing the terms of small business loan guarantee schemes could be one way of achieving this.

\(^{11}\) Note that there will be different ‘local’ relevancies for different markets.
• Allocate structural funds to support capacity building in new member states.

Regional and local level actions

• Explore potential for collaborative working, clusters and consortia among SMEs with complimentary products and those with similar products. Specifically,
  
  o to coordinate policies around a common strategy to improve the efficiency of regional health systems
  o to create an effective and rapid information & communication system among all the key actors in regional health systems (competitive intelligence to develop research, investment and development)

• Encourage new building design solutions combined with flexible models of capital investment procurement that conform to the revised definition of ‘Value for money’. For example, the Groningen Health Campus in the Netherlands or the Joint Ventures approach in Scotland.

• Include performance metrics that operationalise the revised definition of ‘Value for money’ in the monitoring and evaluation of health care provider contracts.