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BY THE U.S. GENERAL ACCOUNTING OFFICE

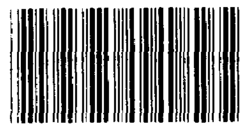
Report To The Administrator Of Veterans Affairs

VA Needs Better Visibility And Control Over Medical Center Purchases

The Veterans Administration (VA) has 172 medical centers and spends about $1 billion annually for supplies and equipment. It has the opportunity and incentive to implement a consistent and efficient centralized purchasing system.

However, individual VA medical centers select the products they use. They are also independently buying $373 million (38 percent) of their supplies and equipment on the open market, rather than from centrally managed supply channels. As a result, products are not standardized and costs are high.

In addition, because descriptive information is not reported, VA has no management visibility for $426 million of medical center expendable supply purchases and cannot properly assess medical center procurement or manage common supply items.



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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-201069

DLG 05634

The Honorable Max Cleland
Administrator of Veterans Affairs

Dear Mr. Cleland:

This report summarizes the results of our review on the Veterans Administration's (VA's) medical center purchasing practices. It suggests ways to improve procurement management as well as reduce operating costs. The points raised in this report were discussed with agency officials, and their comments have been included.

This review was made because, while working at VA's Marketing Center and several VA medical centers, we noted that many different items were being independently purchased on the open market to satisfy common medical center needs.

This report contains recommendations to you on pages 13, 18, and 24. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Director, Office of Management and Budget; the Chairmen, House Committee on Government Operations, Senate Committee on Governmental Affairs, House and Senate Committees on Appropriations, and Veterans Affairs.

Sincerely yours,

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE ADMINISTRATOR
OF VETERANS AFFAIRS

VA NEEDS BETTER VISIBILITY AND CONTROL OVER MEDICAL CENTER PURCHASES

D I G E S T

The Veterans Administration (VA) provides supply support to 172 medical centers. In 1979 supplies and equipment costing nearly $1 billion were purchased by these VA facilities.

VA's purchasing system consists of a marketing center in Hines, Illinois, and individual purchasing offices within most of its medical centers. These purchasing offices order all goods and services for the medical centers. Most items are obtained from VA's supply depots, Federal supply schedules, or open market vendors.

VA's Marketing Center purchases items that are stored and distributed through VA's supply depots and manages supply schedule contracts for certain medical and food items. These centralized procurement programs give VA medical centers the opportunity to obtain supplies and equipment without having to independently solicit and award contracts. VA medical centers are required to use these programs whenever possible. However, the medical centers still annually purchase items costing about $373 million from open market vendors.

GAO evaluated the purchasing practices used by VA medical centers and found that:

--VA has not standardized many common medical center items. Centers, therefore, independently purchase and use many different products to serve their basic needs. This increases VA's purchasing costs. (See ch. 2.)

--VA lacks sufficient visibility over medical center purchases to effectively address central procurement issues. Little or no descriptive information is recorded for items costing about $426 million, most of

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which are locally procured by VA medical centers. (See pp. 7 and 8.)

--Medical centers deviate from VA's mandatory supply sources. Thus, higher open market prices are paid for common items that are available from central supply channels. (See pp. 15 to 17.)

--Competition, although required by Federal Procurement Regulations, is not obtained by medical centers for many purchases exceeding $500. Consequently, VA had little assurance that medical centers paid reasonable prices. (See p. 17.)

--Separate orders are prepared for each departmental purchase request. Consolidation would reduce administrative work and prices. (See pp. 19 to 21.)

--Neighboring VA medical centers independently obtain common goods and services, and because procurement information is not generally shared, they pay different prices for the same thing. (See pp. 21 to 24.)

CONCLUSIONS AND RECOMMENDATIONS

GAO concludes that opportunities for lower prices are being lost because of VA's

--failure to standardize common items used by medical centers,

--failure to maintain visibility over most supplies purchased by medical centers,

--uneconomical purchasing practices of the medical centers, and

--failure to consolidate purchases within and among medical centers.

GAO believes VA should strengthen its role as a central manager of medical center goods and services to obtain the savings available through greater consolidated purchasing. GAO recommends that the Administrator of Veterans Affairs direct the Assistant Administrator for Supply Services to:

--Establish a central standards committee to identify and evaluate common items presently used by VA medical centers.

--Develop an information system that provides greater visibility over all medical center purchases.

--Develop the controls needed to improve and monitor the purchasing practices of individual medical centers.

--Consolidate purchases within medical centers and among neighboring centers.

--Implement the procedures necessary to assure that neighboring medical centers share product and vendor information so they can effectively take advantage of one anothers purchasing and contracting experience.

AGENCY COMMENTS

VA generally agreed with GAO's conclusions and recommendations. VA has been aware of the need for better visibility and control over medical center purchases for many years. VA commented that current staffing levels are not sufficient to provide for improved standardization or better visibility and control over medical center purchases. VA informed GAO that past attempts to obtain resources in these areas have not been successful. The agency expects the 1982 budget will include funds to begin improving and expanding its information computer system.

GAO agrees that VA needs additional resources to provide full visibility and control over medical center purchases. However, GAO believes that the savings resulting from improved procurement practices will more than offset any additional costs. GAO also believes that as a first step VA should use existing resources to improve standardization and control of selected items.

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ABBREVIATIONS

FSS	Federal supply schedules
GAO	General Accounting Office
LOG I	Integrated Procurement Storage and Distribution System
VA	Veterans Administration
VAMKC	Veterans Administration Marketing Center

CHAPTER 1

INTRODUCTION

The Veterans Administration (VA) provides procurement support to one of the largest medical programs operated by the Federal Government. During 1979 VA medical centers spent nearly $1 billion for supplies and equipment.

CENTRAL PROCUREMENT ACTIVITIES

Several centralized VA procurement programs provide individual medical centers with opportunities to obtain economically priced supplies and equipment without having to independently solicit and award contracts. The VA Marketing Center (VAMKC) in Hines, Illinois, is VA's national purchasing activity, providing centrally managed supply channels for VA medical centers. These channels are also available to other agencies such as Public Health Service hospitals, the Bureau of Indian Affairs, and Federal correction institutions. VAMKC centralized programs consist of a national depot distribution system, contracts for direct delivery to medical centers, decentralized contracts for direct ordering by medical centers, and Federal supply schedules (FSS) for items assigned by the General Services Administration.

VA supply depots

VAMKC centrally purchases and stocks medical center supplies and equipment in three VA depots in California, Illinois, and New Jersey. VAMKC

--identifies items to be added or dropped from the depot program,

--monitors the depot stock levels, and

--initiates contracts or reorders stock when depot levels require replenishment.

Medical centers requisition stock from VA's supply depots and the depots ship stock to the centers. In 1979 VA medical centers obtained about $151 million in supplies and $4 million in equipment from VA's supply depots.

Medical center supply requests are transmitted to VA's Data Processing Center, in Austin, Texas, recorded in the automated supply system (the Integrated Procurement Storage and Distribution System (LOG I)), and then sent to

the appropriate supply depot to be filled. Depot receipts and medical center shipments are also recorded in LOG I and provide the basic information for VAMKC's management of depot stock levels.

FSS

Under the FSS program, commercial vendors are contracted to provide Government agencies with a wide range of supplies and services. These schedules allow VA medical centers and other agencies to place direct orders with contractors at preestablished prices. VAMKC manages FSS contracts for certain drugs, chemicals, subsistence, and medical supplies; whereas, the General Services Administration manages FSS contracts for most other items, such as furniture, office supplies, and equipment. In 1979 VA medical centers purchased about $320 million through this program.

Direct delivery and decentralized contracts

Decentralized contracts are similar to the FSS program, where medical centers order from a VAMKC administered contract. Usually, these contracts are for specialized medical equipment items that are not available through the depot program, nor through the FSS program. VA medical centers are primary users but other Government agencies may participate.

Under direct deliveries, VAMKC not only administers contracts but places orders for the medical centers. Vendors then deliver ordered material directly to the centers. This program is primarily used for radiological and nuclear supplies and equipment.

In 1979 these two programs accounted for $58 million in medical center purchases.

MEDICAL CENTER SUPPLY ACTIVITIES

Generally, each VA medical center has a single supply service responsible for

--acquiring goods, equipment, and services;

--managing center inventories; and

--distributing supplies to the appropriate departments.

Most VA medical centers operate independently. However, in some metropolitan areas, they share a single supply service and a central warehouse.

Each department within a center, such as dietetics, engineering, radiology, pharmacy, nursing, and so forth, requisitions supplies through the medical center's supply service. The supply service is required to fill the orders from the proper sources in a timely and cost-effective manner. It should assure that competition is adequate and prices are reasonable.

Expendable supplies received by a medical center are either stocked in the center's warehouse (posted) or delivered directly to the appropriate department (unposted).

LOG I: VA'S AUTOMATED SUPPLY SYSTEM

LOG I provides information for both VAMKC and the individual centers to use in administering and managing procurement. The medical centers input data on procurement orders and receipts, as well as departmental issues of their stock. VA medical centers use LOG I data to reconcile receipts and manage stock levels, whereas VAMKC uses this information to identify posted items with central management potential. LOG I has three basic types of files concerning medical center procurement:

--Expendable posted. Supplies are received and stocked for one or more departments in a centralized medical center warehouse. About $227 million is purchased annually, and information is recorded for each item and each purchase transaction.

--Expendable unposted. Supplies are received and issued to a specific department upon receipt. About $510 million in supplies are purchased annually, but most items are not described in detail.

--Nonexpendable. Equipment retains its accountability through property stock numbers. About $244 million in equipment is purchased annually.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objective was to evaluate the effectiveness of selected VA medical centers' procurement activities. We also assessed VA's practice of allowing individual centers to obtain a major portion of their supplies and equipment on the open market, rather than from centrally managed supply sources, and VA's ability to centrally manage such transactions.

Our review was performed at VA Supply Service Headquarters, Washington, D.C., VA Marketing Center, Hines, Illinois, and the following VA medical centers:

--VA Hines, Hines, Illinois.

--VA Westside, Chicago, Illinois.

--VA North Chicago, North Chicago, Illinois.

--VA Iron Mountain, Iron Mountain, Michigan.

--VA Aspinwall, Pittsburgh, Pennsylvania. 1/

--VA Highland Drive, Pittsburgh, Pennsylvania. 1/

--VA University Drive, Pittsburgh, Pennsylvania. 1/

The size of these centers varied from about 234 to about 1,538 patient beds. Five are general medical centers and two are predominantly psychiatric medical centers, but supply services are similarly organized. Six of the centers were selected because they are close to other centers and large commercial markets. This enabled us to assess consolidating orders and standardizing products among neighboring medical centers. VA Iron Mountain was selected because it is small and relatively isolated. This enabled us to address procurement problems and operating conditions not found in a large metropolitan area.

At each medical center, we flow charted the purchasing organization and system to assure consistency and comparability. We reviewed VA's local and national purchasing policies and procedures. We also interviewed commercial vendors, as well as VA supply and department officials.

All VA medical centers have common supply structures, procedures, and reports, and their procurement characteristics are similar. Although we did not statistically determine the extent problems exist throughout VA, we believe our findings represent situations that occur at most medical centers.

We obtained procurement data from VA's LOG I enabling us to identify the overall purchasing profile of VA's medical centers.

1/Aspinwall, Highland Drive, and University Drive are serviced by a single supply service.

	Approximate annual purchases
	(millions)
Nonexpendable equipment	$244.1
Expendable supplies	738.1
Total	$982.2

Besides generating overall statistical data on VA's purchasing characteristics, the computer files were used to identify procurement patterns at the selected medical centers, as well as to provide assurance that these centers represent the VA network. This procedure enabled us to identify potential weaknesses concerning product standardization, source deviation, and procurement consolidation.

Nonexpendable equipment

We used the nonexpendable equipment file to assess medical center receipts between March 1979 and February 1980. At each center we identified and selected purchases of identical or similar equipment items. The actual purchase orders were then pulled from medical center supply records, verified, and discussed with the appropriate department officials.

Although equipment is not purchased on an annual cycle, the computer data assured us that each center purchased a representative amount of equipment.

Medical center	Approximate annual equipment purchases	Percent of total purchases
	(millions)	
Westside	$1.5	16
Hines	3.3	23
North Chicago	1.3	18
Iron Mountain	0.3	23
Pittsburgh complex	1.6	15

Expendable supplies--unposted

The expendable unposted file was used to identify purchases for calendar year 1979. Although the file represents the largest segment of medical center purchases, $510 million,

reporting normally does not include stock numbers or other product identifiers. Computer data was used to assure that the centers we visited were representative of national procurement patterns. For example, at each of the medical centers we visited, as well as nationally, the most frequently used supply channels were open market and FSS.

To assess purchasing practices at the selected centers, purchase orders and major vendor files were reviewed to identify procurement patterns and potential problems within each center. Selected purchases were verified and discussed with the appropriate department officials.

Expendable supplies--posted

The expendable posted file was used to review medical center supplies received from March 1979 through February 1980. We identified the items being stocked and obtained information such as the number of using medical centers and the supply sources. Specific procurement transactions and departmental issues were discussed with appropriate medical center officials. Overall, the centers visited posted a representative portion of their expendable purchases.

	Approximate annual supply purchases		
	Total	Amount posted	Percent posted
	------(millions)-----		
All VA medical centers	$738.1	$227.4	31
Westside	7.6	2.1	27
Hines	10.9	3.0	27
North Chicago	6.1	1.0	16
Iron Mountain	1.1	0.4	35
Pittsburgh complex	9.7	3.4	35

CHAPTER 2

VA NEEDS TO STANDARDIZE

PRODUCTS USED BY ITS MEDICAL CENTERS

VA has many opportunities to standardize the products used by its 172 medical centers. However, a coordinated effort has not been made to reduce the number of items used by VA centers. At the heart of this problem is the fact that medical centers are permitted to purchase about 38 percent of their needs from the open market with little or no control from a central procurement office. To compound this problem, the Hines Marketing Center identifies an inordinate variety of products for use by its centers rather than recommending a few standard items. As a result, different products are used for the same purpose, prices are higher, and duplicate efforts are performed.

VAMKC HAS LIMITED PROCUREMENT VISIBILITY

VAMKC is responsible for centrally managing items commonly used by VA medical centers. It provides centers with several centrally managed supply channels, but purchases very little directly for the centers. Basically, VAMKC identifies and selects items based on medical center usage. However, it has no management information on most of the medical centers' supply purchases and is unable to accurately evaluate supply items in terms of:

--How many medical centers are users.

--How frequently or how much is purchased.

--What prices are paid.

--What sources are used.

Descriptive procurement information is only reported for posted supplies and unposted drugs, which account for about 42 percent of the total expendable supply purchases.

	Annual medical center purchases	Percent of total
	(millions)	
Visible items:		
Posted items	$227.4	31
Unposted drug items	84.3	11
Total	311.7	42
Other purchases which are not visible to VAMKC	426.3	58
Total	$738.0	100

Usage data reported in the posted file is misleading because any supply item may also have unposted purchases which are not reported. According to VA's records, for example, only two of the four midwest medical centers we visited used a certain liquid cleanser; but we found that a third center was also using this same item. Since purchases were unposted, however, usage was not reported on a central level.

Usage is further understated when a single medical center purchases an item on both a posted and an unposted basis. For example, one center we visited was posting purchases of injection sets used by four different departments. However, this same item was also purchased for two other departments on an unposted basis. Consequently, only the posted purchases were reported, and the center's actual usage was understated.

Without accurate usage information, VAMKC's ability to effectively address central procurement issues, such as product standardization, is severely restricted.

VA ALLOWS MEDICAL CENTERS TO PROCURE A VARIETY OF PRODUCTS

VA medical centers are allowed to choose from a variety of products and package sizes. Furthermore, VA identifies an inordinate variety of products for use by its centers, rather than recommending a few standard items. For instance, the VA catalog identifies the following number of different product choices.

Item description	Number of different products available (unique stock number)	VA's recommended sources
Surgical sponge	46	open market
Surgical sponge	18	FSS
Colostomy-ileostomy bag	85	open market
Colostomy-ileostomy bag	28	FSS
Intravenous injection set	34	open market
Intravenous injection set	97	FSS
Dental wax	31	open market
Dental wax	30	FSS
Radiographic film	10	open market
Radiographic film	236	FSS
Blood collecting tube	7	open market
Blood collecting tube	146	FSS
Hand dishwashing compound	24	open market
Hand dishwashing compound	3	a/GSA
Hand dishwashing compound	3	FSS

a/General Services Administration.

These are common items that offer potential for standardization. However, having so many choices almost seems to encourage a decentralized open market approach to purchasing. For instance, if a medical center does not want 1 of the 6 dishwashing products available through mandatory sources, VA identifies 24 alternatives that can be purchased locally on the open market. In fact, $373 million annually, or 38 percent, of medical center purchases are made in the open market.

EFFECTS FROM INADEQUATE STANDARDIZATION

The environment created by VA is geared too much toward satisfying individual users and not enough toward economy. We found many instances of different products procured for the same purpose within an individual center and among centers at a variety of prices. Standardization efforts have been ineffective.

Different products used for same purpose

Individual users are given latitude in selecting the items they want in those areas not only involving medical judgment, but also concerning common products, such as housekeeping supplies. To some extent, purchasing agents even rely on the individual departments to identify vendors for them.

Our assessment indicated a significant diversity among VA's 172 medical centers, as most stocked items were either unique to a single center or stocked by only a few. According to the data in the LOG I files, there were 18,124 different items stocked by VA medical centers. Of these, 8,868, or 49 percent, were stocked by only one center.

	Number of different items stocked (note a)			
	One medical center	Two to five medical centers	More than five medical centers	Total
Drugs and chemicals	2,482	1,898	1,656	6,036
Medical supplies	3,580	2,014	1,093	6,687
Housekeeping supplies	1,010	530	316	1,856
Subsistence	861	577	483	1,921
Other	935	451	238	1,624
Total	8,868	5,470	3,786	18,124

a/Common items may be used by other centers but not stocked (unposted). The extent, however, cannot be determined through LOG I.

The above statistics do not reflect total medical center supply purchases, but they do summarize the information reported to, and used by, VAMKC for assessing medical center supply products. Although this data may include some emergency or one-time buys, we believe it indicates a need for further attention to standardization on a central level. However, no concentrated effort to evaluate these supply items and to recommend standard items to the medical centers exists.

Prices are higher

When medical centers independently select their own supplies and equipment, they often pay different prices for items used for the same purpose. For example, in 1979

over $1.8 million was spent on examination gloves, and at least 35 different types and sizes were stocked by VA centers. Three of the medical centers we visited buy similar gloves on the open market and are paying 5 cents, 7 cents, and 9 cents a pair, respectively. Since examination gloves are a high use item, standardization among medical centers could offer significant savings.

In another example, hypodermic needles are used by three different departments at one center. Even though these needles all meet the same specifications, each department requested them from different suppliers at prices ranging from $5.37 to $7.15 per box. The department using the most expensive needle was unaware that other vendors offered better prices and was willing to use the cheaper product. However, the medical center's supply service processed each requisition without questioning why different vendors were requested by the departments.

Nonexpendable equipment could also be standardized within individual centers and among centers. For example, in 1979, 51 medical centers bought 121 chair scales costing over $90,000. Four medical centers that we visited bought similar scales on the open market during the same year, but paid significantly different prices.

Medical center	Unit price
A	$299
B	475
C	235
D	585

In another example, different prices were paid for similar items bought during the same year by the same medical center.

Supply item	Price range	Percent difference
Desk calculators	$138 to $291	111
Cameras	305 to 460	51
Examination tables	770 to 860	12
Vacuum cleaners	126 to 160	27

In each instance, users either could not offer a reasonable explanation for the higher priced item or agreed that the less costly one could have been used. In most instances, users requested a specific product and were unaware that alternative, less costly products were available. The medical

center's supply services did not challenge any of the users' selections.

Standardization efforts ineffective

Some individual VA centers have established standardization committees to improve supply support. Their prime objective is to reduce the number of sizes, kinds, types, and grades of items. However, these committees do not emphasize and communicate standardization issues and have not been successful in standardizing common items. We found that committee attention was directed towards new products or spending priorities, rather than an assessment of medical center purchasing practices or supply activities. Also, product information was kept in-house, rather than shared with other VA medical centers.

In some cases, product selections are based on medical center evaluations and tests. This could result in standardization if one or two clearly superior products exist. However, this testing process can be duplicative, time consuming, and may not result in a standard choice.

For example, hand soap for general washroom use is seemingly a standard item; and yet, only two of the five centers' supply services visited purchased a common soap product:

--Medical center A: soap bars (brand 1).

--Medical center B: soap bars (brand 2).

--Medical center C: liquid soap (brand 1).

--Medical center D: soap tissues.

--Medical center E: liquid soap (brand 1).

Independent medical center studies were not coordinated nor shared with one another. For instance, two centers conducted independent evaluations of the same soap product, including tests by their infection control units. A third center was also planning to test the same product. When informed that a neighboring center had already performed an evaluation, this center expressed interest in obtaining a copy, believing its own study efforts may no longer be needed.

CONCLUSIONS AND RECOMMENDATIONS

With 172 medical centers spending about $1 billion annually for supplies and equipment, VA has substantial purchasing power. And yet, VA has not effectively coordinated medical center needs with centrally managed supply channels. Instead, it provides a multitude of products for its centers to select from and has not standardized products for medical center use.

Although responsible for centrally managing VA's common items, VAMKC lacks management information on 58 percent of the expendable supplies purchased by medical centers and, therefore, has limited visibility on product usage and demand. Accordingly, it is doubtful whether VAMKC can effectively manage VA's central purchasing activities, especially when the centers continue to purchase a variety of products for the same purpose.

We recommend that the Administrator of Veterans Affairs direct the Assistant Administrator for Supply Services to:

--Establish a central standards committee to identify and evaluate common items presently used by VA medical centers. This committee should serve as a focal point for increasing standardization and for soliciting, assembling, and sharing product and vendor experiences with all VA centers.

--Develop an information system that provides greater visibility over all medical center purchases. This will enable both VAMKC and the individual centers to identify and manage commonly used items. This effort should provide for more detail in describing unposted purchases, as well as a merge of both posted and unposted transactions so that total medical center purchases can be reported and managed.

AGENCY COMMENTS

VA officials agreed that increased standardization and better visibility and control are desirable and should be pursued. Agency officials also generally agreed with the conclusions and recommendations contained in chapters 3 and 4. VA has been aware of the need for better visibility and control over medical center purchases for many years. VA commented that current staffing levels are not sufficient to provide for improved standardization or better visibility and control over medical center purchases. VA informed us that past attempts to obtain resources in these areas

have not been successful. The agency expects the 1982 budget will include funds to begin improving and expanding LOG I.

We agree that VA needs additional resources to provide full visibility and control over medical center purchases. However, we believe that the savings resulting from improved procurement practices will more than offset any additional costs. We also believe that as a first step VA should use existing resources to improve standardization and control of selected items.

CHAPTER 3

NEED TO IMPROVE MEDICAL CENTER PURCHASING PRACTICES

At the medical center level, the supply services are responsible for assuring that sound purchasing practices are followed. If the medical centers are uniformly administering their individual programs, VA can more effectively manage and control its central purchasing system. However, VA centers have not consistently met their purchasing responsibilities. Specifically,

--mandatory sources are not used,

--required competition is not sought, and

--accurate estimates of needs are not used.

These practices result in VA paying higher prices for items used by its centers.

MEDICAL CENTERS DO NOT USE MANDATORY SOURCES

VA's central procurement system is based on the premise that with less work it can provide lower prices and reliable sources. VA believes that the greater the participation in its central system, the greater the advantages to the medical center network as a whole. VA has established the following priorities for medical center purchases.

Supply channel	VA's priority ranking	Approximate annual purchases
		(millions)
VA excess	1	$ 2.2
VA supply depots	2	155.9
Other government excess	3	0.2
General Services Administration stock	4	36.3
VA decentralized contracts	5	30.4
Federal prison & blind industries	6	0.6
FSS	7	320.3
Open market	8	373.4
Other	no priority ranking	62.9
Total		$982.2

To assure that proper supply channels are selected, VA requires that the medical centers' supply services review each purchase request. The open market may be used to purchase such items as perishable foods and special drug or supply items that are not available from centrally managed sources. Also, medical centers are allowed to deviate from mandatory supply channels when emergency items are needed, or when items are available at lower prices than through FSS.

However, VA medical centers purchase about $373 million, or 38 percent, of their supplies and equipment on the open market. We found that medical centers deviate from mandatory sources even when products are available, FSS prices are lower, and no stated emergency exists. While we do not know the full extent of the practice, we did note many instances at the medical centers we reviewed. For example, one center purchased paint on the open market even though it was available from mandatory sources at lower cost. The medical center's supply chief could not explain the deviations, and the purchasing records lacked proper justification. For only white paint, we estimated the medical center incurred about $2,800 in excess cost between February 1979 and May 1980, by not using the mandatory source.

Other unjustified open market purchases made by the medical centers visited include.

Item	Mandatory source	VA price	Open market price paid	Percent price difference
Blood collecting needles (case of 1,000)	FSS	$71.00	$ 98.00	38
Surgical sponge (each)	VA depot	.08	.11	38
Lime soap cleanser (case of 4)	FSS	24.00	33.00	38
Hand calculator, 8 digit (each)	FSS	10.00	25.00	150
Diet supplement (ounce can)	VA depot	.32	.56	75
Bactrim tablets (bottle of 500)	FSS	20.00	103.00	415

When VA centers deviate from the mandatory sources without justification, they generally pay higher prices and, in many instances, the difference is considerable. We believe this happens when purchasing agents rely on the individual departments to either identify vendor sources or select

items. Many deviations go unnoted because they cannot be identified without reviewing the millions of individual vendor invoices or purchase orders.

REQUIRED COMPETITION IS NOT OBTAINED

Competition is a basic procurement method for obtaining low and reasonable prices. In fact, Federal Procurement Regulations require competitive quotations for purchases exceeding $500. Obviously, as many suppliers as possible should be identified and solicited to maximize competition and assure reasonable prices. However, multiple vendor quotations are not consistently obtained by VA medical centers, even when purchases exceed the Federal Procurement Regulations $500 limit.

At the centers visited, for instance, we reviewed 73 orders that exceeded $500 and were not sole-source or emergency purchases. The medical center records for 45 of these orders, or 62 percent, did not show whether competitive quotations had been obtained. When questioned about some of these purchases, medical center officials gave the following reasons for not obtaining competition.

--Heavy workloads and time constraints.

--User preferences.

--Familiarity with certain suppliers.

We do not believe these are justifiable reasons for not obtaining the competitive quotes required by the Federal Procurement Regulations. Without them, VA has no evidence or assurance that medical centers are obtaining reasonable prices. Since proper solicitation and documentation are required by the Federal Procurement Regulations, we believe it is VA's responsibility to assure that all centers comply.

PROPER ESTIMATES ARE NOT USED

Accurate estimates of future needs for goods and services are an essential aspect of effective procurement planning. We recognize that forecasting requirements with accuracy may be difficult, but centers could do better in certain areas, such as transportation contracts. For example, at two medical centers the supply service repeatedly used the same estimates from prior years, even though current information was available from the departments. At a third center, current data

was just being developed by the department. In each instance, the estimated transportation requirements used by the medical centers supply services differed significantly from that actually needed.

Medical center	Percent estimated trips differed from actual trips		
	Ambulance	Taxi	Medicar van
A	8 over	19 under	33 under
B	51 under	44 under	71 under
C	23 under	22 over	not used

When service contracts have several performance requirements, contracts are awarded by pricing the anticipated work at the quotes obtained from competing contractors. Inaccurate estimates can lead to contractors being paid more than unsuccessful bidders would have received for the same amount of work.

CONCLUSIONS AND RECOMMENDATIONS

VA medical centers are not consistently and effectively managing their procurement programs. Centers purchase supplies on the open market when less costly items are available from mandatory sources. They frequently do not obtain required competition, and they fail to use current estimates of work to be performed under service contracts. We believe these practices need to be corrected if VA is to maintain an effective purchasing system. Accordingly, we recommend the Administrator of Veterans Affairs direct the Assistant Administrator for Supply Services to develop the controls needed to improve and monitor the purchasing practices of individual medical centers. Improvements are needed to assure that VA medical centers

--use mandatory supply sources whenever possible;

--obtain competition for contracts that exceed $500, as required by the Federal Procurement Regulations; and

--develop and use accurate estimates when soliciting for medical center services.

CHAPTER 4

NEED TO FURTHER CONSOLIDATE

MEDICAL CENTER PURCHASES

Better standardization of products used by medical centers, which is addressed in chapter 2, will provide VA with substantial opportunities to consolidate purchases. In addition to the consolidation resulting from standardization, there are opportunities available to consolidate purchases within and among neighboring centers. VA centers do not consolidate most open market and FSS purchases, even when they are with the same vendor. Separate purchase orders are typically processed for each department within a center and for each individual neighboring center. As a result, VA is not only paying higher prices due to small order quantities, but is also incurring unnecessary administrative costs.

PURCHASES WITHIN THE SAME MEDICAL CENTER ARE NOT COMBINED

Posted supply items are purchased when the medical center's warehouse inventory reaches a predetermined reorder level. The quantity ordered represents a consolidated medical center requirement. However, unposted supplies and equipment are purchased throughout the year, as requested by each department. In most instances, separate purchase orders are prepared for each departmental requisition, even though the same vendor is used.

Medical center supply officials are aware that multiple orders are frequently processed. They acknowledge the potential for further consolidation, but cite inhibiting factors such as

--departmental requests for the same items are not always received at the same time,

--requests for the same vendor may be processed by different purchasing agents, and

--inadequate warehouse space may preclude the storage of consolidated quantities.

Through greater visibility of procurement transactions, these inhibiting factors could be alleviated. Specifically, improved visibility would enable the medical center to at least identify those purchases which are recurring and assess

whether they could be effectively consolidated. Better visibility would also permit more efficient use of existing storage space and enable medical centers to identify unposted items that could be more effectively stocked than certain posted slow moving or bulky items. The following situations occur when purchases are not properly consolidated within a medical center.

Quantity discounts are lost

Consolidating purchases into fewer orders of larger quantities can result in lower prices. However, VA medical centers usually prepare separate purchase orders for each departmental request involving unposted supplies or equipment items, which results in higher prices. For example:

--Latex examination gloves were purchased for ambulatory care at $8.55 per box. This same item was already stocked in the warehouse for 15 other departments and was repeatedly purchased in larger quantities for about $6.85 per box.

--Four cases of injection sets were purchased for one department at $68 per case. Eight days later, 12 cases were purchased for another department at $56 per case. This situation occurred several times during the year, with the department ordering the smaller quantity consistently paying the higher price.

--Three cases of cleanser were purchased at $24 per case. However, this item, was already stocked for another department, and larger quantities were purchased from the same vendor for $19 per case.

--One large drug company offers discounts on any purchase that exceeds $10,000. Discounts range from 1/2 percent on a $10,000 order, to 1-1/2 percent on a single order exceeding $20,000. In fiscal year 1979 one VA medical center purchased more than $270,000 in solutions from this vendor but did not receive any discounts because its orders were not consolidated. If consolidated monthly, quantity discounts from this one vendor would have been nearly $3,200. Perhaps not all orders could have been consolidated, but no effort was made to consolidate any of them.

--Oxygen was purchased for three different departments throughout the year and, in most instances, separate purchase orders were issued for each request. Wanting to minimize his own administrative costs, the vendor

said he would be willing to negotiate a discount if multiple orders could be consolidated.

Administrative costs are higher

Administrative costs can be reduced if multiple requisitions are consolidated under one purchase order. For example:

--Two orders for arts and craft supplies were processed on the same day. Besides the additional processing costs, the vendor's shipping charge on one of the orders exceeded the merchandise cost.

--Throughout the year one medical center averaged about seven nonemergency orders each month with the same pharmacuetical company.

--Over a 2-day period, six consecutively numbered purchase orders were issued to the same vendor for identical pocket pagers.

--Three purchase orders for vacuum cleaners were issued to the same vendor on the same day.

Supply officials concurred that these purchases should have been consolidated, thereby eliminating the administrative costs associated with processing unnecessary orders.

NEIGHBORING MEDICAL CENTERS INDEPENDENTLY BUY THE SAME PRODUCTS

VA could further consolidate medical center procurement activities when several centers are closely located to each other. Besides taking advantage of quantity purchases and lower administrative costs, consolidating neighboring center purchases could

--simplify contract administration,

--provide greater coordination among medical centers, and

--attract new suppliers.

Commercial hospitals have recognized the merits of a unified procurement program and many have joined group purchasing associations to increase their purchasing power. The attitude among most of these private hospitals is to

use group purchasing whenever possible. However, the success of group purchasing depends on the willingness of centers to standardize common use items and to share product and vendor experiences with one another. In this regard, medical centers should have a tremendous advantage over private hospitals because they are under one organization and are not in competition with one another. But as discussed in chapter 2, VA needs to improve its standardization efforts.

Although VA regulations encourage neighboring medical centers to use single contracts, the neighboring centers we visited did not usually share information about their procurement experiences. Also, they did not actively try to consolidate purchases among themselves. Products are usually evaluated and selected based on their own independent experiences and tests.

By not exchanging purchasing information, medical centers are unable to fully benefit from each others experiences and are not aware of the consolidation potential that exists. The following examples illustrate the situations that occur among neighboring centers when purchases are not consolidated and procurement information is not formally shared.

By consolidating purchases, neighboring VA medical centers could achieve cost reductions through greater quantity discounts. The prices for the following basic items varied between three neighboring centers because of different quantities ordered or different suppliers used.

	Medical center		
	A	B	C
13x100mm disposable culture tubes (cases of 1,000)	$15.30	$21.75	$19.53
Cotton mopheads (dozen)	70.00	54.97	48.00
Electoplast bandage, 1x5 1/2 in. roll (dozen)	7.20	7.66	7.95
Rubber gloves, size 10 (pair)	1.75	1.62	2.42

In most instances, quantity discounts were also available if larger quantities were ordered. For example, the vendor charging $1.62 for a pair of rubber gloves said that further price breaks could be negotiated for larger orders and that multiple delivery points would be acceptable.

Common supply items are repeatedly and independently purchased by neighboring medical centers from the same vendor. For example, throughout 1979 individual purchases were initiated by two or three neighboring centers for such items as

--dishwasher rinse,

--floor wax,

--electrode cream,

--dental cartridges,

--sterile surgical liners, and

--disposable towel wipes.

Several vendors either offered quantity discounts or expressed a willingness to negotiate quantity discounts for larger orders. Some vendors also would accept orders with multiple delivery points. If medical center orders were consolidated, the added administrative costs associated with processing several independent orders could be reduced or eliminated.

NEIGHBORING MEDICAL CENTERS
INDEPENDENTLY OBTAIN SERVICE CONTRACTS

In some locations, VA medical centers have consolidated certain procurement activities, such as negotiating and awarding single contracts for their basic services, including elevator maintenance, ambulances, and taxis. However, where basic supply contracts are not consolidated, neighboring VA centers share little information, and prices can differ significantly. For example, three large medical centers in the same metropolitan area are paying the following prices for ambulance service.

Medical center	Rate for a 30-mile trip	Charge for oxygen
A	$70	$15
B	83	10
C	77	10

One center had already consolidated its ambulance service with a neighboring Public Health Service and believes this type of service could be consolidated among the neighboring medical centers as well.

Since information is not routinely exchanged among the neighboring medical centers, contractor participation can also be affected. For example, in 1979 one center received only two vendor bids for ambulance service. We contacted two other ambulance contractors, that are normally solicited by a neighboring medical center, and found that both would have bid but were unaware of the solicitation.

CONCLUSIONS AND RECOMMENDATIONS

VA medical centers do not consolidate many of their departmental purchases, even if the same vendor is used. Also, neighboring centers often use common items and services, but these as well are not being consolidated.

Basically, the medical center supply services have limited visibility over most unposted supply and equipment requisitions and cannot forecast or anticipate user needs. In addition, VA's medical centers operate independently. They do not systematically share procurement information with one another and are unaware of the potential consolidation that exists. As a result, medical centers are losing quantity discounts and incurring higher administrative costs.

To take full advantage of its purchasing power, VA needs to further consolidate medical center purchases of common items. Therefore, we recommend the Administrator of Veterans Affairs direct the Assistant Administrator for Supply Services to

--consolidate purchases within medical centers and among neighboring centers and

--implement the procedures necessary to assure that neighboring medical centers share product and vendor information so they can effectively take advantage of one anothers purchasing and contracting experiences.

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