



Triadic relationships in healthcare

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Abstract One of the most important goals in healthcare today is reducing costs while maintaining high-quality care. This article focuses on a triadic relationship that is responsible for a significant amount of nonlabor spending in hospitals: physician preference items. The triadic relationship among salespeople, physicians, and hospitals' supply managers has a direct influence on costs. Regarding some key purchases, the physician-salesperson relationship is closer than the physician-supply manager relationship—even though the latter two entities work for and within the same company and strive for the same mission. This reality creates a type of conflict that is perplexing to solve and costly to ignore. To better understand the sources of friction and opportunities for collaboration in this triad, personnel across hospitals, suppliers, and healthcare consortiums were interviewed. Herein, we introduce strategies to help resolve the conflict. It is essential that hospital supply managers continually negotiate for best solutions that consider both long-run costs and quality of patient care. Yet, salesperson motivations and close salesperson-physician relationships place barriers that prevent negotiations more common to other areas of spending. The strategies offered in this article highlight ways to mute negative and amplify positive effects of the physician-salesperson relationship.

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1. An unhealthy triangle

Supply managers often have internal customers who prefer to interact directly and closely with suppliers of the non-commodity products they use. This is

particularly true when the products involved are complex and a part of high-risk activities. In such cases, the supplier may have unique knowledge required by the internal customer for optimal use of a product. The supplier may provide incentives directly to the internal customer, further encouraging both preference for the product and direct interaction, thus skipping the middleman (i.e., supply manager). Certain suppliers may become 'preferred' in this context, with other suppliers vying for consideration by the internal customer.

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Consider the case of an orthopedic surgeon. This orthopedic surgeon has a strong brand preference for a particular product and has developed a good working relationship with the brand's medical device salesperson. The surgeon prefers to work with the salesperson directly, even going to far as to invite him into her operating room to share invaluable knowledge during procedures. The orthopedic surgeon has consulted and collaborated on several products for the brand, and has received payment. 'Non-preferred' suppliers' salespeople routinely offer quality products to the surgeon, but none is ever considered.

In this scenario, the hospital's supply manager—whose job it is to constantly examine ways in which to strategically source products and thereby reduce overall costs—experiences tension due to the dependencies between the orthopedic surgeon and the medical device salesperson. The greater the relationship between a particular supplier and surgeon, the more difficult it will be for the supply manager to maintain a competitive environment among suppliers and introduce lower-cost suppliers into the mix. This tight triadic relationship, its ramifications, and possible solutions are the focus of this article.

2. Relationships and financial outcomes in healthcare

Hospitals are capital-intensive businesses in terms of not only human resource costs, but also facilities and medical supply costs (Karagöz & Yildiz, 2015). They face the difficult task of concurrently reducing costs while improving quality of care and overall financial performance (Pakdil, 2007). While hospitals compete based on innovativeness and quality of care, it has been suggested that they must also learn how to compete on price (Xu, Wu, & Makary, 2015). New models of healthcare have created this necessity.

Hospitals in the U.S. attempt to reduce operational costs by making improvements to internal processes in response to calls to enhance financial outcomes and address competitive pressures. This places increasing emphasis on the activities of supply managers (Young, Nyaga, & Zepeda, 2016). Organizations offering medical care services have focused on cost reduction efforts, especially in the process of procurement. In this way, hospitals attempt to be more competitive and successful (Ishii et al., 2016; Türkyilmaz, Bulak, & Zaim, 2015).

Yet, embedded in these decisions is surgeons' autonomy and influence over patients. This power is derived from surgeons' expertise and centrality to

the core services of a hospital. Preferences for certain products, which often start as early as medical school, are amplified by the ability of medical device salespersons to incentivize and significantly assist physicians with patients. Such close relationships can be found in both small and large hospitals. In large hospitals, however, the challenge of close relationships may be amplified because there are simply more relationships involved.

Physicians are the fundamental gatekeepers in the healthcare system and have an astounding influence over nonlabor costs. While 10 years ago physician preference items constituted 40% of medical/surgical expenditures, today they constitute 60% (CITATION NEEDED). Despite this large percentage of cost within the physician's purview, physicians are ill-trained and ill-informed regarding how to curb costs and negotiate with suppliers (Okike et al., 2014). Negotiating, conducting spending analyses, and vetting suppliers is the job of supply managers. Product decisions made by surgeons, in particular, are based on factors completely unrelated to cost; indeed, these factors are reflective of their personal experiences with certain products and their relationships with the medical device salespeople. For this reason, a disconnect can exist between physicians' preferences and hospitals' targets of cost reduction (Montgomery & Schneller, 2007).

Medical equipment manufacturers make millions of dollars of investments in the sector and are very anxious about their ROIs. Therefore, medical device manufacturers routinely offer both financial and non-financial incentives to surgeons. These incentives are designed to encourage preference for their products. Examples of incentives include visits by salespeople during surgeries, financial resources for surgeons to attend conferences and medical seminars in desirable locations, and physician-specific naming of instruments (Sah & Fugh-Berman, 2013). Hospitals, by necessity, must constantly keep costs under control. To this end, hospitals must negotiate and inject competitive practices with all suppliers—even those preferred by their highest-paid, in-house experts who are central to their business: physicians.

The fact that total healthcare expenses, especially in the U.S., have been rising annually increases the importance of cost reduction. Average total healthcare expenses per person in the U.S. reached \$9,990 in 2015. That same year, the share of the economy devoted to healthcare spending was 17.8%, up from 17.3% in 2013. National healthcare expenses in total climbed to \$3.2 trillion in 2015 (Centers for Medicare & Medicaid Services, 2017). Medical device expenses also are increasing at the same rate as

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