Industry opinion

Standards movement shifts toward GS1 version
More standardization, but is it worth the conversion costs?

by Ted Almon

Our industry appears to be in the middle of a resurgence of interest in supply chain standards. This is curious, as the standards have existed for many years and calls for reform have gone unheeded before.

Why the change now?

Standards are common ways of identifying products, trading partners, and locations within the medical supply chain. Such standards have been widely used on the vendor side of the industry for many years but largely eschewed by the provider community. The electronic transmission of data, which on any broad scale requires the use of standards, largely benefits the party receiving, not the party sending, the data.

Consequently, the benefit balance has generally slanted away from the provider at the beginning of the replenishment chain, where the value proposition of admittedly costly and difficult implementation has never seemed worthwhile. This is particularly true when weighed against the potential benefit of receiving uniformly labeled products at the end of the chain.

So how has the rest of the channel adapted? The answer is “cross-referencing.”

We are told that all this cross-referencing is a cumbersome, expensive, and imprecise process—but for the most part, it is work already done out of past necessity, and frankly, it works passably well. One could reasonably argue that the present system, in which providers generally use proprietary identifiers integrated into legacy systems, could suffer considerable disruption by the simultaneous conversion of the entire provider community to some arbitrary set of standards.

Conversion to GS1 no day at the beach

There is also the matter of which standards to adopt. To the bemusement of many on the vendor side of the supply chain, the very question has been ridiculed in the current discussion. Concurrently, some elements in the provider community seem to have settled on the GS1 schema, in spite of the fact that most vendors use standards developed by the Health Industry Business Communications Council (HIBCC). Conversion to GS1 would be no day at the beach and is sure to generate more resistance than the current movement in that direction seems willing to acknowledge.

Many of the arguments in favor of GS1 over HIBCC standards seem rather flimsy to established HIBCC users. For example, both sets of standards are clearly global, and although the UPC format of GS1 is prevalent in retail, the emergence of autodiscriminate scanners has largely eliminated the problem of competing labels in the channel. A much more valid concern is the fact that

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not only would conversion from HIBCC to GS1 be difficult and costly, but GS1 registration and usage is considerably more expensive. In spite of what appears to be an energetic marketing campaign by GS1 and its endorsers, there has been no measurable diminishment of HIBCC users. In fact, 2007 saw the largest growth ever in worldwide HIBCC labeling.

**Dual development, low usage**

How did it happen that we apparently now have two competing standards development organizations (SDO) when almost no one on the provider side has implemented any standards at all?

Automated data capture in the form of bar coding emerged relatively late in the medical channel, long after it became quite common in some other industries—most notably retail/grocery. When it appeared that proprietary formats might begin to dominate the medical supply chain, ultimately inhibiting competition among manufacturers and distributors, an intra-industry task force formed.

This group approached the leading grocery channel SDO, then known as the Uniform Code Council (UCC)—or today’s GS1. The principal issue was that the medical group insisted on an alphanumeric standard to fit the most common labeling practice in the industry. There were also current studies at that time that said alphanumeric identifiers were more reliably scanned, potentially affecting patient safety.

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**Premier mandates GS1 standards adoption**

Premier, Inc., one of the nation’s largest and most influential GPOs, toughened its stance on industry standards and says it will require its providers and suppliers to support two key GS1 supply chain standards by 2012.

The Charlotte, NC-based group called for GS1 standards adoption that include Global Locator Number implementation by 2010 and G10 adoption no later than 2012. G10 refers to global trade item numbers, which are similar to the UPC codes used by many retail industries to standardize product identification.

A December 1, 2008, letter from Premier’s Strategic Advisory Committee (SAC) to its 800-plus contracted suppliers said broad GS1 adoption should “improve patient safety and reduce supply chain costs.” The letter was signed by supply chain leaders from the 25 SAC-member healthcare systems, large institutions whose spend makes up at least 50% of the total Premier spend (owners and group affiliates). The group, which represents 2,100 hospitals overall, first announced public backing of the GS1 and its UPC bar code in July 2008.

Premier is the first GPO to embrace a timetable for standards implementation, says Dennis Harrison, president of GS1, an international organization based in Brussels, Belgium, and Lawrenceville, NJ, that advocates global standards adoption.

“Premier has sent the clearest message and has tried hard to set specific dates,” Harrison says, describing the recent announcement as “an aggressive move to get both suppliers and providers on board.”

Harrison says St. Louis–based Amerinet; ROI, a smaller GPO based in Chesterfield, MO; and Mayo Clinic, are actively working toward similar action. Several other GPOs and suppliers are listed on the GS1 Web site as member companies.

For years, the adoption of industrywide standards in healthcare has been stalled by major suppliers worried that such a move would lead to uncontrolled price transparency. Harrison now believes those concerns have been set aside.

“Those suppliers have decided that, on balance, supply chain efficiency and patient safety outweigh price transparency issues,” he says.

Although he concedes that GS1 standards are “no better or worse” than those supported by the Health Industry Business Communications Council, Harrison says GS1 standards “are gaining momentum, and we need to have something in place.”

“You can’t put your head in the sand and not think about [widespread adoption of standards],” he says. “Lessons learned in the grocery industry and elsewhere have benefits to healthcare.”

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UCC/GS1, a group clearly dominated by grocery industry interests, saw no need to modify its all-numeric UPC. Hence the decision by these founding members to form their own, industry-specific SDO, and HIBCC was born. It quickly earned accreditation by the American National Standards Institute.

Questioning the rush to change

Fast-forwarding to the present, it would seem that the current rush to standards is leaving several significant questions unanswered:

➤ At this late stage, is there still an ROI for providers converting to standards, considering the cost and likely disruption it would cause?
➤ Given that the standards themselves are relatively generic, has the case for choosing GS1 over HIBCC truly been made?

➤ Must we choose at all, given that current technology already allows competing standards to coexist?

To many longtime industry observers, the question of whether to now abandon a generation of work by HIBCC volunteers in favor of those of an organization over which we have limited control seems arbitrary and more than slightly political. There are numerous excellent reasons why many industries far less substantive than medical insist on their own dedicated SDOs, over which they exercise exclusive governance. Is it really wise for us to cede ultimate control of this potentially critical function to outside interests? ■

Editor’s note: Almon is president and CEO of Claflin Company in Warwick, RI, an independent regional medical distributor.

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