

## Clinical Buyers versus Economic Buyers

Interview with Carlo Medici  
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Interviewer: Dr. Christian Renaudin, TMTG

**CR:** We are exploring today the vendor dilemma: within the US health system, who should the vendor target—the clinical buyer who focuses on technical capabilities or the economic buyer who focuses on the financial return. Rising healthcare costs and constrained reimbursement growth seems to have placed more influence in the hands of organization administrators—i.e., the economic buyers—as long as minimal clinical requirements are made. It follows that price and life-time costs are becoming a key factor in the decision. Do you agree with these observations? Why? Why not? If so, is this a recent phenomena or has there always been a clinical and an economic buyer?

**CM:** I believe there is a foundation to argue there have always been this duality of an economic and a clinical buyer. However, it is clear to me that in the last 10 to 15 years, the introduction of managed care, integrated health care networks and GPOs have made the economic buyer gain importance and become more empowered in the purchase process.

Looking back to my years in the in-vitro diagnostics industry and now in the medical imaging industry the same tendency is true, although I would not qualify it as a “war” or a “conflict”, but more as a “power play” for the last word or for the final decision.

**CR:** Who is the customer: the technical buyer or the economic buyer?

**CM:** The customer is both. When managed care and GPOs were created, some vendors, believing that the technical buyers would be left with no power, concentrated only on the economic buyers and the strategy failed.

It is necessary to craft a special strategy with messages and appropriate language targeted at each buyer. Alienating any one of them will haunt the vendor in the future. As an example of the remaining importance of the technical buyer often disregarded is the effect of word-of-mouth, which is very powerful among the clinical community and needs to be nurtured.

**CR:** What MedTech product categories do you see where technical vs. economical antagonism is strongest or weakest? Please share examples both in contrast media and capital equipment.

**CM:** It seems to me that the least specialized, or more inter-exchangeable the product, the more the decision power shifts toward the economic buyer. The technical buyer can exert a veto power with good reasons (safety or clinical issues) and it can happen but it is rare. This phenomenon exists right now in contrast media with MRI Gadolinium contrast agents: economic buyers cannot argue with the published evidence of safety concerns related to nephrogenic systemic fibrosis, and there are potential liability issues.

Since I mentioned the technical buyer’s power to veto a product, I must state that eventually this is hard to understand from the economic buyer’s perspective. However, it will usually be based on patient safety issues, bringing in the risk management people and liability issues, which are very clear to the economic buyer.

**CR:** In what market segment do you believe such technical buyer vs. economic buyer antagonism is particularly strong?

**CM:** I believe that confrontation between both buyers may increase with the complexity of the customer’s organization. The greater the number of constituencies involved, the harder to manage the duality of technical versus economic buyers. Although organizations have placed good governance practices in place, with well defined processes for evaluation and adjudication, I still see strong differences among them. Very large GPO groups, despite the heavy scrutiny they are submitted to and the many “checks and balances” they have set up, may still be subject to more internal

struggles. This is the case for Novation or Premier, member-based GPOs that have very structured processes and have streamlined the analysis and scoring of vendors but experience some confrontation with their members who would enjoy more freedom of choice and seek their own procurement (out of contract) at times. In such cases, vendors have to walk a fine line and can find remedies such as selling off contract.

Different groups, however, may have faster decision processes because they own their hospitals and are therefore less constrained by too many stakeholders. For example, HPG have a good process, very streamlined and with high compliance since they own the member hospitals.

CR: But who is the client: the GPO or the member?

CM: Without a contract, vendors try to work directly with the members. Members have the freedom of choice, but are limited by economic incentives and disincentives. Typically out-of-contract sales tend to focus on customers who are technically focused.

CR: Do you see customers segments that are more technically vs. economically oriented?

CM: Not really in the USA. Even academic centers have to integrate the economic element. I do not see a strong line between profit and non-profit hospitals. In Europe, technical buyers in high-end academic segments hold the decision power and do not care about the economic issues. It will take a while for EU to catch on with the US model.

CR: TMTG has observed two types of sales strategies. The first focuses on targeting clinicians (technical buyer) and work with them on the premise that administrators can delay but not avoid physician's demand. The second focuses on administrators (economic buyer) with the understanding that technology differentiation is low so that sales success depends on pricing negotiations with GPOs or other buyers. What risks do you see in each strategy?

CM: As I previously mentioned, a successful vendor needs to address both buyers. What is questionable is in what sequence. I am not sure there is a single pattern that always works. It depends on the customer and the territory. In general, I would recommend a parallel approach, but it certainly varies depending on individual customers: on a territory sales level, each sales rep should have a strategic business plan for each of his/her accounts.

As an example, imagine a DIC, let's say in Boca Raton, FL. It is not a huge account, but it is very prestigious and can generate a lot of "word-of-mouth" on your product. You may want to start with the technical buyer and convince him of the clinical value of your offer. But you must also prepare the economic buyer for the clinical request and make sure your prices are aligned with his expectations.

On the other hand, you may have a very large GPO. This is a much longer and complex process that could take up to two years before you convince both buyers. You may now prefer to start by making the economic buyer aware that you want to make a presentation of the value proposition, which is usually to save him money on the long run. The economic buyer will then tell you to work with their clinicians, which can be a very long process, involving several tests, evaluations, etc. The vendor needs to move back and forth between both buyers during this period and eventually be successfully accepted by the technical buyers. Then it is time to come back to the economic buyer with the spreadsheets to show the savings initially promised. Then a long process of negotiations starts: committees, the CFO and sometimes the CEO.

It is a very extensive, costly process, but again it represents a large account that can generate robust growth and strong word-of-mouth on your products and your company.

CR: What has been your observation: increased rift between technical and economical buyer or on the contrary more organized multidisciplinary committee decisions?

CM: The adoption of committees is not a golden pill as it still generates split votes and long lasting conflicts. We have seen many cases where a contract rejected by a large GPO ends up being adopted by individual members, as long as compliant with the group's rules and policies. Typically, members are able to opt-out one single product category; otherwise they would be limited on the percentage they can buy outside of the GPO contract.

CR: How are vendors recognizing the clinical (patient safety, convenience, morbidity/mortality rates, etc) vs. financial perspectives (reimbursement rates, financing options, NPV, ROI, workflows, LOS, marketing appeal)? Do you see more detailed claims of clinical or economic performance?

CM: There has been an increasing recognition of the need for dual sales language: to differentiate strategy, sales tactics and messaging. The technical buyers have traditionally been recognized and serviced, but I see an untapped opportunity when dealing with the economic buyers. To different extents the vendors have been able to address reimbursement, financial options, financial analysis (NPV and ROI, cost of procedures). But the industry is lagging behind in terms of workflow improvements, and demonstrating how the vendor's solution can improve workflow and show the overall economic value.

Both the vendor and economic buyer must become better at evaluating the economic value of the products. Vendors must be able to show where that value is (cost per patient versus cost per gram of product, lower dose when products are more efficacious, reduction of risk and increased safety).

Buyers must be able to manage and rigorously measure these parameters. The problem is that, unlike big pharma, the diagnostic world does not know how to measure reduced morbidity or mortality. Few customers measure both direct and indirect costs (adverse events management) but many don't.

The buzz word now is "outcome" and every buyer wants to see "improved patient outcome". Well, MRI is a good example of a very useful modality that no one has been able to demonstrate generates improved patient outcome. Buyers have asked for improvements in morbidity/mortality rates in order to justify substituting products, although these were not even considered for the original adoption of their current product.

The diagnostic industry will need to move beyond demonstrating increased diagnostic accuracy and show outcome differentials combining clinical and economics like the pharmaceutical/therapeutic industry has done.

**CR:** In institutions where opposed views are strong (clinical vs. financial), what is your recommendation to vendors who wish to succeed?

**CM:** Never ignore the existence of the two different buyers. If you try to choose your mistake will haunt you in the future.

Start-up companies may be naïve regarding their sale process. They tend to focus on the technical buyer and how their technology appeals to them. Because they either want to be an attractive target for an acquisition or need to secure a very fast turnaround of their capital, they like to charge a premium price.

This is quite a recipe for failure. When they have a highly disruptive, breakthrough technology, the economic buyer will reject it as not ready. They want to wait until it is fully developed and settled no matter how much the technical buyers are hungry for the innovation. The economic buyer will also be cautious about fast changing technologies as he must obtain a return from one investment before paying for the next up-grade.

When their technology is not a true disruptive break-through, an economic buyer who has not been properly approached and educated, may reject the purchase for considering it expensive or lacking enough value for what it costs. A great example is cardiac CT: economic buyers would like to wait for the technology to stabilize with the appropriate reimbursement framework. Early sales are based upon good will.

However strong the opposition between economic and technical buyers, my recommendation stands: don't ignore either one.



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