



# Decentralized Pharmacy Procurement Is Costing Health Systems More Than They Know



How fragmented purchasing erodes margins, multiplies labor and leaves millions on the table, and what it takes to fix it

**SureCost: The Smarter Purchasing Solution™**

Procurement workflows and consistent purchasing strategy are just a few things that become exponentially more challenging when managing multiple locations.

## Executive Summary

### The Hidden Cost of Doing It the Way You've Always Done It

Health system pharmacy leaders are navigating one of the most financially hostile environments in recent memory. U.S. hospitals spent \$39 billion on drugs in 2024, and that number is climbing at nearly 5% year over year, with tariff-driven pressures threatening to push increases even higher. At the same time, more than one in five pharmacy technician positions sits vacant, leaving already-stretched teams to manage more complexity with fewer hands. Against this backdrop, most health systems are still running pharmacy procurement the way they've always run it: decentralized, siloed and reactive. Each site orders on its own, manages its own vendors, its own contracts and its own receiving process. Leadership watches the drug spend line grow while struggling to get a clear picture of why, let alone what to do about it.

This white paper makes the case that decentralized pharmacy procurement isn't just operationally inconvenient. It's a structural financial problem, one that silently erodes margin across five distinct cost categories, multiplies administrative burden with every site added and systematically prevents health systems from leveraging the purchasing power they already have. It also outlines what a real solution looks like: not a retrospective analytics report, not a dashboard that tells you what went wrong last month, but a unified procurement platform that changes what happens at the point of purchase, every day, at every site.

**\$39B**

what U.S. hospitals spent on drugs in 2024

**+4.9%**

year-over-year increase in drug spend

**>20%**

pharmacy technician vacancy rate

Sources: Tichy EM et al., American Journal of Health-System Pharmacy, 2025 (PubMed PMID: 40263109); Safecor Health, Pharmacy Technician Shortage (safecorhealth.com)

## How Health Systems Got Here

Decentralization isn't a mistake pharmacy leaders made. It's the natural byproduct of how health systems have grown. Over the past decade plus, hospitals and health systems have expanded dramatically, adding sites of care, diversifying service lines and accelerating through mergers and acquisitions at a scale that would have seemed improbable a generation ago.

Each acquisition brought its own wholesaler contracts, its own pharmacy management systems, its own purchasing habits and its own staff. The result is the sprawling, fragmented pharmacy enterprise that most health system leaders are managing today, not by design, but by accumulation.

The challenge is no longer theoretical. Mega-mergers are forcing health systems to coordinate pharmacy procurement across not just campuses, but states and regions. What works as a local conversation between a pharmacy director and a wholesaler rep becomes operationally untenable when you're trying to align purchasing strategy across an enterprise spanning multiple markets, classes of trade and regulatory environments.



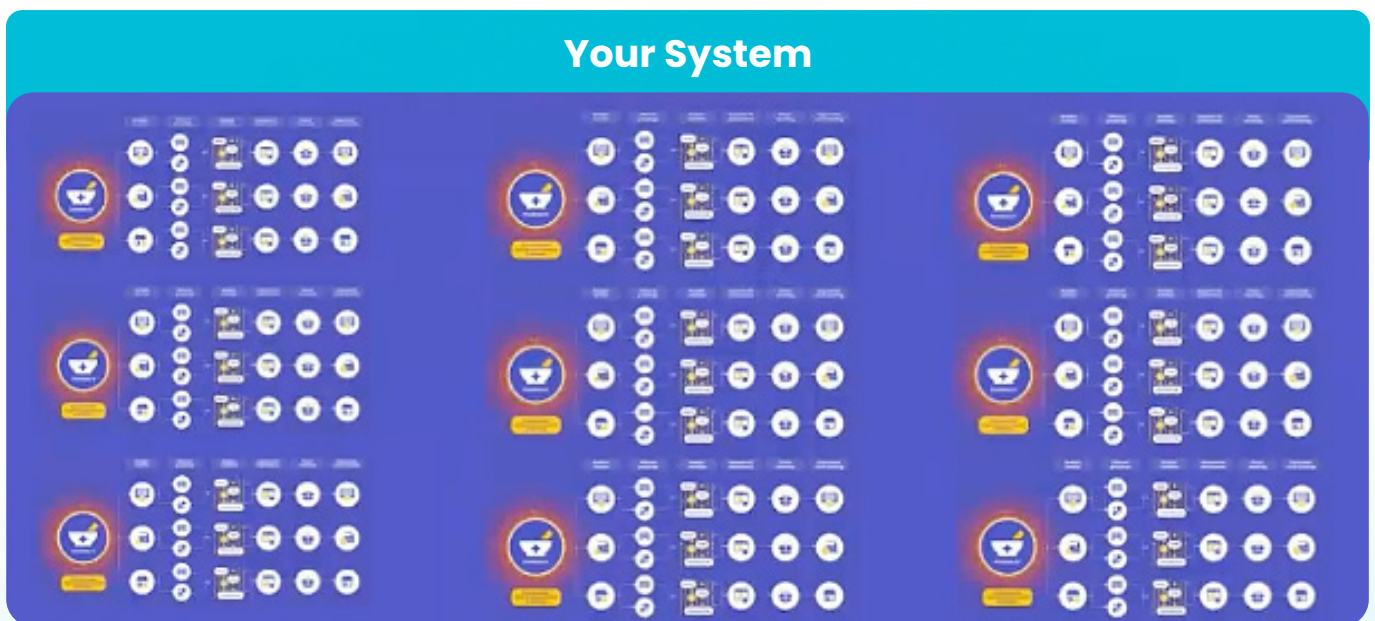
**Decentralization isn't a failure of planning. It's a symptom of growth. The question isn't how you got here. It's whether you can afford to stay here.**

Management often struggles to identify purchasing trends, find waste or discover new savings opportunities.

## What Decentralized Procurement Actually Looks Like

At its most basic, decentralized procurement means each pharmacy site manages its own purchasing. Each site shops multiple vendor catalogs separately, submits individual purchase orders and reconciles deliveries without system-wide visibility. Multiply that complexity across 5, 10 or 20 sites, and the scale of the problem becomes clear.

For a single pharmacy, the procurement workflow spans multiple sources, different product groupings, separate PO submissions, siloed receiving and segmented issue tracking, with each vendor operating in its own lane and its own process. For a health system with dozens of pharmacies, that complexity doesn't add. It multiplies.



Limited visibility into the performance and compliance of each location also impacts primary vendor compliance, leading to penalties and damaged relationships.

## Why the Cost Is Higher Than You Think

Ask most pharmacy directors what decentralized procurement costs them, and they'll describe a workload problem. What they're less likely to quantify, because the data rarely surfaces in one place, is the cumulative financial damage happening across five distinct cost categories, simultaneously and silently.



Most health systems know they're leaving money on the table. Few realize how many tables there are. Price leakage, processing cost, inventory waste, disruption cost and unrecovered waste don't just add up. They compound each other.

The financial and operational ROI of proactive shortage management is substantial and multidimensional. The ROI of proactive shortage management operates across five distinct value drivers, each with direct, measurable impact on pharmacy performance.

The Problem	What It Looks Like	Cost Category
Split volume across sites and vendors	Each site's order volume fails to reach the contract tier thresholds that unlock better pricing. Off-contract purchases fill the gaps at higher costs.	Price Leakage
Excess invoices and manual receiving errors	Without systematic scanning and verification, receiving errors go undetected and uncorrected credits accumulate across the system.	Processing Cost
Sites buffering inventory independently	When each site orders to protect itself, excess inventory builds system-wide. Drugs expire. Credits from reverse distribution are partial, at best.	Inventory Waste
Drug shortages and emergency buys	Shortage drugs carry a significant cost premium over contract price. Large hospitals spend substantial staff hours each week managing shortages, driving both labor and financial drains.	Disruption Cost
Expired stock and unreconciled credits	Inventory that silently expires alongside credits that are never tracked or collected represents pure loss. The money left the building and never came back.	Waste

Every one of these compounds the others. Together, they add up to losses most health systems never see coming.

Even if most locations maintain a lean, efficient inventory, a single location that orders excessively or fails to prevent spoilage makes a significant impact on the entire chain.

Taken individually, each of these represents a manageable gap. Together, they create a pattern of loss that's easy to miss precisely because the data sits in so many different places. SureCost data consistently shows that optimizing pricing across all available relationships and contracts, not just the top 200 drugs, delivers meaningful cost of goods sold improvement. Notably, two-thirds of those savings come from outside the top 200 items, where purchasing decisions are most likely to be made without strategic oversight.

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"Two-thirds of the savings come outside those top 200 drugs. There's huge savings even on one item because they tend to be not competitive items and there's opportunity there, but being able to have that visible to you and actually have it as an actionable thing is super challenging."

-- Calvin Hunsicker, Founder and Chief Product Officer, SureCost

## The Operational Multiplier: Every Site Makes It Worse

Beyond the direct financial cost, decentralization imposes an operational tax that grows with every pharmacy added to the enterprise. That tax shows up in four specific ways.



### Labor Waste

Purchasing and receiving tasks are replicated at every site with no shared process or standardization. In a market where technician vacancies exceed 20%, every hour spent on redundant administrative work is an hour that can't be recovered.



### Inventory Inefficiency

When a shortage hits, most health systems can't tell you what's on the shelves across their enterprise. Site-level buffering creates phantom inventory system-wide while individual sites continue placing emergency orders.



### Data Chaos

Purchasing data sits in separate systems, fragmented by site, by class of trade and by vendor portal. You can't run an intelligent enterprise on data you can't see, let alone act on it in real time.



### Integration Overhead

Every additional system is another integration to maintain: cabinets, pharmacy management systems, EHR and wholesaler portals alike. More systems mean more failure points and more manual workarounds.

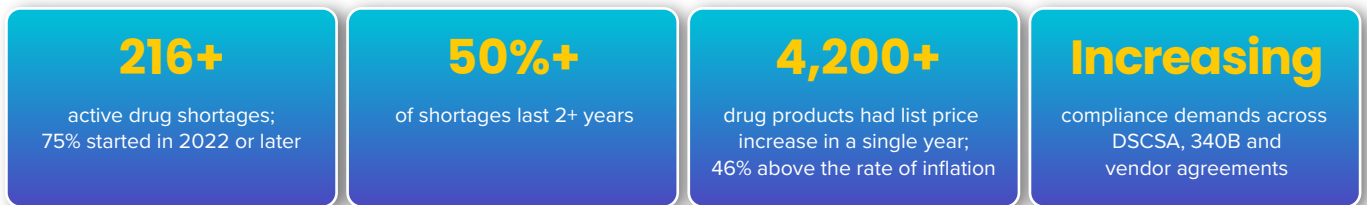
Which is your biggest pain point?

With every location using a different method for shopping and ordering, maintaining a consistent purchasing strategy is nearly impossible.

## The Pressure Isn't Letting Up

The financial case for fixing decentralized procurement would be compelling in any environment. In the current one, it's urgent.

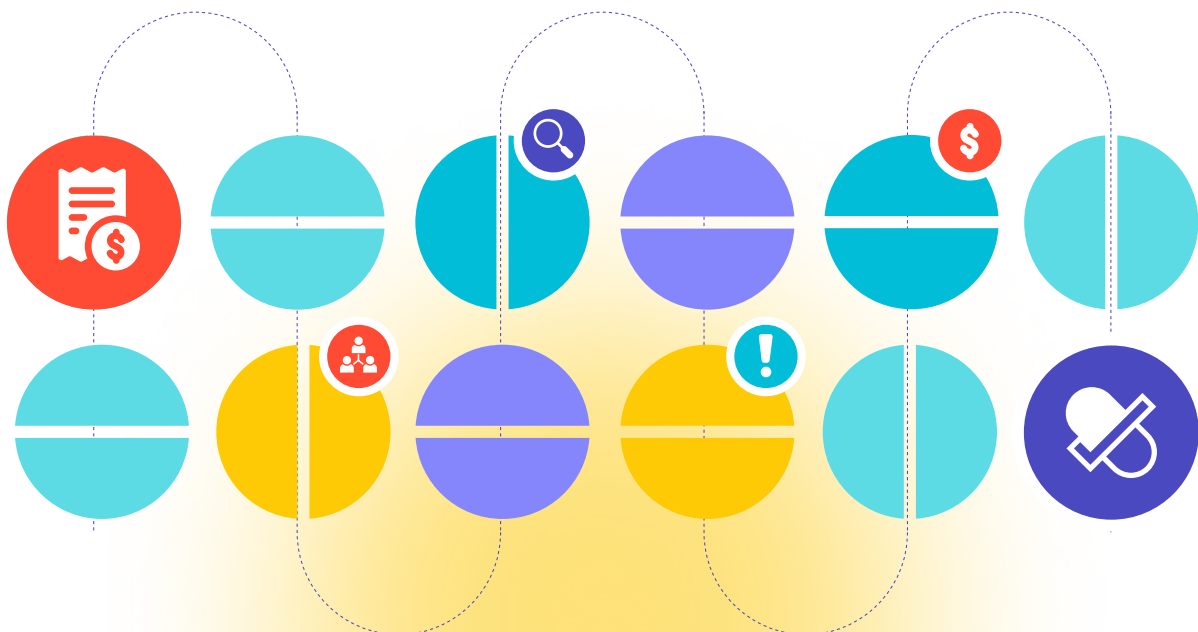
Drug shortages remain a persistent reality. More than 216 are active today, with 75% starting in 2022 or later and more than half lasting longer than two years. More than 4,200 drug products saw list price increases in a single year, with 46% of those increases outpacing the rate of inflation. Supply chain disruptions and rising compliance demands across DSCSA, 340B and vendor agreements are adding further pressure on already stretched teams.



Compliance complexity is rising alongside cost complexity. DSCSA requirements, 340B program integrity demands and increasingly intricate vendor agreements all add layers of accountability that decentralized teams are poorly positioned to manage consistently across sites.



**75% of hospital pharmacy leaders cite drug shortages as their number one operational concern. That's not a shortage problem. It's a visibility and preparation problem. Source: ASHP drug shortages statistics.**



The more manual processes teams are saddled with, the greater their chances of making manual errors.

## What Real Centralization Looks Like and Why Most Approaches Fall Short

The conventional response to fragmented procurement is centralization. The goal is right: concentrate purchasing authority, standardize processes and unify data into a single picture of system-wide spend. The problem is how most health systems try to get there.

Retrospective analytics tools can tell you where you left money last quarter. GPO reporting can flag compliance gaps after the fact. Neither changes what happens at the point of purchase. In a market where prices shift daily, last month's data isn't a decision-making tool. It's a post-mortem.

Central distribution centers and central-fill models introduce structural efficiency but don't resolve the underlying visibility problem. A CDC can consolidate purchasing leverage on a defined formulary, but if satellite sites can still order direct from wholesalers, and they often do, the system still doesn't know what's actually being purchased, where or why.



**The question isn't whether to centralize. It's whether you have a platform that makes centralization real and not just aspirational.**

See It	Decide It	Do It
Real-time spend	Best option surfaced automatically	Order spend
Compliance gaps flagged	Non-compliant items caught	Guardrails applied
System-wide inventory	Reorder triggers set	Credits and returns managed

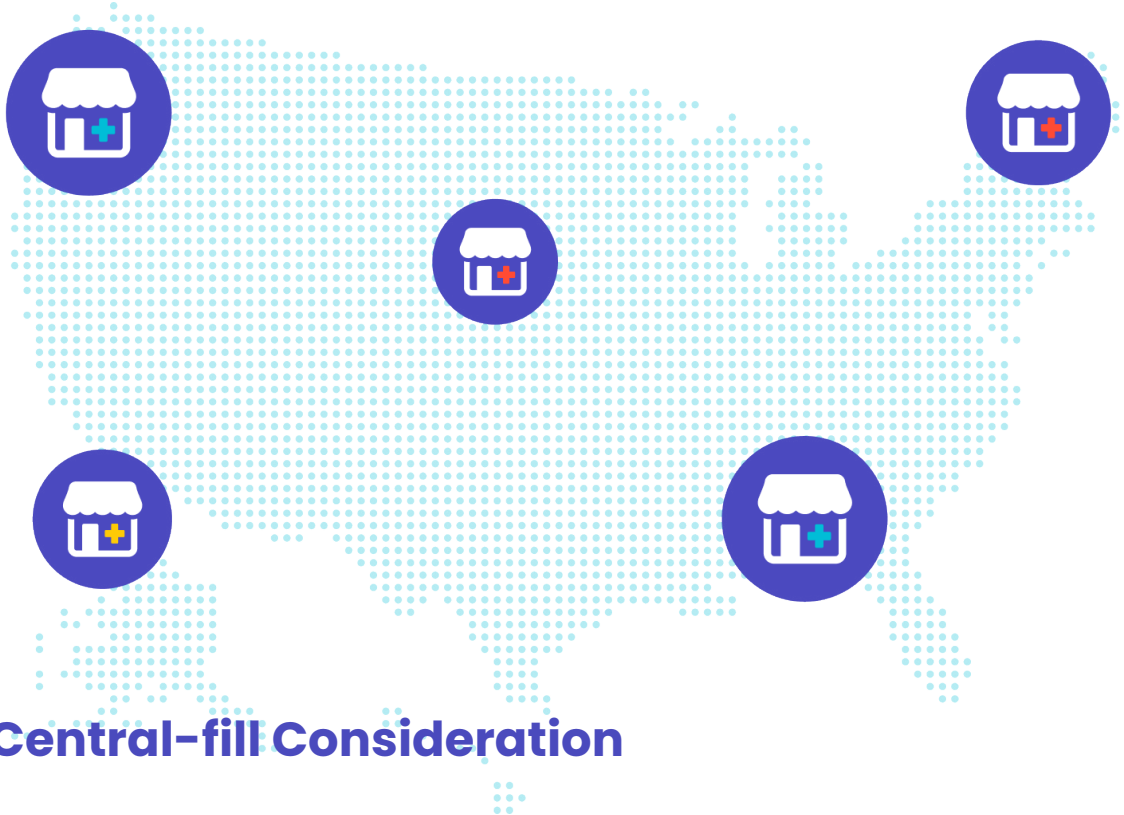
**Not a report or analytical tool.  
A platform your teams work inside every day.**

The more locations a pharmacy oversees,  
the more complicated its operations become.

## The Central Distribution Center Reality Check

CDCs and central service centers offer real advantages: direct manufacturer contracting, greater volume leverage and the ability to move markets that would otherwise remain under wholesaler control. But they introduce a new layer of operational questions that don't answer themselves.

How do you ensure satellite pharmacies pull from the CDC instead of ordering direct? How do you track lot numbers, expiration dates and serial numbers across the hub-and-spoke flow? How do you distribute accurate cost-of-goods information downstream so each site can manage its own P&L? Without a platform that spans the entire procurement picture across the CDC, satellites and manufacturer relationships, a CDC creates visibility for one slice of the system while leaving the rest dark.



## The Central-fill Consideration

Central-fill models are growing across health system outpatient, specialty and mail-order settings. They promise efficiency at scale and deliver it when the data infrastructure is in place. The challenge is inventory management: decrementing product from the right location at the right time, managing formulary consistency between fill sites and handling shortage substitutions simultaneously across every location the central fill pharmacy serves. Most pharmacy management systems aren't built to span that complexity. The result is manual workarounds that undermine the efficiency the model was designed to create.



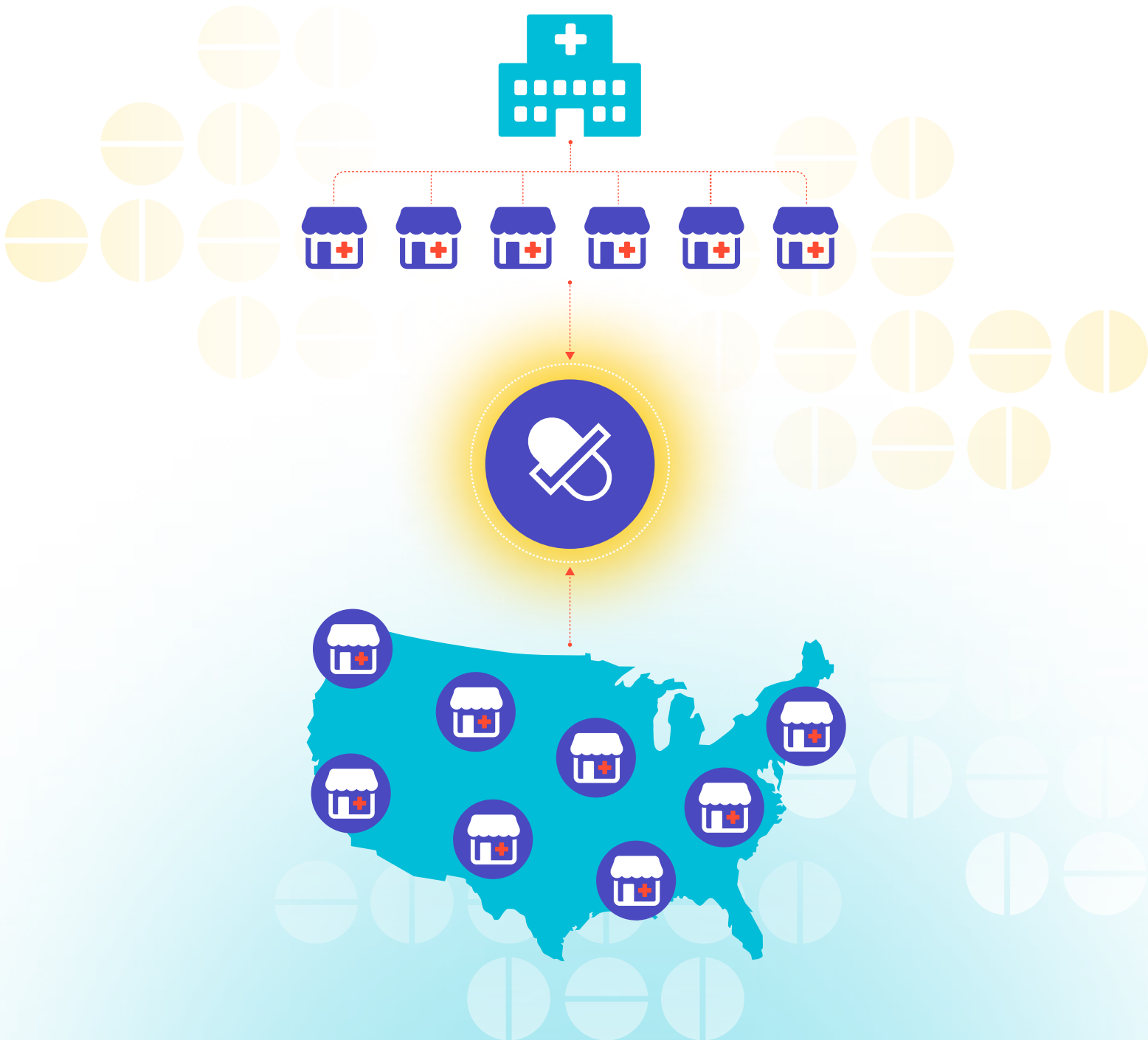
**A CDC or central-fill model gives you structural efficiency. A unified procurement platform gives you operational intelligence. You need both, and they need to talk to each other.**

Applying consistent purchasing rules across all sites drives efficiency and pharmacy cost savings.

## One Platform. Every Purchase. Every Site.

SureCost: The Smarter Purchasing Solution™ was built specifically for the complexity that health system pharmacy enterprises face today. Not as a reporting layer on top of existing systems. Not as a retrospective analytics tool. As the platform your teams work inside every day, at every site, for every purchase.

The SureCost model operates on a simple but powerful premise: the best time to optimize a purchasing decision is before it's made. That means surfacing the right information at the point of purchase, not after the invoice has been processed and the opportunity to capture value has passed. Price, availability, contract compliance, formulary alignment and GPO impact are all visible before you commit.



Robust yet flexible reporting capabilities transform data into actionable information. That requires a variety of both configurable reports and preset dashboards as well as clear data visualizations.

Capability	What It Solves
Unified Vendor Catalog Shopping	Every vendor is accessible in one interface: primary wholesaler, GPO contracts, secondaries and direct manufacturer. No more portal-switching or missed savings from a catalog you didn't check.
Real-time Compliance Monitoring	GPO contracts and wholesaler agreements are audited at the point of purchase and again at invoice receipt. Discrepancies are flagged automatically for recovery.
System-wide Inventory Visibility	See what's on shelves across every site. Optimize transfers before placing new orders. Reduce site-level buffering and the expired stock that comes with it.
Automated Receiving and DSCSA Verification	Mobile-enabled, standardized receiving works the same way regardless of vendor: primary, secondary or CDC. DSCSA validation is built-in, not bolted-on.
Formulary Management	Drive procurement toward formulary-compliant products dynamically. Exceptions are flagged, tracked and accounted for so you always know who is buying what and why.
A/P and ERP Integration	Three-way invoice matching, credit tracking and accounts payable data feed upstream automatically, reducing manual data entry and ensuring financial systems reflect actual cost of goods.
Drug Shortage Insights™	Predictive shortage intelligence covers severity, likelihood and duration, all powered by supply-side data. Know what's coming before it hits your formulary. (Coming Q3 2026)

## For Organizations of Any Size

The case for unified procurement intelligence isn't limited to the largest health systems. A single hospital system with three pharmacies that is rural and staffing-constrained with a CFO who needs better answers on drug spend, has exactly the same structural problem at a smaller scale. The cost categories are the same. The vendor complexity is the same. And the savings opportunity, as a percentage of cost of goods, is the same.



**It doesn't matter if you have 3 pharmacies or 30. If you're managing procurement across sites without a unified platform, you're paying a fragmentation, tax and it's growing every year. SureCost pays for itself many times over, regardless of system size.**

It can never replace teams, but automation enhances their work, leading to improved business outcomes and increased employee satisfaction.

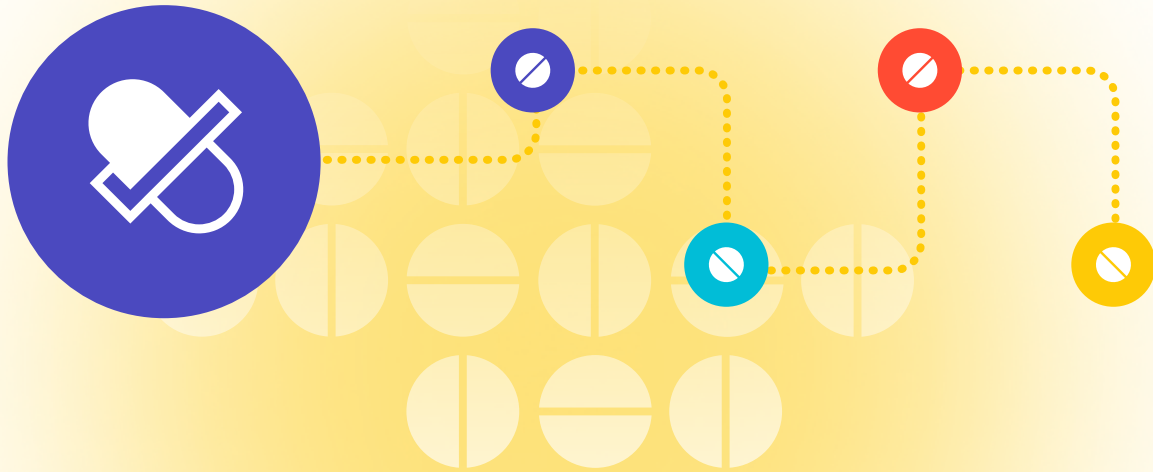
## The Status Quo Is No Longer Neutral

Decentralized pharmacy procurement has never been the optimal model. But for a long time, it was a manageable one. Today, with drug spend climbing, shortages compounding, staffing gaps widening and compliance demands multiplying, it's becoming an active liability.

The health systems that win on pharmacy margins in the next three to five years won't necessarily be the largest. They'll be the ones that figured out how to see every purchase, enforce every strategy and act at the point of decision, not after it.

That's what SureCost makes possible.

**Not eventually. Today.**



## See What Decentralization Is Costing You

Book a meeting with SureCost to see your actual cost-of-goods opportunity and what your enterprise could look like with unified procurement intelligence.

[Book a Meeting](#)