CONVERGENCE IN HEALTHCARE: WHY CAN'T A PRODUCT BE MORE LIKE A SERVICE?

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ABSTRACT

This paper discusses a fairly recent development in healthcare: Convergence, or the combining of a drug with a medical device. Combining previously separate physical products into a service offers a new approach to competing strategically for drug firms and medical device companies.

INTRODUCTION

An interesting development is emerging in healthcare: Convergence. Convergence refers to the melding together of healthcare products like drugs and medical devices into services. For example, Roche discovers and manufactures drugs but it also makes medical devices for monitoring diabetes and manufactures diagnostic tools for markers that can identify whether a patient has a certain disease. Roche's corporate partner, California-based biotech, Genentech, makes a biologic, Herceptin. Herceptin is for breast cancer; but only for those patients who over express a certain gene, the HER-2 gene. This gene exists in only 25 percent of breast cancer patients. Hence, the biologic will not work in the other 75 percent of cancer patients. Genentech partners with another firm, Vysis, that offers a diagnostic test to determine which breast cancer patients have that gene. Hence, the right drug gets to the right patient. This is important because the drug is very effective but it is very expensive: $40,000 for a year's treatment.

Roche is also active in congestive heart failure ("CHF"). CHF is difficult to diagnose. Half of all patients with CHF are not diagnosed until too late. If CHF could be caught early, this would reduce complications and save money. And Roche has a drug for CHF treatment (Diller 1998).

The purpose of this paper is to explore this emerging development. Also, the implications for strategy and marketing in healthcare will be discussed.

BACK TO THE BEGINNING

This notion of "servicification" of product goes back to the late 1980s (Howard 1991). Long before healthcare spotted servicification, non healthcare marketers were applying it. Relationship marketing holds that selling a product is a one time transaction. Marketing a service, on the other hand, is based on a relationship leading to the powerful metric, Lifetime Value of a Customer.

For example, cars on the road represent a base of over 200 million cars in existence; new car sales register only 15 million a year (Wise & Baumgartner 1999). In personal computers, 20 percent of revenue goes to hardware purchase but 80 percent is spent on training, installation and maintenance (Wise & Baumgartner 1999).

The emergence of sports franchises into brands such as ESPN and NASCAR typify the combining of the basic offering, the game, plus much more in the way of value added services. For example, the Atlanta Braves offer much more than just a baseball game:

- the spectacular $250 million Ted Turner ball park;
- video games;
- electronic kiosks for scouting reports;
- watch other games in the clubhouse store;
- licensing deals, including Warner Bros. cartoon characters in children's areas (Johnson 1997)

Another example of enhancing the value of a commodity through servicification is the mundane world of utilities. How do you differentiate energy, electricity; cable, etc.? In the early 1990s a housing development in Southern California integrated water, cable, electricity, natural gas, the internet and phone services and security into one package. If another utility offering, say electricity, prices at a discount, the switching costs of losing the package tends to minimize price discounting and helps reduce the "commoditization" inherent in fungible commodities such as utilities (Zellner, Palmeri & Cohn 2001).

The use of warranty service contracts for consumer electronics retailers can make the difference between profit and loss. In 2003, profits from warranties accounted for all of Circuit City's operating income and half of Best Buy's: the profit margins, 50 to 60 percent or 18 times the profit margins on the products themselves (Berner 2004).

Arguably, the best at servicification of product is General Electric, especially, GE Healthcare. GE spent over $80 million to build a state of the art training studio that can deliver education programming. For fees ranging up to $20,000, hospitals can dial up live broadcasts. If you buy a certain amount of medical equipment from GE Healthcare (such as $3 million Magnetic Resonance Imaging units), you also can get GE's management services and its vaunted 6 Sigma consulting (Smart 1996).

We now turn to the prototype of servicification in the healthcare industry: Pfizer's recent foray into the State of Florida Medicaid Program

PFIZER IN FLORIDA MEDICAID

Apocrypha has it that Florida Governor Jeb Bush and Pfizer CEO at the time, Dr Henry McKinnell met at a social gathering (Petersen 2003; Ross 2002). Reportedly, Governor Bush and Dr McKinnell got into a discussion on how fast drug costs were rising in state Medicaid programs, faster than any other healthcare component. Dr McKinnell was reported to have said: why not use drugs, 10 percent of the healthcare Medicaid budget, to leverage down the other more expensive 90 percent of healthcare costs, hospital stays and doctors (Slowik 2003). And so was born the creative partnership between a drug company and a state Medicaid program to try to reduce healthcare costs overall .

First, some definitions are in order. Healthcare is replete with jargon and "alphabet soup" that can make up another language:

Medicaid: is the state program for healthcare for poor people, as distinguished from Medicare which is healthcare for those over the age of 65; State Medicaid Programs are reeling from rapidly increasing healthcare costs, the fastest rising component of which is drugs;

Predictive Modeling: this is used to forecast what a cohort of patients defined by how many comorbidities or diseases they have are likely to cost. For example, people over 50 with high blood pressure, high cholesterol and overweight are pre-diabetic and will suffer that serious disease unless intervention in some form can prevent them from that progression;

Hospital Visits/Emergency Room Visits/ Doctors: these are very expensive encounters. Going to an emergency room when a patient could have taken a drug or gone to a less expensive venue is to be reduced. Similarly, seeing a doctor for every ailment is more expensive than changing healthcare lifestyle or taking an over- the -counter medicine;

Preferred Drug Lists ("PDLs"): PDLs are tantamount to virtual medicine cabinets or formularies. Typically, to get on a state formulary, a drug company must discount its drugs. No drug company likes to discount its drugs. If a drug does not get on a PDL, that means that a patient is likely to have to pay full price for the drug instead of having its cost absorbed substantially by a healthplan insurer;

Prior Authorization: this is despised by doctors. Typically, expensive branded drugs require prior authorization before they can be prescribed for a patient. A busy doctor has to call an 800 – number to get approval to prescribe the drug vs just prescribing a no – hassle cheaper generic drug;

Co-Payments / Deductibles: these are weapons in managed care's or a healthplan's armament to raise the price to the patient for using more expensive services and drugs.

Disease Management: refers to a systemic way to manage and deliver healthcare over the life cycle of the patient from the moment the patient is diagnosed throughout the treatment process, including physician care, hospitalization and drugs (Kongstvedt 2001).

THE SITUATION IN WHICH MEDICAID FINDS ITSELF

State Medicaid programs offer medical services to the poor. They are funded anywhere from about 50 percent to 72 percent of their budgets by the federal government. All State Medicaid programs are hemorrhaging. The following constraints are being put in place by various state agencies:

- more than 25 states are restricting eligibility for Medicaid; in other words, it will become more difficult for the disadvantaged to qualify for Medicaid benefits;
- More than 20 states have reduced benefits to the poor;
- More than 20 states have increased co-payments, a very drastic action for the disadvantaged where they have to pay more for their co-pay share of medical benefits;
- More than 25 states have cut reimbursement to providers such as hospitals and physicians (Pear 2003).

Furthermore, states have taken action to rein in prescription drug costs:

- More than 30 states have expanded the list of drugs requiring prior authorization;
- More than 20 states have established Preferred Drug Lists ("PDLs");
- More states are requiring the use of generic drug substitutes for the more expensive branded drugs;
- About a dozen states have imposed monthly limits on the number of prescriptions that can be filled (Pear 2003).

All of these adverse impacts on State Medicaid programs provide an opportunity for pharmaceutical manufacturers to offer innovative convergence packages that result in solutions that enhance patient lifestyle behavior and reduce costs to healthcare payors.

WHAT PFIZER WAS TRYING TO DO IN FLORIDA MEDICAID

The rationale underlying disease management is to focus on administering and monitoring chronic diseases such as asthma, diabetes and congestive heart failure ("CHF"). A disease management program offers case managers, usually nurses, to monitor progress and compliance among patients on their medical regimens. As the quality of oversight increases, total healthcare costs should decrease due to less patient usage of expensive emergency room visits and unnecessary physician visits (Slovik 2003).

Pfizer, and other drug manufacturers including Bristol-Myers Squibb, GlaxoSmithKline, and AstraZeneca, argued that instead of giving additional price discounts to get their drugs on the PDL, they would pay to hire nurses to monitor the healthcare of tens of thousands of the most difficult patients to deal with: the poor and disadvantaged, most of whom do not have phones or computers, are difficult to locate, and many do not speak English. The three diseases Pfizer aimed at were: asthma, diabetes and congestive heart failure. Interestingly, Pfizer has no drug franchise in these three disease states, until recently with its inhaled insulin, *Exubera*.. but it was able to get all of its drugs on the PDL without having to discount further. Pfizer was able to get around The Antikickback law by offering services in lieu of price discounts pursuant to an exemption in the Florida State Statutes (Florida Statute 2001). By encouraging this most difficult patient population to take their medicines as prescribed, follow better diets and exercise, in essence, change to a healthier lifestyle, Pfizer and others sought to save the state money (Gold, Hensley & James 2001). Pfizer also guaranteed the State of Florida that it would make up any shortfall in expected savings to the tune of $33 million over the two-year contract (Baghdadi 2005). Unfortunately for Pfizer, a public watchdog group in the state reported that the state could have gained more by demanding discounts from the drug manufacturers than seeking lifestyle behavior change (Carroll 2004).

CONCLUSION

This article has discussed an application of an increasingly important development in the healthcare field, convergence. By melding physical products like drugs and medical devices with services, the manufacturer can provide a much more differentiated offering. "Servicifying" a product makes the physical product less vulnerable to price competition because competitors have to address the whole value added package, not just the physical product. It is likely that more convergence will be seen in the healthcare marketplace as more becomes known on identifying markers in patient populations that match patients most likely to respond to medicines with the right medicines. The implications for strategy are that market segmentation will focus on narrower market targets with customized medicine and healthcare offerings.This will impact the sales force by reducing the size of the force which previously was sized to reach mass markets such as cholesterol, blood pressure and heartburn, numbering millions of patients.

REFERENCES

Baghdadi, Ramsey 2005. "Lilly Stands Firm Against Florida Price Negotiations", In Vivo (October), 39 – 42

Bemer, Robert 2004. "The Warranty Windfall", Business Week (December 20), 84 – 86

Byrne, John 1998. "Going Where the Money Is" Business Week (January 26), 14

Byrnes, Nanette 2002. "Was Jack Welch's Run All That It Was Cracked Up to Be?" Business Week (April 29), 86

Carroll, John 2004. "Pfizer: Disease Management Did Not Fizzle in Florida Medicaid", Managed Care (September), 10 – 12

Diller, Wendy 1998. "Roche's Grand Vision" In Vivo (October), 43 – 55

Florida Statutes Sections 409.91195, 409.91196, 409.912 (2001)

Gold, Russel, and Scott Hensley and Joni James 2001. "Drug Intervention" Wall Street Journal (July 9), A1, A6

Howard, H. 1991. "'Servicification' of Product" Harvard Business Review (January – February), 70 – 79

Kongstvedt, Peter 2001. ESSENTIALS OF MANAGED HEATLHCARE. (4th ed) Aspen Press: Gaithersburg MD

Pear, Robert 2003. "Rising Costs Prompt States to Reduce Medicaid", New York Times (September 23), A 18

Petersen, Melody 2003. "Drug Makers Expand Their Aid Role", New York Times, (April 23), C1, C4

Ross, Warren 2002. "New Rules, New Roles for the Sales Force", MM&M, (November), 39 - 48

Sing, Ashish and Chris Zook and Norbert Hueltenschmidt 2004. "Healthy Convergence", In Vivo (July / August), 61 – 68

Slowik, Heather 2003."Changes to Medicaid Drug Spending Stirs Manufacturers", In Vivo (April), 55 – 62.

Wise, Richard and Peter Baumgarten 1999. "Go Downstream", Harvard Business Review (September / October), 133 – 141

Zellner, Wendy, Christopher Palmeri and Laura Cohn 2001. "Power Play", Business Week (February 12), 70 – 80