Manufacturer–Provider Alliances: Case Studies of the Nature of and Prospects for Several Model Arrangements

Four case studies are presented as examples of how providers are "partnering" with the pharmaceutical industry. Read about providers in transition, physician networks, and niche marketing.

The pharmaceutical industry is witnessing a paradigm shift in which the industry focus is moving from a product to a service base. The prize for this adventure is a larger piece of the health care dollar beyond the 7% currently provided to these companies by pharmaceuticals. This change and expansion of the pharmaceutical industry is taking many forms as manufacturers experiment with the concept of "disease management" and the need for "outcomes" data to provide competitive advantage for current product portfolios.

To control the distribution channel of pharmaceuticals, some manufacturers are embarking forward into integration by forming closer relationships.
with the provider community. The various forms of these relationships provide an interesting look at how the industry seeks to understand its new customer base and struggles to meet the new requirements of becoming more service-focused.

The following four case reviews provide a glimpse of different possible approaches to the integration of manufacturers with providers. They provide a spectrum of options ranging from acquisitions to manufacturer dispensing of prescriptions. These cases show various options; they are only representative and not meant to be exhaustive. The rationale for the selected cases is as follows:

**Mullikin Medical Centers** focuses on a physician group (reviewed before its recent acquisition) in the process of acquiring capital to maintain growth. Working in a capital-intensive business with a need for physician autonomy, Mullikin illustrates the needs of a provider in transition and the issues germane to a potential acquisition prospect for a drug manufacturer.

**Caremark Physician Resources** provides an example of a recent manufacturer divestiture that is forming integrated networks of physicians, pharmacy benefits management, and mail order services. Caremark focuses on the opposing situation of the problems associated with retention of a subsidiary with provider alliances and the resultant development of those alliances after the manufacturer spin-off.

**The Zeneca Group–Salick Health Care** alliance provides a view of a purchase of a niche provider in the cancer chemotherapy market. This case views the potential synergies and pitfalls of a manufacturer purchase of a provider group.

**Athena Neurosciences** provides a view of an interim step by a manufacturer to identify and control its customer base in anticipation of new product offerings within its specialty niche. This manufacturer has focused on building relationships with providers while at the same time integrating a distribution network directly to patients.

**MULLIKIN MEDICAL CENTERS**

(This review considers the situation of this particular provider group before their recent acquisition; however, the issues are presented as germane to provider groups in similar situations.)

Mullikin Medical Centers of Long Beach is one of the largest physician groups in California. With an estimated $300 million in annual revenues (85% in managed care contracts), Mullikin is the second largest medical group in California. It is owned by 200 staff physicians and dominated by primary care doctors (65%). Mullikin comprises approximately 400 salaried physicians, 53 clinics and office sites, and the 99-bed Pioneer Hospital in Artesia, California. The group provides medical services for a patient base of 320,000 covered lives located across the States of California and Oregon.

Mullikin has grown rapidly over the past few years through acquisition of medical groups to become the predominant provider in a local service area. As the area's primary provider of physician services, Mullikin is well-positioned to gain favorable contracts with managed care plans and a larger share of the MediCal population currently being rolled-over into managed care.

Growth by acquisition has been facilitated by the poor financial performance of many local physician groups, allowing Mullikin to purchase them at bargain-basement prices. However, this capital-intensive growth formula requires continual expansion to maintain competitiveness and economics of scale for contracting purposes. As a result, Mullikin has recently applied to the equity markets to secure additional funds. Yet, as a management company, Mullikin depends on the continued viability of its contracts for financial stability. This dependence on contracts and the contractions on premium driven by public and private (employer) payers may make it difficult for Mullikin to raise expansion capital. To raise capital and assess its worth, Mullikin hired Smith Barney as its investment banker.

This case focuses on the need of large provider groups to find sources of capital for expansion while trying to maintain autonomy for physician practice. Pharmaceutical manufacturers with a depth of capital reserve and a current focus on vertical integration into service areas to pursue 'disease state management' may provide an ideal partner for groups such as Mullikin. This option has not been lost on industry observers who have analyzed the Mullikin situation and promoted a sale of part or all of the company. Mullikin management has emphasized the need for physician autonomy, which would be a factor against a merger with a hospital alliance or benefits management company. However, it is argued that a drug manufacturer may be able to gain a vertical alliance partner while mitigating the legal (restraint of trade, unfair competition, price discrimination) and ethical (breach of patient confidentiality and conflicts of interest) concerns incumbent in such arrangements. Additionally, the large primary-care patient base would provide a manufacturer with an opportunity for outcomes research and marketing intelligence for current and future provider and patient needs.

**CAREMARK PHYSICIAN RESOURCES**

Before 1992, Baxter International Inc. was an example of a pharmaceutical manufacturer owning an alternative site provider business (i.e., nonacute hospital). This business integrated the provision of infusion therapy, pharmacy benefit management, and alliances with providers. However, well-publicized legal problems with reimbursement issues and complications with provider payments for services rendered led to serious concerns with the influence of the alternate-site business over the other business segments. As a result, regulations for provider payments and legal ramifications of the home infusion business, coupled with the environmental pressures on the alternate-site business, led to a spin-off.
of the home infusion and related businesses. This response to legal pressures exemplifies one of the difficulties in operating manufacturer alliances with alternate sites and their providers.

Caremark International Inc., based in Northbrook, Illinois, was formed in June 1992 as a divestiture of Baxter International Inc. Caremark offers an integration of pharmacy benefit management—the second largest mail order operation in the country—and a multispecialty physician clinic operation. Its home infusion therapy services business was recently sold in a controversial deal to Coram.

As a provider of health care products and services, Caremark is integrating health care networks with the physician alliances at the core of its business. Each business unit is operated as a cost center to focus the overall business on operated/managed care contracting. This emphasis on cost management and the focus on processes in delivering services is a key success factor for service management. Pharmaceutical manufacturers have not placed the same emphasis on cost management.

Alliances with Oklahoma City Clinic, Kelsey–Seybold Clinic (Houston, Texas), Friendly Hills HealthCare Network (La Habra, California), and North Suburban Clinic (Chicago) have broadened Caremark’s business in managing physician practices and integrating them into other product/service offerings. While the clear purpose of these alliances is the development of an integrated network to contract with managed care plans, they also provide additional business opportunities for the Caremark pharmacy benefits management business and its high-margin mail order operations. Since the history of management experience in these arrangements is limited, the actual operation of integrated networks and the success of these alliances is still unclear.

The Caremark example is illustrative of some of the difficulties of maintaining and operating a manufacturer–provider alliance. Provider emphasis on process and cost containment is inconsistent with the current manufacturer emphasis on revenue. Thus, the alliance of manufacturers and providers requires a fundamental shift in the management paradigm of each party.

**ZENECA GROUP–SALICK HEALTH CARE**

The Zeneca Group (parent of Zeneca Pharmaceuticals) purchased a 50% controlling interest in Salick Health Care in 1993 and an option to acquire the remainder within 30–48 months. This purchase is described by Zeneca as “designed to put its move in the context of the evolution of the drug industry from product provider to service provider.”

Salick Health Care comprises 10 comprehensive cancer outpatient care centers, nine outpatient dialysis centers, and Aurora Medical Supplies (a pharmaceutical and medical supplies purchasing business). Although Salick has a close relationship with approximately 130 oncologists, it does not employ physicians. As a result, Salick provides a service layer between the physicians and Zeneca Pharmaceuticals and focuses both companies on the cancer chemotherapy market from the outset. (Note: Focusing alliances on market niches is also being pursued by Glaxo through investments in asthma centers.)

Zeneca Pharmaceuticals has an expertise in cancer treatment, most particularly breast cancer treatment. Salick focuses on breast cancer as a practice subspecialty. Synergies from the alliance have been proposed:

- A learning laboratory for Zeneca to learn first-hand about cancer treatments from practitioners
- Provide intelligence for research and development and marketing decisions

The ownership of SalickNet, a Salick subsidiary, which has signed capitatively managed care contracts with CAPP CARE and PCA, is an additional benefit to Zeneca. Zeneca may benefit from the managed care expertise as well as gain potential coattail business for its pharmaceuticals business.

Disease management provides a synergy for the alliance by combining the proposed marketing package for managed care of Stuart Pharmaceuticals (a subsidiary of Zeneca) with the existing disease management program of Salick. Salick’s program (developed with ValueHealth) focuses on proprietary guidelines for bone marrow transplants in breast cancer, colon cancer, antiemetics, and biological growth factors.

As alluded to in the Caremark example, regulatory, competitive marketing threats, and market erosion of Salick contracts create threats to the alliance. The following issues must be considered:

- “Firewall” assurances (arms-length boundaries) for protection of competitor purchasing information and research on new products is necessary in such an alliance. The Aurora purchasing subsidiary of Salick is of particular concern. Regulatory approvals similar to those sought by the Federal Trade Commission in the Lilly/PCS deal should be expected.
- Competing cancer care centers and other oncology providers may present purchasing problems for Zeneca products.
- The Inter-Center Cancer Research Group, a not-for-profit clinical trials group owned by Salick, has research relationships with the National Cancer Institute, the Southwestern Oncology Group, and pharmaceutical companies. Confidentiality of research data may be a problem.
- Current contracts for Salick cancer centers affiliated with hospitals have terms of 10–36 years. These affiliations would seem to be secure. However, a crucial contract with Cedars–Sinai Medical Center expires on September 30, 1999. The security of the Cedars contract is unknown.

In the final analysis, the Zeneca–Salick alliance may represent a more substantial issue than the influences affecting the current businesses discussed above. This issue is the intent of some manufacturers (e.g., Zeneca, Pfizer) to control a greater share of the entire health care dollar than the 7% represented by pharmaceuticals. Provider alliances may be directed to this expansion. As noted in the Pink Sheet of January 2, 1995, “Zeneca said
the Salick deal shows its desire to 'expand its presence in the cancer market,' where the company noted, pharmaceuticals can claim only six percent of an annual $40 billion spent on cancer therapy.'

ATHENA NEUROSCIENCES

Athena Neurosciences, established in 1986 in South San Francisco, California, has developed a novel approach to manufacturer-provider rapprochement. (Note: Athena was acquired by Elan Corp. on March 18, 1996.) Athena is a biotechnology company developing expertise and products in neuropharmacologic treatments for Alzheimer's disease, migraine headaches, and Parkinson's disease. As an interim step to developing relationships with neurologists, Athena has licensed a retail and mail order pharmacy, through which it dispenses generic neuropharmacologic products. Athena provides an interesting integration of a research-based company with a mail-order pharmacy service and distribution network.

Athena Rx Home Pharmacy provides a service and a distribution route for the neurology community. Although neurologic therapeutics for Alzheimer's, multiple sclerosis, and Parkinson's disease are under intense scrutiny for new treatments, older medications are frequently off patent and sold as multi-source agents (i.e., generics) through the traditional manufacturer-to-wholesaler-to-pharmacy networks. Many of these products require skill in dosing to avoid the situations of dosages that are either too high (drug toxicity) or too low (subtherapeutic effect). Since many of these medications display small windows of advantage through which doses for therapeutic effect and toxic effect are not widely separated, clinicians monitor these medications very carefully. Appropriate dosing by physicians and clinical pharmacists frequently requires blood samples to monitor the effective target dosage for a given patient. In addition, adults and children require different dosing guidelines. Therefore, the neurology community has traditionally taken a strict view on product quality.

The Athena Rx Home Pharmacy focuses on the concern for quality generic products for neurology patients, which, under the usual wholesaler-to-pharmacy distribution route, may necessitate that the patient receive generic alternatives from multiple manufacturers for successive refills. Athena has capitalized on the traditional product quality concern by taking a proactive approach to validating product quality and standardizing the product that the patient receives for each refill. A measure of the quality of a pharmaceutical agent is its bioavailability, which is an indicator of the completeness of its absorption. A frequent concern for neurologic agents is that the product prescribed is either the branded product or an equivalent generic product. In either case, clinicians wish to ensure that their patient is receiving the same medication so that variability in response may be laid to pathologic or therapeutic issues rather than product variability.

In response to the above concerns, Athena guarantees the bioavailability of their generic offering by laboratory testing through their Seneca subsidiary. They then take the process a step further by using express, second-day delivery directly to the patient's home. Additional services include optimal pharmacy interventions such as refill reminders, 24-hour patient consulting line, and physician reports on patient compliance with medication regimens. As a result of this service program, Athena boasts a 92% refill rate.

The Athena approach to offering a high-caliber service component places Athena Rx Home Pharmacy on the high ground, with respect to rationale for their market presence. However, limitations on the size of the neurologic market provide a limit to the growth of Athena Rx without the infusion of new pharmaceuticals at a regular rate. Alternatively, the Athena Rx strategy is well-designed and positioned to function in a capitated environment.

The Athena approach to aligning with a specific specialty provider provides the case products and services for integrating. As opposed to ownership of physician practices, Athena's approach is similar to the Salick example (i.e., the provision of services direct to patients). It is interesting that both Athena and Zeneca–Salick have emphasized niche expertise and focused marketing. As growth of manufacturer-driven service components from product bases increases, the varieties of approaches to patient care begin to blur the traditional manufacturer and provider distinctions. However, the product link is still apparent in the Athena and Zeneca–Salick cases since biotechnology product research and development has a major interest in cancer and neurologic treatments.

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CONCLUSION

The vertical integration of the pharmaceutical industry provides an interesting paradigm shift in the development of the market. Viewed as a simple way to control the distribution channel of pharmaceuticals, manufacturer–provider alliances are a complicated mixture of forward integration and legal/ethical questions of conflict of interest. However, viewed as a change in business focus toward “disease management,” these alliances provide an opportunity to expand the pharmaceutical industry into purveyors of a larger piece of the health care pie. Disease management changes the complexion of the industry from a product-focus to a service-focus.

Manufacturer–provider alliances may provide an intermediate step in the learning curve toward a service industry, and a promise for a substantial expansion of industry revenues unrelated to product price inflation. However, emphasis on cost control and marketing in an information-rich environment, where the customer is more aware of competitive options, has not been outweighed by a service-focused strategy. The cases presented reflect a strong interest in service.

The service orientation of a care management in the managed care sector has not gone unnoticed. The cases provided indicate that the market has not settled on a formula for growth from product to service, or how to integrate service with product. Rather, the transition of an industry in the presence of a competitive environment should lead to further examples and experiments probing the limits of customer and regulatory requirements.