

**A SURVEY OF THE STRATEGIC RESPONSE OF THE
PHARMACEUTICAL INDUSTRY TO BARGAINING POWER OF
HEALTH MANAGEMENT ORGANISATIONS (HMOs)**



BY

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D/61/P/7942/98

**A RESEARCH PROJECT SUBMITTED IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF BUSINESS ADMINISTRATION, FACULTY OF
COMMERCE, UNIVERSITY OF NAIROBI**

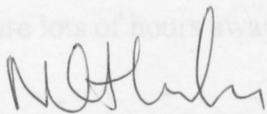
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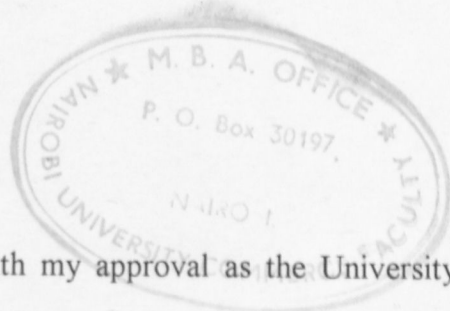
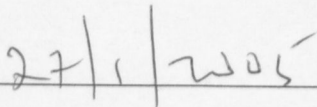
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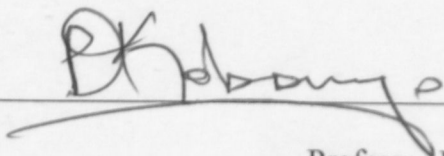
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DEDICATION

To my dear husband, Dr. Samson Njuguna Maina who gave me a lot of moral and technical support, making it possible for me to complete this work. And to my son Stephen who had to endure lots of hours away from me in the course of this work.

to guide and encourage me

Joyce Kariu, thank you for your moral support

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I wish to sincerely thank my supervisor, Prof. K'Obonyo who worked with me during the course of the whole study and guided me through.

I also give my heartfelt appreciation to my husband Dr. Maina, who worked behind the scenes to guide and encourage me.

Joyce Katuu, thank you for your moral support.

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ABSTRACT

Health Maintenance organisations (HMOs) have been in operation in Kenya since 1985. In the 1990's many new players came into the market and more still continue to enter the market. HMOs are organised health plans and manage both financing and health delivery to their clients. Many salaried Kenyans have already enrolled into these schemes in search of affordable health care.

HMOs carry out a lot of cost cutting measures in the course of health delivery and have many exclusion criteria for numerous illnesses causing a lot of complaints from their clients. To the Pharmaceutical industry as a buyer group, they negotiate for price cuts and are involved in measures to maximise their profits like substitution of branded drugs with cheaper generics. HMOs constitute a powerful buyer group and are responsible to some extent for decreasing profitability in the Pharmaceutical industry. The aim of this study was to find out the response of the Pharmaceutical industry to the emergence of HMOs.

The study examined various ways in which HMOs decrease profitability in the Pharmaceutical companies and looked at strategies that some companies have put in place in order to counter the reduced profitability.

The study showed that HMOs are indeed a powerful buyer group and the industry should employ strategies like product differentiation and stringent credit controls to counter the effect of HMOs. The industry should also lobby with the government to introduce certain controls among the HMOs who at present do not operate under any government act or regulatory mechanisms. This is bound to contain some of their buyers and benefit both the enrollees of the HMOs and the Pharmaceutical industry.

CHAPTER 1

INTRODUCTION

1.1 Background

The Pharmaceutical Industry in Kenya comprises different sectors namely, manufacturers (local manufactures and multinational corporations), distributors, wholesale pharmacies, retail pharmacies and consumers (Drugs and Chemists, 2001).

Multinational corporations who have branches in Kenya may manufacture products locally or import some or all products as finished goods. Distributors are local agents of manufactures and have agreements, usually exclusive agreements, to distribute the products on behalf of the manufacturer. They may also operate on contractual agreements enabling them to import the goods directly from the country of origin, on behalf of the manufacturer. Distributors sell the goods to Wholesale pharmacies who in turn sell them to retail pharmacies and the consumer obtains his drugs from retail pharmacies.

The Pharmaceutical Industry plays a key role in the economy of this country. It ensures provision of drugs and vaccines to the Kenyan people and it also employs big numbers of people in manufacturing, research and marketing. In 1999, this industry in Kenya was estimated to have imported goods worth 111,577,172.15 U.S dollars (Pre-shipment Inspection Agencies, 1999).

Traditionally, private health in Kenya has been managed on retrospective payment or 'fee for service methodology'. Under this system, an individual who requires healthcare attention chooses a doctor or hospital, undergoes the prescribed treatments and individually pays the costs incurred or is reimbursed by his insurance or employer. This system has no capacity to control costs or administration of health services. As a result,

Managed care has emerged as an alternative financing and control mechanism. This concept has been accelerated by the poverty situation in Kenya with many Kenyans looking for affordable medical services. According to Omondi 2001, only 10 % of Kenyans can afford medical cover at present. He says that the concept has already taken root in Kenya among salaried people and those in business.

Health Maintenance Organisations (HMOs) are organised health plans that are responsible for both financing and delivering a specified set of health services to an enrolled population for a pre-paid fixed fee. They endeavour to ensure that their members have access to the services and that any care provided is appropriate and of high quality. To assure appropriateness of care, HMOs often use primary care doctors as 'gatekeepers' who control utilisation of health care delivery system.(Okanga , 2001).

The concept of HMOs was launched in Kenya in 1985 with the first such organisation being African Air Rescue(AAR) which started as a private air rescue company but has since spread its wings to become a managed Healthcare. Others followed in quick succession. Currently there are 4 established HMOs in Kenya and the East African region namely AAR, Avenue Healthcare, Healthfirst and Bupa. Mediplus (established in January 1997 has recently been declared bankrupt. Medex established in the year 2000 has also gone down. (Omondi , 2001).The most recent entrant into this market is Resolution Health which began operations in June 2003.In total there are 15 HMOs operating currently in Kenya. In addition there are a number of Insurance companies offering similar health management services. These are ALICO, UAP Provincial, Apollo, Madison, Fleximed, Jubilee, Kenya Alliance, HealthPlan Services (established in 1996), and British American (Omondi, 2001).

According to Dr Nyikal, the Director of Medical Services and immediate past Chairman of Kenya Medical Association , HMO schemes are now using Cartel like approaches to form controlling organisations, preferred provider lists, organised undercutting and gate keeping organisations. Health Maintenance Organisations have become increasingly powerful and they are now dictating to the doctor what treatment procedures to prescribe and to the pharmacist what drugs to dispense to the patient. They determine which doctor their clients should see and which pharmacies they should visit to fill their prescriptions. Through restrictive clauses in agreements, patients access to services are strictly controlled. Patients cannot for example visit specialists or clinics of their choice, and professional 'gatekeepers' have limited authority. Patients are also made to sign contracts that include waiver of confidentiality about their illness (Nyikal, 2001).

Business strategies in the Pharmaceutical industry have been controlled by the customer, where the customer is either the prescribing doctor or the patient. However, in the last few years the emergence of HMOs is changing the environment of the Pharmaceutical industry . The HMOs have been in existence in other western countries for a number of years but it is a relatively new concept in Kenya and is now threatening the survival of this industry (Ndungu, 2001).

A powerful buyer group can lower industry profitability by forcing down prices and demanding higher quality of goods or more service (Porter 1980).

According to Avegoropoulos, 2000, a firm can limit the power of buyers by controlling the factors that make the buyer group powerful, for example by differentiating its' products. A firm can also limit the power of buyers by targeting and selling to buyers who possess the least power to influence it adversely. In general a company can only sell

profitably in the long term to powerful buyers if it is a low cost producer or if its product is sufficiently differentiated. If the company lacks both, each sale to a powerful buyer makes the company more vulnerable, and targeting and selling to the weaker buyers only becomes very important.

Depending on the strategies that the industry puts in place HMOs can either be a threat or a God sent opportunity.

1.2 Statement of the problem

The emergence of HMOs, is changing the environment in the Pharmaceutical industry because HMOs have emerged as a powerful buyer group. This increase in the bargaining power of buyers is threatening survival of the players in the Pharmaceutical Industry. This is because the buyers have a lot of power to determine prices of pharmaceutical products and can also demand more service and bring down profitability in the industry. With declining profitability, employment in the pharmaceutical industry has to inevitably decline.

This no doubt necessitates a change of strategy for the players in the Pharmaceutical Industry if they are to survive in this era of HMOs. The Pharmaceutical firms have to put in place certain strategic responses that will counter the threat from this powerful buyer group.

In America, Companies have responded to the cost containment pressures by HMOs by increasingly forming strategic alliances, mergers and acquisitions. Others have attempted to differentiate their products (Pharmaceutical Research and Manufactures of America,2000).

A few studies have been carried out in Kenya to document strategic management practices in the Pharmaceutical industry and in a few other sectors as follows; Local Pharmaceutical manufacturers, (Sagwa, 2002), Manufacturing (Aosa, 1992), Retailing (Karemu, 1993), Public sector (Kang'oro, 1998) and Not for profit organisations (Kiruthi, 2001). As far as the researcher is concerned, no study has been carried out in Kenya to document the influence of industry forces on profitability of the Pharmaceutical industry or the strategic responses to these industry forces. One of the forces that can affect profitability in an industry is the power of buyers (Porter, 1980). Since the 1990s, with emergence of HMOs this force has greatly increased and there is therefore need for a study to shed more light on what the industry in Kenya is doing in response to this, and especially to the cost containment procedures that HMOs have adopted. This study endeavored to capture the ways in which business strategies in the Pharmaceutical industry have been changed by the emergence of HMOs. It looked at the influence of HMOs on the bargaining power of buyers as part of Michael Porter's 5 forces in Industry analysis and how this is changing strategic management practices in the Pharmaceutical industry.

1.3 Objective of the study

To establish the response of the Pharmaceutical industry to the bargaining power of Health Management Organisations as buyers of Pharmaceutical Products.

1.4 Significance of the study

To the Pharmaceutical industry, this study will endeavor to give recommendations to enable the industry survive. By the end of the study the researcher hopes to be able to advise different players in the industry on how to change their business strategies in order to survive in this era of HMOs.

To the government the data gathered will be useful in policy making for the Health Industry. (AAR, 2001)

The modern day HMO was first developed in America around the turn of the 19th century and since then, HMOs have continued to gain in strength and number with some of the large ones covering over 8 million members. HMOs form a close link between insuring bodies and providers of healthcare, unlike traditional health insurance organisations (which tend to play a very passive role as the provider of healthcare and merely act as a conduit for funds).

2.1 Classification of HMOs

Health Management Organisations can be classified into four different models, namely, group, Independent Practice Associations, Network and Staff model (Okunuga, 2001).

Group models

These are composed of doctors who form a legal entity separate from the HMO, which then contracts with an HMO to provide medical services to the enrollees of the HMO.

Payment from the HMO to the doctors group takes the form of a negotiated per capita rate. This is a closed panel in which non-group doctors cannot participate. In certain cases it incorporates a laboratory, X ray services and a Pharmacy and the enrollees are obliged

CHAPTER 2

LITERATURE REVIEW

The history of HMOs can be traced back to the ancient China when people used to pay the local doctor a small fee every month in return for continuous advice on how to stay healthy. Preventive medicine was the doctor's primary role, and he would not charge for treatment (AAR,2001).

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to obtain all their services in that particular centre. In Nairobi, examples are Acacia Medical centre and Laser medical services

Independent practice associations (IPAs) model

IPA HMOs contract with an association or multiple associations of doctors in order to provide healthcare services to their members. Each doctor is a member of the IPA, but remains an independent practitioner and retains his own separate facility and practice.

Network model

This is similar to group model except that network HMOs contract with two or more doctors' groups. This model does not involve exclusivity contracts and doctors retain ability to treat non-HMO patients. It may be closed or open panel. An example is Hazina Medical consultants.

Staff model

In this type of model, the HMO operates its own facilities and employs its own salaried doctors. Enrollees are restricted to use staff doctors and are required to visit a primary care doctor (General practitioner) before being treated by a specialist. African Air Rescue (AAR) and Avenue Healthcare are such examples operating in Kenya. These are closed panel programs and restrict non-staff doctors from participating in the plan. They also have their own Pharmacy run by their employees and the enrollees must use whatever medication is available there. The HMO will have a 'formulary' i.e a list of medicines approved for their enrollees which are the only ones stocked in the Pharmacy.

The Philosophy of HMOs is to emphasise primary and preventive care while controlling costs by utilising the most cost-effective treatments and eliminating unnecessary care.

They control the 'formulary', vet prescriptions and in most cases offer cheaper generic drugs as opposed to branded original drugs. They maintain selection of health providers, vet the treatment procedures and have to authorise admissions for their enrollees.

HMOs are getting more and more subscribers because their insurance-like policies are able to offer Healthcare to pre-paid members and this removes the headache of paying medical bills from many Kenyans. This system is therefore preferred to direct payment to doctors (Okanga, 2001).

2.2 Characteristics of HMOs

According to the Pharmaceutical Research and Manufacturers of America, 2000 the following are the characteristics of a HMO.

An HMO assumes a contractual responsibility to provide and ensure the delivery of specific kinds of health services, including outpatient and hospital services.

An HMO also provides medical care for those enrolled in the health plan.

An HMO requires a fixed periodic payment that is independent of the volume of health services consumed.

Finally, an HMO bears at least part of the financial risk or gain in the provision of services.

2.3 HMOs cost containment techniques

Managed Care Organisations frequently use a variety of cost containment techniques specifically for pharmaceutical expenditures. About 90 % of HMOs use formularies. Drugs are selected principally on the basis of therapeutic value, side effects and cost.

Formularies range in restrictiveness from 'open' where both listed and unlisted drugs are reimbursed, to 'closed' where only listed ones are reimbursed. In 1998, an estimated 48.4 % of HMOs used closed formularies up from 38.1 % in 1997 (SMG marketing Group, 1999).

A study published in the March 1996 issue of the American Journal of Managed Care found that overly restrictive formularies used by managed care organisations often have unintended consequences. The researchers looked at six HMOs in various parts of the U.S, all of which used formularies with varying degrees of restrictiveness. The study focused on asthma, ear infections, arthritis, ulcers and high blood pressure-diseases that are usually treated with prescription drugs. They found that restrictive formularies increased patients' use of other medical services. In general, the greater the limitation on physicians' use of medicines, the more patients used physicians' emergency rooms, and hospitals. In all of these the costs were more than the drugs which should have been used (Horn et al, 1996).

The more widespread use of cost containment techniques in Managed Care Organisations is especially significant given their increasing share of total prescription drug payments. According to IMS Health, third party sources including HMOs and insurance plans paid for 82 % of all retail outpatient prescription drugs in 1999, up from 37 % in 1990. The proportion of prescriptions paid by private third parties has more than doubled since 1990 (Pharmaceutical Research and Manufacturers of America, 2000).

The use of formularies means that if a drug does not appear on the 'formulary' it will not be purchased. Companies have therefore to lobby to ensure their products appear on this formulary.

Another cost containment technique is the use of therapeutic interchange. This involves dispensing a different drug having a different chemical composition than the one prescribed, usually in the same therapeutic class. About 40.2 % of HMOs now use therapeutic interchange, up from 22% in 1980, substituting the prescribed drug with a cheaper one (Pharmaceutical Research and Manufacturers of America, 2000).

Step care therapy is another technique used by HMOs to cut costs. This requires physicians to follow a sequence of treatment for a given condition, starting with the lowest cost treatment and progressing to higher cost treatments if previous ones are ineffective. This may result in delayed recovery for patients if patients are denied immediate treatment with the most effective drugs. The percentage of HMOs using this technique increased from 35% in 1996 to 68.5 % in 1998 (Pharmaceutical Research and Manufacturers of America, 2000).

Drug Utilization Review (DUR) is also used by HMOs to cut costs. These involve retrospective monitoring of physicians prescribing patterns. Historically, they have been used to ensure appropriate, safe and effective use of prescription drugs. More than 90% of HMOs now require DUR. Intense cost pressures in the managed care environment, however threaten to change the focus of DUR programs from quality and patient safety to cost savings (Pharmaceutical Research and Manufacturers of America, 2000).

Generic substitution, where a brand name is replaced with a generic copy is another cost cutting measure. This increased from 63 % in 1984 to 72.4 % in 1998. Switching patients from a brand product to a generic copy can cause problems particularly with illnesses such as heart failure, cancer, diabetes and seizure disorder that are treated with drugs that have a narrow therapeutic index, i.e narrow dosage range between an ineffective amount

of a drug, a safe and effective amount, and an amount where the risks of the drug begin to exceed its benefits (Pharmaceutical Research and Manufacturers of America, 2000). This has resulted in a lot of competition from generic drug companies.

Over the past decade, generic drugs have more than doubled their share of the prescription market, from 18.6% at the end of 1984 to 47.1% in 1999. The large number of innovator products due to lose patent protection over the next 10 years will foster robust growth in the generics industry. The commodity nature of the generic drug business will not sustain Research and Development programs (R&D). Funds available for R&D depend on the ability of companies to discover, patent, and bring to market a steady stream of innovative products (Pharmaceutical Research and Manufacturers of America, 2000).

The increasing trend toward managing drug benefits has spawned specialized companies called pharmacy benefit managers (PBMs). These evolved in the late 1980s from insurance claims-processing and mail order prescription companies. PBMs now provide managed pharmacy benefits for approximately half the insured population in the United States (Congress of the United States, 1995).

Some managed care organisations have found that disease management programs are a good way to control costs while improving health outcomes. Most disease management programs focus on chronic diseases, which account for 60% of U.S medical costs (Kilborn , 1998). Currently, more than half of HMO plans take part in some form of disease management program. Asthma is the most common disease targeted, with nearly 60 percent of HMOs having programs to manage the disease (Interstudy, 1997).

Early intervention and prevention techniques, including proper use of steroids and physician education programs aimed at earlier identification and appropriate specialist referral, could save up to 25 percent of these costs (Boston Consulting Group, 1993).

Other conditions that are the focus of disease state management programs include diabetes, allergies, depression and arthritis.

2.4 The growth of managed care

“HMOs have introduced a novel innovation in America healthcare, incentives for physicians not to treat patients. If a medical practitioner practices less, the company makes more, kind of like paying farmers not to grow crops!”

“HMOs make money for not providing a product. The cost is pain and suffering which won't show up in balance sheets. 100 years after Lincoln, we have found a new way to trade lives for money, it is called 'managed care' and it is perfectly legal!” (Pharmaceutical Research and Manufacturers of America, 2000)

These are some of the sentiments expressed towards HMOs with bitterness

But despite these complaints, managed care is the fastest growing industry in America outpacing computers and Cable TV (Pharmaceutical Research and Manufacturers of America, 2000). In East Africa, AAR with a membership of over 70 000 people, is growing at a rate of 35 % per year (Omondi, 2001)

The way healthcare is delivered and paid for in the U.S has been undergoing rapid, market driven change. These changes have had and continue to have profound effects on the pharmaceutical industry. In the U.S, HMOs had 105.3 million members in 1998, up from 33.6 million in 1990. Almost 80 % of employed Americans are now covered by either an HMO, a preferred provider organisation or a point of service plan- all examples of managed care network (American Association of Health plans, 1999).

With the government's reduced budget on public spending, the need for alternative ways to finance healthcare is fuelling the growth of HMOs. In a symposium held in Nairobi on 22nd October 1997, the role of HMOs was recognised, but there was a plea that they operate within the insurance act (Towards better health in Kenya, 1997).

The government last year decided to bring HMOs under the insurance act. The insurance amendment bill (2002) was published to introduce this measure among other things. The bill is still pending before parliament (Makove, 2003)

Trends in the recurrent Kenya government's budget expenditure of the Ministry of Health (MOH) between 1979/80 and 1996/97 fiscal years show a general decline from per capita expenditure of U.S \$ 8.65 in 1979/80 to U.S \$ 3.09 IN 1996/97.

Examination of the general government recurrent expenditure allocated to the MOH shows it has also declined from 9.26 % in 1979/80 to 7.61 % in 1996/97 (Wang'ombe, 1997). Examination of the sources of Finance to the health sector shows that in 1983/84 the government financed 52.07 % of healthcare expenditures, while as much as 40.88 % derived from contributions of individuals to their own healthcare. Missions, Companies, donors and Non Governmental Organisations together contributed 5.82% while Insurance companies contributed 1.23 %. With the government expenditure going down, these other sources of financing have been growing and are likely to continue to grow. In a study conducted to examine the extent to which Nairobi residents are served with public health care services in recent years, the authors demonstrated that health care services have increasingly become inadequate and that there is an acute imbalance in the distribution of health care services in relation to the population (Ngau and Chege , 1993)

In another study on health care financing, J.K Wang'ombe concluded that 'health insurance and risk financing are underdeveloped programs in the Kenyan health sector, therefore there is need to explore possibilities of providing insurance and other forms of risk sharing.' (Wang'ombe 1993).

According to Dr. J. W Nyikal, managed healthcare is an American product whose consumer market is the general public. He reckons that in the U.S A the market is now saturated and the need for exportation of this product is now urgent. This is the reason the HMOs are now establishing themselves in Africa and specifically in Kenya. In a presentation made to the Pharmaceutical Society of Kenya members in a symposium held in June 2001, Dr Nyikal says that American HMO companies have performed well in Latin American countries with good results and Africa is the next target.

In fact, the system is now established in South Africa. He says that in Kenya USAID is financing the introduction of the managed healthcare. He quoted one of the experts involved as saying:

"We are trying to establish a model of managed healthcare for Kenya. There is no doubt in my mind that a market is being created where public health services have literally collapsed." As an American executive in Latin America commented; 'This is a lucrative business' (Pharmaceutical Journal of Kenya, vol 12, June 2001, page 22). Dr. Nyikal reckons that the world bank may support this as one of the structural changes recommended for improved healthcare.

Dr Nyikal says that Kenya is ill prepared for HMOs because most of the people are not well informed on the schemes they get into, which have obvious shortcomings such as many diseases being in the exclusion criteria. Also, the professional autonomy and self

regulation in the medical field is weak, while the present statutory mechanisms in the medical and Pharmacy professions do not adequately address corporate profit-oriented health care services.

As a way forward, he proposes proper regulatory mechanisms including new legislation being put in place to make provisions that will force the health care industry (medical and pharmaceutical) to work together for the well being of the public.

In short, the HMO industry has flourished in other parts of the world and is now establishing itself in Kenya. The parties affected must look at how to collaborate with this powerful force.

2.5 Forces driving industry competition

According to Michael Porter (1980), the analytical foundation for the development of competitive strategy is built on the analysis of industry structure and competitors. The essence of formulating competitive strategy is to relate a company to its environment.

Thus when the environment changes, the strategies must change to reflect the new environmental conditions. Industry structure has a strong influence on the competitive rules of the game as well as the strategies that are potentially available to a firm.

Porter has identified five fundamental forces of competition in an industry. The five competitive forces- entry, threat of substitution, bargaining power of buyers, bargaining power of suppliers, and rivalry among current competitors- reflect the fact that competition in an industry goes well beyond the established players. Buyers, suppliers, substitutes, and potential entrants are all 'competitors' to firms in the industry and may be more or less prominent depending on the particular circumstances. The state of

competition in the industry depends on these five basic competitive forces. The collective strength of these forces determines the ultimate profit potential in an industry.

A change in one of these forces will result in a change in the profit potential of the industry. A decline in the profit potential threatens the long term survival of the industry.

The goal of competitive strategy for a business unit in an industry is to find a position in an industry where the company can best defend itself against these competitive forces or how it can influence them in its favour. This means that the company must analyse each of these competitive forces in order to understand them. Knowledge of these underlying forces of competitive pressure highlights the critical strengths and weaknesses of the company, clarifies its position in its industry, and highlights the areas where industry trends promise to hold the greatest significance as either opportunities or threats. Different forces take on prominence in shaping competition in each industry.

One of these forces in the pharmaceutical industry that is obviously highlighted as either a threat or opportunity is the bargaining power of buyers. This force has become quite strong owing to the emergence of HMOs which have a lot of bargaining power in the industry. This force has therefore become a key force in the pharmaceutical industry and is crucial from the point of view of strategy formulation. Porter's five competitive forces considered in industry analysis are explained below:

Threat of entry

New entrants to an industry bring new capacity, and dilute the market share because they take control of part of the market previously belonging to the existing occupants. This can bring prices down and hence cut down the profitability for all the Industry players.

The threat of entry into an industry depends on the barriers to entry that are present. If the barriers are high the threat of entry is low.

There are six major sources of barriers to entry:

Economies of scale.

Economies of scale deter entry by forcing the entrant to come in at large scale and risk strong reaction from existing firms or come in at a small scale and accept a cost disadvantage, both of which are undesirable options. In the Pharmaceutical industry economies of scale that are entry barriers are in research and marketing & sales force size with large multinational corporations (MNCs) that are strong in research and marketing being the best performers in the industry.

Product differentiation

Large established firms have brand identification and customer loyalties stemming from past advertising and customer service and their being first in the industry. This barrier to entry in the pharmaceutical industry is very well developed because the MNCs which come in with innovator products (original brands) are usually able to entrench themselves in the market through heavy advertising to medical personnel. This is further helped by patent protection where patents for up to 20 years are given to research companies before generics can be introduced into the market.

Capital requirements.

The need to invest large financial resources in order to compete creates a barrier to entry. In the pharmaceutical industry research is capital intensive as well customer credit facilities. With increasing competition from many entrants and economic recession in

Kenya, companies are being forced to have credit facilities for customers and this has become a major entry barrier.

Switching costs

Switching from one supplier to another is not a major barrier in the pharmaceutical industry but retraining new employees is, because products are very specific with high differentiation.

Access to distribution channels

This is not an entry barrier in the pharmaceutical industry with the presence of many established distributors willing to stock many different products.

Government policy .

This has become a very major barrier to entry with the passing of the Industrial property bill which allows parallel importing and compulsory licensing for essential drugs and especially antiretroviral drugs (Pharmaceutical Society of Kenya,2001). This has affected the MNCs adversely as they are no longer patent protected on the essential drugs.

In the U.S , during the 1980s the profitable lifetime for drugs- the time companies have to recoup development costs and build future drug development was greatly shortened. This is due to passage of the drug Price competition and Patent term restoration act of 1984 which allowed quick approval of generic products. This has intensified competition in the pharmaceutical markets. For example Tagamet- a drug used to treat ulcers which was introduced in 1977,had an exclusive period of only 6 years before Zantac- a drug in the same class was introduced.

Intensity of rivalry among existing competitors

Rivalry among existing competitors takes the familiar form of jockeying for position using tactics like price wars, advertising wars, new product introductions and increased customer service. In the pharmaceutical industry all of these are very common tactics and are leading to decreased profitability. Rivalry occurs because one or more competitors either feels the pressure, or sees the opportunity to improve position. In most industries, competitive moves by one firm have noticeable effects on its competitors and may incite retaliation or efforts to counter the move. This pattern of action and reaction may or may not leave the initiating firm and the industry as a whole much better off.

Some forms of competition, notably price competition may leave the industry worse off from the standpoint of profitability. Price cuts are quickly and easily matched by rivals, and once matched, they lower revenues for all firms. Advertising battles, on the other hand may expand demand or enhance the level of product differentiation in the industry for the benefit of all firms. Where the product is perceived as a commodity or near commodity, choice by the buyer is largely based on price and service, and pressures for intense price and service competition result. Product differentiation, on the other hand creates layers of insulation against competitive warfare because buyers have preferences and loyalties to particular sellers.

In the Pharmaceutical industry, price wars do exist. Large price differences between branded and generic products has intensified this war with MNCs trying to lower the prices of their branded products to at least approximate that of similar generic products. This move is mainly aimed at capturing business from buyers who float tenders for medicines by generic name. Tendering by generic name or physician prescribing by

generic name is likely to intensify this war, since product differentiation strategy may not work under these circumstances.

Over the past decade, generic drugs have more than doubled their share of the prescription market- from 18.6 percent at the end of 1984, to 47.1 percent in 1999 (The changing pharmaceutical marketplace, 2000). The large number of innovator products due to lose patent protection over the next 10 years will foster robust growth in the pharmaceutical industry. Although some brandname companies own and operate generic subsidiaries, the commodity nature of the generic drug business will not sustain R&D programs.

Funds available for R&D depend on the ability of companies to discover, patent, and bring to market a steady stream of innovative products. (The changing Pharmaceutical marketplace, 2000)

Threat of substitute products

This force is anticipated to become quite strong especially with the passing of the industrial property bill which will allow local manufacturing of generics to substitute branded original products. With poverty on the rise in Kenya, many people are opting for cheaper generic drugs rather than branded drugs which are more expensive.

Increasing emphasis on generic substitution by managed care organisations has led to more rapid share erosion for originator products once their patents expire. For originator products first facing generic competition in 1989-1990, generics gained 47 % of the market share after 18 months. For drugs whose patents expired in 1991-1992 generic competition claimed 72 % of prescriptions after 18 months (Grabowski, and Vernon, 1995).

Bargaining power of suppliers

Suppliers in this industry do not constitute a major force in the industry. There are many suppliers for raw materials as well as packaging and since the pharmaceutical Industry globally has a very high turnover, it constitutes a very important client group to these suppliers and so it has a lot of bargaining power.

Bargaining power of buyers

This is the newest threat to the industry and is slowly eroding away profits (Ndung'u, 2001). With the high rate of poverty in Kenya many final consumers cannot easily afford products at very high prices. The government has also cut its budget on medicines as it cuts the budget on health (Wangombe 1997). With high rate of literate populations compared to the 1980's Customers are more informed and are demanding for better service with every purchase they make.

However, the greatest threat from buyers has come with the rising numbers of Health Maintenance Organisations which exude a lot of power against the Industry. These buyers can force down prices, or demand higher quality or more service. To do this, they may decide to play producers against each other or refuse to buy from any single producer.

2.6 Characteristics of a successful buyer group

According to Michael Porter (1980), a buyer group is successful if the following characteristics are met:

Large volume purchases relative to seller sales

HMOs purchase large quantities of drugs because of the large numbers that they serve.

When one single buyer purchases a large percentage of a seller's goods this raises their importance and gives them a lot of bargaining power. In this way, HMOs are able to dictate to the pharmaceutical industry at what prices they will buy. This would bring down the prices of medicines and hence cut down the industry's profitability.

The products purchased are standard or undifferentiated.

Despite the fact that many companies have branded their products, there are many alternative drugs available to treat one condition or even the same medicine going under different brand names. In this way the HMOs may force the companies to bring down prices by putting them in competition with one another resulting in price wars. This will also cut down the profitability of the industry.

The buyer faces low switching costs.

There are few or no costs in switching from one supplier to another hence an HMO may be able to move freely from one supplier to another without being locked into one.

The industry's product is unimportant to the quality of the buyers' products or services.

When the quality of the buyer's product is very much affected by the industry's product, buyers are generally less price sensitive. In the case of drugs, HMOs may want to believe that all drugs marketed in Kenya are duly licensed and of standard quality.

This would hold true if the Regulatory authorities- Ministry of Health have a good system to ensure quality is maintained.

These conditions are all met in the case of HMOs as the buyer in their relationship with the Pharmaceutical Industry players as the suppliers. This therefore means that HMOs have a lot of bargaining power and can cut down the industry's profitability.

According to Avegoropoulos, 2000, a firm can limit the power of buyers by controlling the above factors, for example by differentiating its' products. A firm can also limit the power of buyers by targeting and selling to buyers who possess the least power to influence it adversely. In general a company can only sell profitably in the long term to powerful buyers if it is a low cost producer or if its product is sufficiently differentiated. If the company lacks both, each sale to a powerful buyer makes the company more vulnerable, and targeting and selling to the weaker buyers only becomes very important .

In America, Companies have responded to the cost containment pressures by HMOs by increasingly forming strategic alliances. The total number of such alliances grew from 121 in 1986 to 712 in 1998. These alliances are diverse and involve domestic and foreign pharmaceutical companies, biotech firms, contract research organisations or other parties. Companies have also responded by forming mergers or acquisitions. This has had the effect of slowing down employment in the pharmaceutical industry. According to the bureau of labour statistics annual employment growth in the industry averaged a healthy 2.9% during 1983-1993. Since 1993 when it peaked at 264,000, it has since declined to about 260,300 in 1997 (Pharmaceutical Research and Manufacturers of America ,2000).

Another response of the industry has been the formation of specialized companies called Pharmacy Benefit managers which emerged from insurance claims processing and mail order prescription processing. These provide managed pharmacy benefits for approximately half the insured population in the United States (Ngau and Chege , 1993).

In Kenya some companies have responded to this threat by differentiating their products through aggressive advertising. The creation of a position of 'Key account Manager' to manage selling to these organisations is another response. Intense competition from generic drug companies has also forced down prices for example of antiretroviral drugs used to treat HIV-AIDS.

Pharmaceutical Industry on the threat of increasing power of buyers

3.2 Population

The population for this study consisted of all the 32 pharmaceutical manufacturers and distributors listed with the Pharmacy and Poisons Board and Drug and Chemists. The list is presented as Appendix 2. All the 32 firms were used in the survey.

3.3 Data collection

A structured questionnaire was used. The questionnaire was divided into two sections. Section A contained general information on the firms (questions 1-4). Section B contained information on the Strategic responses of the Pharmaceutical firms to the emergence of HMOs (questions 11-14). The questionnaire was self administered.

3.4 Data analysis

Data analysis was carried out using SPSS software. Basic descriptive statistics. Results were presented globally for the pharmaceutical industry as a whole and also broken down according to the sector.

RESEARCH METHODOLOGY

3.1 Introduction

The study design was a survey that collected cross-sectional data from firms in Pharmaceutical Industry on the threat of increasing power of buyers.

3.2 Population

The population for this study consisted of all the 32 pharmaceutical manufacturers and distributors listed with the Pharmacy and Poisons Board and Drugs and Chemists. The list is presented as Appendix 2. All the 32 firms were used in the survey.

3.3 Data collection

A structured questionnaire was used. The questionnaire was divided into two sections. Section A contained general information on the firms (questions 1-4). Section B contained information on the Strategic responses of the Pharmaceutical firms to the emergence of HMOs (questions 13 -24). The questionnaire was self-administered.

3.4 Data analysis

Statistical analysis was carried out using SPSS software- classic descriptive statistics.

Results were presented globally for the pharmaceutical industry as a whole and also broken down according to the sector.

RESEARCH FINDINGS

4.1 Summary of responses

As shown in table 1, out of the 32 companies that were surveyed only 20 responded. This represents a response rate of 63%. Multinational Corporations represented 40 % of the firms, local manufacturers represented 10% of the firm, Distributors were 40% and 10 % wholesalers. One of the firms that did not respond cited reasons of confidentiality of data, while the rest were not willing to give their time to fill the questionnaire.

4.2 Biographical data

50 % of the firms produced or marketed branded products, 20% produced or marketed generic products, and 30% produced or marketed both branded and generic products. All multinationals produced branded products with one producing both branded and generic products. The distribution of companies according to the type of pharmaceutical firm and the type of product marketed is shown in table1 below.

Table1: Distribution of responses by type of Firm and Product

Pharmaceutical firm	Type of product			
	Branded	Generic	Both	Total
Multinational	7 (87.5%)	0	1 (12.5%)	8 (40%)
Local manufacturer	0	0	2 (100%)	2 (10%)
Distributor	3 (37.5%)	3 (37.5%)	2 (25%)	8 (40%)
Wholesaler	0	1 (50%)	1 (50%)	2 (10%)
Total	10 (50%)	4 (20%)	6 (30%)	20 (100%)

4.3 How firms respond to the bargaining power of HMOs

Out of the 20 companies surveyed, only three of them (15%) did not have any HMO as their customer. One was a multinational, one a distributor and the other a wholesaler. These three companies did not therefore proceed with the rest of the questionnaire.

This study sought to establish how pharmaceutical firms operational in Kenya have responded to the bargaining buying power of HMOs. To this end data was obtained on volume of purchases that HMOs make relative to other customers, prices charged to HMOs vis-a vis other customers, HMOs use of substitute products, relative cost of doing business with HMOs, relative bargaining power of HMOs, special attention given to HMOs., use of merger and strategic alliance, and development of strategies for bargaining with HMOs. The data collected on these issues are presented below.

4.3.1 Volume of purchases

In question 7 respondents were asked if HMOs make large volume purchases relative to other buyers.

Table 2: Volume of purchases by HMOs compared to other customers

Volume of purchase higher than other customers	Yes	No	Total
Firm			
Multinational manufacturer	3 (42.86%)	4 (57.14%)	7 (100%)
Local Manufacturer	1(50 %)	1(50%)	2 (100%)
Distributor	3 (42.86%)	4 (57.14%)	7 (100%)
Wholesaler	0 (0%)	1 (100%)	1 (100%)
Total	7 (41.18%)	10 (58.82%)	17 (100%)

41.2% of the respondents felt that HMOs make large volume purchases compared to their other customers, while 58.8 % felt the purchases were of the same quantity with those of other customers.

4.3.2 Price levels

The respondents were required in items 8 through 11 in the questionnaire to rate the level of prices for the products on the formulary list for HMOs in relation to the products they sell and to show the percentage differences in the prices if any; rate how frequently HMOs bargain for price reductions; and rate HMOs use of their bargaining power to obtain preferential prices. The findings are presented in tables 4.4.1 (a) to 4.4.1 (d)

Table 3 : Difference between the prices of the products on formulary list and those outside the formulary list

Prices Firm	Higher	Same	Lower	Total
Multinational manufacturer	1 (14.29%)	3 (42.86%)	3 (42.86%)	(7) 100%
Local Manufacturer	0 %	1(50%)	1 (50%)	2 (100%)
Distributor	0 %	3 (42.86%)	4(57.14%)	7 (100%)
Wholesaler	0%	1(100%)	0%	1(100%)
Total	1 (5.88%)	8 (47.06%)	8 (47.06%)	17 (100%)

As shown in table 3, 47.1 % of the companies priced their products to HMOs at a lower price than to other customers, 47.1 % priced them at the same price and 5.9% priced them higher. For those that priced them lower the discount given was an average of 20%.

Table 4 : Frequency of Bargain by HMOs for Price Reduction

Frequency of Bargain						
Firm	Always	Often	Sometimes	Rarely	Never	Total
Multinational manufacturer	4 (57.14%)	1 (14.29%)	0%	0 %	2 (28.57%)	7 (100%)
Local Manufacturer	0%	0%	2 (100%)	0%	0%	2 (100%)
Distributor	3 (42.86%)	3 (42.86%)	1(14.29 %)	0%	0%	7 (100%)
Wholesaler	1 (100%)	0%	0%	0%	0%	1 (100%)
Total	8 (47.06%)	4 (23.53%)	3 (17.64%)	0%	2 (11.76%)	17 (100%)

From table 4, it appears that the frequency of bargain for price reductions is highest among multinational firms followed by distributors .The practice is lowest among the wholesaler firms. In total 47% of the firms that responded answered that HMOs always bargain for lower prices.

Table 5a: HMOs Bargaining power in price setting

Level of Bargaining Power						
Firm	Very strong	Strong	Moderate	Weak	Very Weak	Total
Multinational manufacturer	0%	2 (33.3%)	4 (66.67%)	0%	0%	6 (100%)
Local Manufacturer	0%	0%	2 (100%)	0%	0%	2 (100%)
Distributor	0%	2 (28.57%)	5 (71.43%)	0%	0%	7 (100%)
Wholesaler		1 (100%)				1 (100%)
Total	0%	5 (31.25%)	11 (68.75%)	0%	0%	16 (100%)

It is evident from table 5a that all the respondents felt that HMOs had at least some moderate power in forcing down prices. 68.75 % of the respondents felt that HMOs had moderate bargaining power in forcing down price reductions, while 31 % felt the power to bargain was strong.

Table 5 b: HMOs Bargaining Power Relative to other Buyers

HMO's Relative Bargaining Power						
Firm	Much Higher	Higher	Same	Lower	Much Lower	Total
Multinational manufacturer	1 (16.67%)	3 (50%)	2 (33.33%)	0%	0%	6 (100%)
Local Manufacturer	0%	1 (50%)	1 (50%)	0%	0%	2 (100%)
Distributor	0%	4 (57.14%)	3 (42.86%)	0%	0%	7 (100%)
Wholesaler	0%	1 (100%)	0%	0%	0%	1 (100%)
Total	1 (6.25%)	9 (56.25%)	6 (37.5%)	0%	0%	16 (100%)

As shown in table 5b, HMOs bargaining power relative to other buyers is perceived as being higher by 56.25% of the respondents and the same as other buyers by 37.5%. 6.25 % felt it was much higher and none of the respondents felt it was lower than for other buyers.

4.3.3 : Use of Substitute Products by HMOs

Item 12 in the questionnaire asked the respondents to indicate how frequently HMOs buy substitute products. The findings are presented in table 6.

Table 7: Relative costs of doing business with HMOs

Table 6: Frequency of use of substitute Products by HMOs

Use of Substitute Products						
Firm	Always	Often	Sometimes	Rarely	Never	Total
Multinational manufacturer	4 (57.14%)	1 (14.28%)	2 (28.57%)	0%	0%	7 (100%)
Local Manufacturer	0%	0%	1 (50%)	1 (50%)	0%	2 (100%)
Distributor	1 (14.28%)	5 (71.43%)	1 (14.28%)	0%	0%	7 (100%)
Wholesaler	0%	1(100%)	0%	0%	0%	1 (100%)
Total	5 (29.41%)	7 (41.18%)	4 (23.53%)	1 (5.9%)	0%	17 (100%)

As shown in table 6, 29 % of the respondents had HMOs substituting their products always and another 41 % had HMOs substituting their products often. There is no respondent who has never had an incident of substitution of their product by a HMO.

4.3.4 (a): Relative cost of doing Business with HMOs

The respondents were asked to rate the level of costs they incur in doing business with HMOs compared to their other customers. The results are presented in table 7 below.

Table 7: Relative costs of doing business with HMOs

Level of costs						
Firm	Much higher	Higher	Same	Lower	Much lower	Total
Multinational manufacturer	1 (14.29%)	3 (42.86%)	2 (28.57%)	1 (14.29%)	0%	7 (100%)
Local Manufacturer	0%	1(50%)	0%	1 (50%)	0%	2 (100%)
Distributor	0%	4 (57.14%)	3(42.86%)	0%	0%	7 (100%)
Wholesaler	0%	1 (100%)	0%	0%	0%	1 (100%)
Total	1 (5.9%)	9 (52.94%)	5 (29.41%)	2 (11.76%)	0%	17 (100%)

Costs of doing business with HMOs were deemed much higher by about 6% of the respondents, higher than for other customers by 52.94% of the respondents, equal by 29% and lower by 11.76% of the respondents.

4.3.4 b) : Costs that are unique to doing business with HMOs.

Respondents were asked to indicate any costs they incur in doing business with HMOs which they do not incur in their business dealings with other customers.

The following were identified as costs unique to HMOs:

• Lots of visits	Yes	No	Total
• Supply of materials Product information leaflets	3 (50%)	3 (50%)	6 (100%)
• Extra discounts			
• Delivery of products even if volume is small	2 (100%)		2 (100%)
• They come for annual audits and companies have to spend a lot of time to prepare.			
• Demand Special favours- promotional items like bags and writing pads, demand for sponsorships to congresses, which is costly			

It was found that some companies have employed special sales representatives to deal

4.3.5 Staff employed to deal with HMOs

In questions 15 to 17 respondents were asked if they employed special sales representatives or assigned managers to deal specifically with HMOs. They were also asked when they first employed these staff dedicated specifically to HMOs.

The results were as presented in tables 8 and 9.

Respondents were asked if they make formal marketing plans in their firms and if any of

Table 8: Sales representatives employed to deal with HMOs only

Firm	Yes	No	Total
Multinational manufacturer	3 (50%)	3 (50%)	6 (100%)
Local Manufacturer	0 (0%)	2 (100%)	2 (100%)
Distributor	0 (0%)	4 (100%)	4 (100%)
Wholesaler	0 (0%)	5 (100%)	5 (100%)

Table 9: Manager (s) assigned to deal with HMOs only

Firm	Yes	No	Total
Multinational manufacturer	1 (16.67%)	5 (83.33%)	6(100%)
Local Manufacturer	0 (0%)	2 (100%)	2 (100%)
Distributor	0 (0%)	7 (100%)	7 (100%)
Wholesaler	0 (0%)	5 (100%)	5 (100%)

It was found that some companies have employed special sales representatives to deal with HMOs; one company had both sales representatives and a manager dedicated to HMOs. All the companies that employed staff dedicated to HMOs were Multinational firms. None of the other companies had staff dedicated to deal with HMOs only.

4.3.6: Marketing Plans

Respondents were asked if they make formal marketing plans in their firms and if any of the marketing strategies are tailored to capture business from HMOs. They were also asked if they formulated a strategy for product differentiation for their products. The results are presented in tables 10,11 and 12.

Table 10: Formal Marketing Plans

Firm	Yes	No	Total
Multinational manufacturer	7 (100%)	0%	7 (100%)
Local Manufacturer	1 (50%)	1 (50%)	2 (100%)
Distributor	4 (57.14%)	3 (42.86%)	7 (100%)
Wholesaler	1 (100%)	0 (0%)	1 (100%)
Total	13 (76.47%)	4 (23.52%)	17 (100%)

As shown in table 10, 76% of the respondents do make marketing plans while 24 % do not. Making of formal market plans is practiced by 100% of the Multinational manufactures and wholesalers, 50% of the Local manufacturers and by 57% of the distributors.

Table 11: Marketing Plans Tailored to Capture HMO Business

Firm	Yes	No	Total
Multinational manufacturer	4 (66.67%)	2 (33.33%)	6 (100%)
Local Manufacturer	1 (100%)	0 (0%)	1 (100%)
Distributor	3 (50%)	3 (50%)	6 (100%)
Wholesaler	1 (100%)	0 (0%)	1 (100 %)
Total	9 (69.23%)	4 (30.77%)	13 (100%)

As shown in table 11, 69.2% of the companies that make formal marketing plans have strategies that are geared towards capturing business from HMOs s, while the other 30.8 % of the strategies are not tailored to capture HMO business. 50% of the distributors tailor their marketing plans to capture HMO business while 50 % do not. 100% of the Local manufacturers and 100% of the Wholesalers also tailor their business to capture HMO business.

Table 13: Firm longevity: 1993-2003

Table 12: Use of Differentiation Strategy

Firm	Yes	No	Total
Multinational manufacturer	7 (100%)	0 (100%)	7 (100%)
Local Manufacturer	0 (0%)	2 (100%)	2 (100%)
Distributor	4 (57.14%)	3 (42.86%)	7 (100%)
Wholesaler	1(100%)	0 (0%)	1 (100%)
Total	12 (70.58%)	5 (29.41%)	17(100%)

From table 12, it is evident that 70 % of the respondents do have a strategy for product differentiation. It is also evident from the table that all the multinational manufacturers have strategies for product differentiation while all the local manufacturers do not. 57% of the distributors and 100% of the Wholesalers also use product differentiation Strategy. The First firm to implement this strategy was a Multinational firm in 1990 and the last firm implemented it in 2000.

4.3.7 Involvement in Mergers/Strategic Alliances in the period 1993 to 2003

In question 21, Respondents were asked if their firms had been involved in a strategic merger or alliance in the last 10 years and what were the main reasons for the mergers or alliances. The results are presented in table 13.

Table 13: Firm involvement in a Merger/Alliance in the Period 1993-2003

Firm	Yes	No	Total
Multinational manufacturer	4 (66.67%)	2 (33.33)	6 (100%)
Local Manufacturer	1 (50%)	1 (50%)	2 (100%)
Distributor	2(28.57%)	5 (71.43%)	7(100%)
Wholesaler	0 (0%)	1 (100%)	1 (100%)
Total	7 (43.75%)	9 (56.25%)	16 (100%)

As shown in table 13, 43% of the firms that responded had been involved in a strategic merger or alliance in the period 1993-2003. Multinational firms were the most affected by mergers as 67 % of them had undergone a merger or strategic alliance in this period compared to only 28 % of distributors. Wholesalers were not involved at all.

4.3.7 (b) Reasons given for undergoing Mergers or Alliances

The main reasons given by firms for undergoing Mergers or Strategic Alliances are as follows;

- To increase profitability
- To fight competition better
- Lack of patent protection
- To strengthen Research and development activities hence more new products
- To strengthen managerial capacity and information systems
- To get synergy in Marketing, Sales and Research and Development.
- Lower operation costs and get lower product costs

4.3.8 Strategies Put in Place By Pharmaceutical Firms to Respond to the Bargaining Power of HMOs

In question 23, Respondents were asked if they have put in place any strategies in order to have the upper hand when bargaining with HMOs. The responses were as follows.

Table 14 : Strategies Put in Place to Respond to the Bargaining Power of HMOs

Firm	Multinational	Local manufacturer	Distributor	Wholesaler	Total
Strategy					
Branding & promoting the product	2 (50%)	0 (0%)	1 (25%)	1 (25%)	4 (16%)
Close relationships, being a customer of HMOs	0 (0%)	0 (0%)	3 (100%)	0 (0%)	3 (12%)
Giving discounts, bonuses	2 (50%)	0 (0%)	2 (50%)	0 (0%)	4 (16%)
Added services to HMOs such as, Education through congresses, clinical trial support	4 (100%)	0 (0%)	0 (0%)	0 (0%)	4 (16 %)
High quality products, quality services, trained staff	1 (33.33%)	2 (67.67%)	0 (0%)	0 (0%)	3 (12%)
Innovative or exclusive products, wide range of products	1 (33.33%)	0 (0%)	2 (67.67%)	0 (0%)	3 (12%)
Patenting company's products	1 (100%)	0 (0%)	0 (0%)	0 (0%)	1 (4 %)
Key Account Manager to deal with HMOs	1 100%)	0 (0%)	0 (0%)	0 (0%)	1 (4%)
Stringent credit terms	0 (0%)	0 (0%)	2 100%)	0 (0%)	2 (8%)
Total	12 (48%)	2 (8%)	10 (40%)	1 (4%)	25 (100%)

From table 14, It appears that companies have indeed come up with certain strategies to respond to the HMOs' bargaining power. The most common strategies are branding, giving discounts and providing added services, each strategy comprising 16% of the total number of strategies. Other commonly used Strategies to respond to HMOs' bargaining power include Quality Products and Services (12%), Good Personal Relationships (12%) and Innovative or Wide Range of Products (12%). Other less commonly used Strategies include Patenting Products (4 %), employing a Key Account Manager in charge of HMOs (4%) and Stringent Credit Terms for HMOs (8%).

Multinational firms have put in place more strategies to deal with HMOs' bargaining power than all other firms 48%). These are followed by Distributors (40%), then Local Manufactures (8%). Wholesalers have the least strategies to deal with HMOs bargaining power (4%).

The Strategy used most by Multinational Firms is Providing added Value such as Education and Clinical Trial Support (100% of the Firms). The Most common Strategy with Local Manufacturers is Providing High Quality Products and Services (67%).

The most common Strategy with Distributors is Providing Innovative or Wide range of Products (67%), and with Wholesalers it is Branding (25%).

5. DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

HMOs have tremendous bargaining power in the Pharmaceutical industry. They are a powerful buyer group that possess the characteristics of a powerful buyer group as identified by Porter (1980). They make large volume purchases and are seen to have a lot of bargaining power in the Pharmaceutical industry (rated moderate- strong) and stronger than other buyers.

HMOs reduce the profitability of the industry by forcing down prices and also demanding for services that increase the cost of doing business with them. The cost of doing business with HMOs was rated higher by 45 % of the companies. The price discounts given averaged 20%. This means that HMOs buy at lower prices and also have higher costs of service delivery hence decreasing the industry profitability. The increased costs come from demand for transportation of the goods during delivery, demand for donations and free samples, promotional items like writing pads, pens, bags. HMOs also require lots of documentation with every purchase hence bureaucracy.

Three Pharmaceutical companies also have sales representatives dedicated to HMOs. This obviously increases the costs for the company. One company has a manager assigned to HMOs only.

In addition to bringing down Industry profitability, HMOs also substitute products with cheaper generics or therapeutically equivalent products. This amounts to loss of business to the companies. This affects the multinationals who market branded products and distributors of multinationals more than the local manufacturers who sell cheaper generics.

As shown by the findings of this research, Pharmaceutical companies have put in place strategies to counter the bargaining power of HMOs. One such measure is strategic mergers and alliances. 7 companies (representing 43.8 %) have been involved in mergers in the last 10 years. This period corresponds to the period when HMOs mushroomed. The mergers were mainly of international nature affecting 4 multinationals, 2 distributors and 1 local manufacturer.

This matches what has been found in America (Pharmaceutical Research and Manufacturers of America, 2000).

Another response involves differentiating of products. Companies have established marketing plans with differentiation of their products being a key strategy. 7 companies cited this strategy as one of the strategies put in place in order to have an upper hand when dealing with HMOs. Other strategies involve giving price discounts, although this leads to price cuts being quickly matched by rivals and therefore intense price wars in the industry which eventually lower profitability. Hence this strategy is not recommended.

Other responses by the Pharmaceutical companies involve building closer personal relationships with HMOs. One company has done this by being a customer of one major HMO. Giving added services like education are also used in order to win over HMOs as customers. Giving high quality service and also having high quality products are other strategies used in the industry when dealing with HMOs.

Other less frequently used strategies are patenting products and stringent credit terms to avoid company profitability being eroded by lack of payment in time. Another response involves controlling the HMOs the company will deal with. This strategy is useful in limiting the power of buyers (Avegoropoulos, 2000).

According to Avegoropoulos, 2000, a company can only sell profitably in the long run by limiting the power of buyers which can be done by controlling the characteristics which make the buyer group successful or powerful. This involves differentiating its products and selling to less powerful groups.

One of the characteristics which make the HMOs powerful is lack of government controls or regulation in this industry. This has been cited by several companies. A bill is pending in parliament to bring HMOs under the Insurance act (Makove, 2003). This should introduce certain controls and limit the number of cost containment techniques that they can use and also limit their bargaining power hence restoring industry profitability.

5.2 CONCLUSION

Due to the gap in delivery of health services arising from inadequate resource allocation for health by the government, HMOs are continuing to enter this market. Since they are in the market in order to realise profits, they have put in place systems which ensure maximisation of profits by lowering the costs of health delivery to their clients and negotiating or demanding for the lowest possible prices from the Pharmaceutical companies. In this study it was found that the cost of doing business with HMOs was rated higher than that of other buyers by 45 % of the companies. The price discounts given averaged 20%. HMOs were found to constitute a powerful buyer group in the pharmaceutical industry

It was found that the Pharmaceutical companies have realigned their business strategies to counter this powerful group. These strategies include formation of strategic alliances and product differentiation among others.

Despite the cost cutting measures that HMOs have put in place, a number of them have in the recent past closed their operations. 'HMOs appear not to be doing well for example Medex and Mediplus closed in June 2003 and AAR is re-organising '. (Dr Barnabas Bwambok , Key Account Manager in charge of HMOs, Aventis Pasteur).

5.3 RECOMMENDATIONS

1. Regulations should be put in place by the government to ensure HMOs operate within the Insurance Act. This should be bring down some of their powers.
2. Pharmaceutical companies should sit together and agree on the price discounts, if any that should be given to HMOs in order to stop propagating a price war between them.
3. Multinational companies whose products are almost always substituted by HMOs for cheaper ones, should embark on a differentiation strategy to lessen this threat.

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APPENDIX 1

QUESTIONNAIRE

SECTION A: GENERAL INFORMATION

1. Name of organisation

_____ (optional)

2. Name and position in the firm

_____ (optional)

3. Type of Pharmaceutical firm

Multinational []

Local manufacturer []

Distributor []

Wholesaler []

Any other, specify []

4. Do you produce or market branded or generic products?

Branded []

Generic []

Both []

SECTION B: STRATEGIC RESPONSE OF PHARMACEUTICAL FIRMS TO THE EMERGENCE OF HMOs

5. Do you have any Health Management Organisation or Health Insurance company as your customer?

Yes []

No []

6. When did you first have an HMO as a customer? _____

7. Do HMOs make large volume purchases relative to your other customers?

Yes []

No []

8. How are your products on the formulary list for HMOs priced relative to the price on your general price list?

Higher []

Same []

Lower []

9. If higher or lower, by approximately what percent is the difference in pricing?

Rate the extent to which the following apply

10. How often HMOs bargain for a price reduction

Never []

Rarely []

Sometimes []

Often []

Always []

11. Rate HMO's use of bargaining power to force you to sell to them at reduced prices by probably threatening not to purchase from you or to purchase from your competitor e.t.c?

Very Weak []

Weak []

Moderate []

Strong []

Very strong []

12. Substitution of your products by the HMOs for another therapeutically equivalent one or for a generic.

Never	[	]
Rarely	[	]
Sometimes	[	]
Often	[	]
Always	[	]

13. Compare the cost of doing business with HMOs with that for other buyers (such as delivery costs, provision of information e.t.c)

Much lower	[	]
Lower	[	]
Same	[	]
Higher	[	]
Much higher	[	]

14. Compare the bargaining power of HMOs with that of other buyers as regards prices.

Much lower	[	]
Lower	[	]
Same	[	]
Higher	[	]
Much higher	[	]

15. Do you have special sales representatives dealing specifically with HMOs?

Yes	[	]
No	[	]

16. Do you have a manager assigned to deal specifically with HMOs ?

Yes	[	]
No	[	]

17. When did you first employ special sales representatives or managers assigned to deal specifically with HMOs?

18. Do you make formal marketing plans in your firm?

Yes []
No []

19. If yes, are any of your marketing strategies tailored to capturing business from HMOs?

Yes []
No []

20. Do you have a strategy for product differentiation for your products?

Yes []
No []

If yes, When did this begin? _____

21. Has your firm been involved in a strategic merger or alliance in the last 10 years?

Yes []
No []

If yes, what were the main reasons for this merger or alliance?

22. What costs, if any, do you incur when dealing with HMOs which are not incurred with your other buyers?

23 . What strategies has your firm put in place in order to have the upper hand when bargaining with HMOs?

LIST OF PHARMACEUTICAL MANUFACTURERS AND DISTRIBUTORS

1. Bata Healthcare International

2. Cosmos Ltd

3. Didi Pharmaceuticals

24 . If you have any other comments on HMOs which are not captured in this questionnaire please note them down below.

4. Gesio Pharmaceutical Ltd

5. Glaxo Smithkline Ltd

6. Laboratory and Allied Ltd

7. Merck Pharmaceuticals Ltd

8. Pharmaceutical products Limited

9. Proctor and Gamble (E. Africa) Ltd

10. Regal Pharmaceuticals

11. Spharx Pharmaceuticals

12. Universal Pharmacy Ltd

13. Novelty Manufacturing Ltd

14. UB Pharma Kenya Ltd

15. Bayer E Africa Ltd

16. Infusion Kenya Ltd

17. Highchem Pharmaceuticals

18. Aventis Pasteur S.A (E. Africa)

19. Novartis E. Africa

20. Birkbecker Ingelheim division

LIST OF PHARMACEUTICAL MANUFACTURERS AND DISTRIBUTORS

1. Beta Healthcare International
2. Cosmos Ltd
3. Didy Pharmaceuticals
4. Elys Chemical industries
5. Gesto Pharmaceutical Ltd
6. Glaxo Smithkline Ltd
7. Laboratory and Allied Ltd
8. Mac's Pharmaceuticals Ltd
9. Pharmaceutical products Limited
10. Proctor and Gamble (E. Africa) Ltd
11. Regal Pharmaceuticals
12. Sphinx Pharmaceuticals
13. Universal Pharmacy Ltd
14. Novelty Manufacturing Ltd
15. UB Pharma Kenya Ltd
16. Bayer E.Africa Ltd
17. Infusion Kenya Ltd
18. Highchem Pharmaceuticals
19. Aventis Pasteur S.A (E. Africa)
20. Norvatis E. Africa
21. Boehringer Ingelheim division

22. Eli Lilly & Co. (Suisse) S.A- Kenya
23. Astra Zeneca
24. Pfizer- Warner Lambert
25. Pharmacia Upjohn
26. Roche Products Ltd
27. Surgipharm
28. Howse & McGeorge Laborex Ltd
29. Europa Pharmaceuticals
30. Sandpa Pharmaceuticals
31. Omaera Pharmaceuticals
32. Phillips Pharmaceuticals