



Healthcare: at the crossroads

Healthcare reform today is being avidly discussed in political, social, medical and business circles around the world. In developing countries, the billions of dollars spent on containing the spread of HIV/AIDS and other pandemic diseases such as TB and malaria, are beginning to show some positive results. In Europe, the cost of government-sponsored healthcare is having a negative impact on GDP, while in the US, the Obama Administration is embarking on the country's most ambitious attempt at providing universal coverage for some 47 million plus people in the country without health insurance.

Addressing these issues was the overall theme of the INSEAD Healthcare Alumni Summit, held here earlier this month.



The hands-on, need-for-change tone was set at the start by Elizabeth Teisberg, co-author of *Redefining Healthcare* and healthcare advisor to the US Senate, in her keynote address. In the US, 65 per cent of healthcare costs are “for chronic diseases, long-term care,” states Teisberg, an associate professor at the University of Virginia’s Darden School of Business. “The cost structure, however, is based around acute care,” she adds. “This is a strategic

mis-match.”

Teisberg challenges the debate on universal care now raging in the United States. “The US does have universal care: it’s the emergency room, and care delivered at this; the last stage of a disease or condition is more expensive and less efficient than earlier care. The fact that so many in the US are uninsured drives costs up. US healthcare costs are three times those in Europe.”

“Health is wealth,” contends Dr **Karl Schweitzer** (MBA ‘90D), VP for Medtronic’s Neuromodulation business in Europe, Russia and Central Asia. Schweitzer was one of the co-authors of a white paper bearing the slogan as its name. “We need to get away from the idea that healthcare is a burden; we need to focus on increasing people’s productive lives.”

Schweitzer says Medtronic, which invented the self-sustaining, implantable pace-maker back in the 1960s, is focused on neuromodulation nowadays because it allows the world’s increasingly older population to function more efficiently with

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implanted devices that can stimulate dormant nervous systems, contain pain, and even control incontinence. The company recently received FDA and EU approval for its device to control obsessive-compulsive behaviour (OCD).

But as miraculous as devices such as these may sound, there is a hard bottom line: "Everything we do has to undergo an economic impact evaluation," says Schweitzer. "From the reimbursement point of view, will it pay for itself?"

"Healthcare is expensive," says Roche Vice-Chairman **Andre Hoffmann** (MBA '90D), and a member of the INSEAD Board. "Payers can't increase the price they give, hospitals can't deliver proper care, stringent government regulations increase costs and delay entry to market; everyone must do his part to reduce costs."

Hoffmann is also concerned with what he calls a crisis in innovation. "Size and innovation are an inverse correlation," he claims, noting that big companies are loathe to take the risk, the time, and involve the personnel when it's so hard to make back that investment. "Roche research is organised around disease management areas to better identify targets for our efforts, and we will be looking to Genentech (the US pharmaceutical company which Roche bought in its entirety this year) for a lot of R&D."

One of the biggest challenges healthcare faces today is not just innovating for the future, but containing pandemics. HIV/AIDS, TB and Malaria are three of the worst. "There are over 30 million people with HIV today, and some two million new cases a year," says Dr. **Rifat Atun**, Director of The Global Fund to fight AIDS, tuberculosis and malaria. "A third of the world's population is infected with TB, and eight million of those become active each year, and two million of those people die. Malaria infects 250 million people a year, and a majority of the one million deaths per year from that disease are children." Created in 2002, the Global Fund believes it has made some progress in the ensuing seven years.

"On the HIV front, we can say the epidemic has flattened; that is, the rate of increase is going down, as well as the number of deaths from AIDS. In a number of countries we are also seeing the number of pregnant women with HIV/AIDS declining," says Atun. "Concerning TB, 4.5 million people have been put on WHO-approved treatment since 2004, and regarding malaria, installing insecticide-treated bedding nets has significantly decreased death levels."

Delivering healthcare is a challenge everywhere, but it is especially tricky in third world countries

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where corruption and political unrest present huge obstacles. Atun says innovation is the way around all this. "Countries are invited to submit proposals; we're now in round nine and an independent review panel recommends those (or not) to the Board. There are several weeks of intensive evaluation, then contract negotiations between governments and non-state players can take several months. It takes time because these are national projects, ranging from a few million to hundreds of millions of dollars," he says. But some of the Global Fund's funds go to the grass roots, paying for healthcare workers in places such as Malawi. "We have funded a large number of health workers in this region," says Atun. "In some cases, we pay the salaries of existing workers; elsewhere we provide financial incentives and recruitment and retention funds. Retention of health workers is a problem."

Much of the Global Fund's money comes from governments (the US, Japan, the EU and its member countries, particularly France, UK, Italy and the Nordic countries), some six per cent from the private sector and organisations such as the Bill and Melinda Gates Foundation. And then there's cross-marketing at shops such as Starbucks and The Gap. "For each product sold at stores such as these, a percentage of the revenue goes to the Global Fund to be invested in countries," says Atun.

South Africa is one such place; a country that combines both the developed and undeveloped worlds within its borders. **Gert Hoogland** (MBA '85D), arriving from his native Netherlands, founded Pharmaplan a dozen years ago to help small- and medium-sized pharmaceutical companies enter the market. "Many of these smaller companies couldn't by themselves get through some of the government requirements to have a business in South Africa, but they had the drugs that fit the market. So we act as a sort of department store where their goods are displayed on our shelves." Though South Africa is home to the three pandemics that most concern healthcare providers: HIV/AIDS, tuberculosis and malaria, the government does not provide any financial incentives to pharmaceutical companies. "They don't impose any import duties, either, though," says Hoogland, "so it's an open market. And there are advantages to producing locally, especially if you have a Black Economic Empowerment Partner."

There is no way to separate funding care from providing care, participants at the INSEAD healthcare summit concluded, but the measurement tools can be questioned. "This debate on the right percentage of GDP that needs to be spent on healthcare is the wrong debate," says Medtronic's Schweitzer. "The right debate is what we do to keep the population productive longer."

“Healthcare is really two words,” says Teisberg.
“‘Health’ and ‘care.’ And we need to improve both.”

The INSEAD Alumni Healthcare Summit was held in Basel, Switzerland on October 8, with some 150 people from around the globe taking part in panel discussions on three key topics: Reinventing Healthcare Innovation; Consumer Healthcare -- Up Close and Personal, and Healthcare Business in the Age of Globalisation.

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