

Carry on regardless?

How NHS

interaction needs to change



Gaining access to GPs is becoming harder. Traditional methodology is proving less effective. But what is the solution? Charles Joynson offers his own radical solutions in this controversial and thought-provoking piece. Like all visionaries, many of his ideas are unworkable, but the debate is worth having. At the very least, it is not an option for the industry to Carry On Regardless.

Last month, *Pf* looked at the challenges facing drug companies as their relationships with the NHS evolve. The facts made uncomfortable reading: call-rates have steadily dropped while almost a third of GPs are refusing to see medical representatives. The number of details being made to GPs has fallen by 25 percent. But the prospect of meltdown in the relationship appears unlikely. Despite undeniably worrying access statistics, dialogue with sales professionals remains valuable to core NHS customers, with the provision of education, sponsorship and traditional clinical information welcomed by the majority of GPs. There is clearly a balance of positives and negatives in the NHS/pharma relationship. The question remains: how can the relationship improve? This month, we look at some potential solutions. Doing nothing is not

among them.

Surgery time

Let's first consider the surgery time issue. The biggest difference pharma could make would be to move away from 'spec' to a completely appointment-based system. This would have advantages for both NHS and pharma. Economies for pharmaceutical companies would include car and fuel costs. Economies for the NHS would include less reception time lost to the 'spec queue', which is currently one of the main reasons surgeries stop seeing representatives altogether.

Patient focus

How could representatives be made to concentrate on the GP's core priority, patients? Doctors see patients all the time, but most medical representatives don't. To achieve a high degree of patient focus the training process would

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have to change. Moving away from the six week initial training course and toward something altogether more rigorous which might involve contact with patients or patient groups.

Too much push and not enough pull

How can the present 'push' relationship be changed to 'pull', and how can a 'pull' linkage between a doctor who wants advice and a pharma company that can give it, be created? Currently, a GP might call the pharma company and speak to the medical department. But if representatives were trained to deal with diagnosis and patient issues, then the process might be somewhat different.

Dr McSwackle needs to discuss pain control in bone cancer as he has a number of patients still in pain. He discovers there are two

companies that have specialist knowledge in this area, but that one has expertise in an approach he has already tried. At this point he can either go back to talking to the clinicians – who for whatever reason have failed to eliminate his patient's bone pain, or he can ring the second pharma company.

In reality medical situations are not as cut and dried as this. Maybe the pharma company can help, but maybe they can't. But making contact is an effort. It will need a receptionist to make phone call and set up an appointment. Perhaps it would be easier to go on swapping letters with the consultant, or sedate the patient and tell the relatives nothing can be done. Finding the time to see a representative is difficult with a large patient list and a full diary.

How can the pharma company encourage Dr McSwackle to make the call? There are a range of options here, from gifts, through a variety of service offers, to various levels of medical education and sponsorship. However, any chance of linking the appointment with a direct benefit to the doctor has to be avoided, as it may affect clinical judgement.

To avoid these dangers we have little choice but to adapt a technique from another industry: 'carbon offset' becomes 'healthcare

offset'. Healthcare offset would work by compensating the NHS for the time taken out of healthcare by a doctor seeing a representative – let's call it Pharma-Care. Thus the hour the doctor spends talking about bone pain with the representative from the second pharma company is compensated for by sponsorship of patient care in another sector of the NHS. This would result in a win-win situation for the NHS, as not only does it gain sponsorship as a result of the call, but Dr McSwackle is better able to reduce his patient's pain.

Any such system would be web-based, and need to be handled at a central (PCT or DH) level, with a very high degree of probity and transparency.

Weighted Pharma-Care

There is an intrinsic potential for unfairness in the degree of offset for different sorts of pharma/NHS contact. Dr McSwackle had urgent reasons to ask for assistance, but in many instances the motivation is likely to be less urgent, and take the form of breakthrough symptoms or therapy ineffectiveness. Here again we need to adapt an approach from another industry: 'Pay per click'.

In Dr McSwackle's case he might say that any offset for his time could be small, because of the patient's pain and the degree of

urgency. So bone pain might need an offset of one, whilst haemorrhoids might get a ten, meaning that elsewhere in the NHS, a clinician is sponsored for a few minutes to offset Dr McSwackle's hour discussing bone pain. But if he met with the haemorrhoids representative, it might be longer. This information could then be integrated into an appointment system, with a Weighted Pharma-Care rating set by the doctor or his administrators for each disease or diagnosis.

In such a Weighted Pharma-Care system, gifts, hospitality and charity donations suddenly become superfluous. If the pharma company is genuinely there to help, gifts become pointless and hospitality becomes purely functional.

Changing times

There is no reason why Weighted Pharma-care would not work in the current environment, provided representatives are trained well enough to deal with the situation. But would these ideas work in a new HTA driven NHS? The imposition of NICE or HTA formularies would change the pharma/NHS relationship in ways which, unless pharma can get from product to patient-centred selling, would lead to very bleak calls for pharma representatives indeed.

Call rates

Call rates can only be improved if everything else is 'fixed'. Thus they serve as an indicator of the health of the pharma/NHS relationship. If a Weighted Pharma-Care direct sponsorship linkage between pharma and the NHS were formalised and centralised, it would need to be completely transparent for both sides. The aims of pharma and the NHS would need to be met, and in ways that improve patient care.

In Dr McSwackle's case, a high degree of control rested in his hands on behalf of his patients.

Equally, selecting the required degree of offset by diagnosis or therapeutic category would encourage newer, perhaps less well known companies to make contact with doctors who have patients with difficult or unusual diseases, and not to bear a high sponsorship cost in the process.

But how does the doctor choose one company over another in the same therapeutic category? In Dr McSwackle's case there were two companies that specialised in bone pain. In any web-based solution, Dr McSwackle would need to be able to override the default offset of one he had given to bone pain, and make it five or higher for the company he no longer believes can help. Leaving it at one for the company he is interested in talking to.

Thus Dr McSwackle would need to complete a list of his interests with low offset requirements, marginal conditions with medium offset requirements and known, easy or conditions not seen with high offset requirements. If Pharma-Care sponsorship were allowed, then to ensure that transparency and ethical standards were maintained, the website would probably need to be run at the DH / ABPI level, with the devolution of sponsorship offsets back to the PCTs which accumulated them in the first place.

I hope the concepts of offset and weighted Pharma-Care will serve to get discussion going as to how the pharma industry will turn the corner over the next twenty years. If a brick wall collision is to be avoided, the pharma industry will have to adapt to a changing NHS. Negotiating the corner is the only sensible strategy. Straight on won't do, and neither will applying the breaks (withdrawal). The only question is, left or right?

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Does the traditional view of the NHS need to change?