

Is the pharma/NHS relationship heading for meltdown?

With call-rates dropping and the customer-base changing, how can sales professionals demonstrate their true value at the NHS/industry interface? In the first of a two-part series looking at the NHS/pharma relationship, Charles Joynson assesses the current environment.

Almost a third of GPs in today's market refuse to see medical representatives. In turn, industry call-rates have dropped and the number of details being made to GPs has fallen by 25%. But claims that the pharma/NHS relationship is heading towards a meltdown are wide of the mark. The market is changing. So too, must the industry's approach. This month, Pf begins a series of articles looking at the evolving relationship between pharmaceutical companies and their NHS customers. Sales professionals have always played a central role in that relationship. It is highly likely that, in the medium-long-term, this will remain the case. The question is, how?

Meltdown is not an option for the pharmaceutical industry. But a glance at the current environment suggests that serious changes in the NHS/pharma relationship are necessary if that prospect is to be avoided in the long-term. There are, of course, areas where the relationship is working well. Equally, there are companies who are already taking a proactive approach in how they manage their customer interactions. Despite this, however, it is clear that certain aspects of the

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traditional approach to sales and marketing are no longer sufficient. In this first article, we survey the current environment and look at the major challenges facing the industry.

Call rates

The UK pharmaceutical industry is committed to benefiting patients by operating in a professional, ethical and transparent manner to ensure the appropriate use of medicines and support the provision of high quality healthcare. However, even with such ethical ABPI guidelines, the numbers of GPs not seeing reps has increased from under 10% in the late 1980s to over 30% today (mediary & doctors.net.uk). If the current rate continues, by 2020 some 50% of GP surgeries will be closed to representatives, and by 2030 something like 60%. Some experts consider this is an under-estimate. Today, out of 37,500 GPs, only 20,000 see representatives regularly.

Call rates have come down from over three in the late 1980s to approx 2.3 today (Binley's) and between 1999 and 2003 there was a 25% fall in details to GPs (Isis Research). If the pharma/NHS interface was working effectively, this should not be happening!

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The key question is therefore: will it stabilise at some point, bounce back up or continue to fall to meltdown?

Too much push and not enough pull

The relationship is currently one of 'push' from the pharma side. Any element of 'pull' from the NHS side is either small or cloaked by 'reply paid card' giveaway issues. Perhaps too much 'push' is the reason call rates are falling?

Pharma companies have recently begun downsizing their sales forces, but this may be too late to stop the slide. Turning your customer off your products in the pharma industry seems a bad way to run a client/supplier relationship.

The ABPI has even imposed a maximum of three calls per year per GP. However, in a recent Pf article, compliance specialist Steven Gray said this had resulted in mirror territories where several representatives sell the same product to generate the necessary share of voice. As a result, the historically strong personal bond between prescriber and representative is diminished.

The obvious question here is whether the relationship can be turned around, so that doctors see the pharma industry as a resource to be called upon in difficult patient diagnosis or medication issues. Interviews of this sort would be of considerably greater quality, but could they be gained at all?

Surgery time

Not only do medical representatives take up time during meetings and calls, but they also take reception time in their attempts to see doctors on 'spec' and without appointment. When a doctor's time runs short and she finds herself working a 25 hour

day, the easiest thing to offload is pharma contact.

Gifts and hospitality

The danger as stated in section 18.1 of the ABPI code is that gifts or hospitality may affect clinical judgement. The anti-hospitality group Nofreelunch, (<http://www.nofreelunch-uk.org>) is committed to removing the link between prescribing and hospitality by complete probity through transparency.

The maximum value of allowed gifts has been set in the 2006 code to £6 ex VAT. This clause also prohibits items which are intended for personal use.

Charity

Giving to charities as a payment for pharma contact is banned under clause 15.3 of the ABPI Code of Practice. The inherent danger being that there is a linkage between the clinician and the charity. However, clause 18.1 does allow modest donations for attendance at company stands. This is not a contradiction, as attendance at stands is not under the control of the pharma company, and selection of the charity is not in the control of the visiting clinician.

Patient focus

In March 2005 Doctors.net.uk published the results of a survey in which 500 GPs were asked how drug representatives' visits could be improved. The GPs questioned thought that representatives should be more patient focused and concentrate on benefits to both GPs and patients. The number of products discussed in a meeting was also thought to be too high. This begs the question: 'is it possible that the message is being diluted by the number of products promoted in each visit?' True patient focus must be difficult to achieve if you have to cover three or more clinical areas during the call. Moreover;

many representatives have never met anyone with the condition they are discussing.

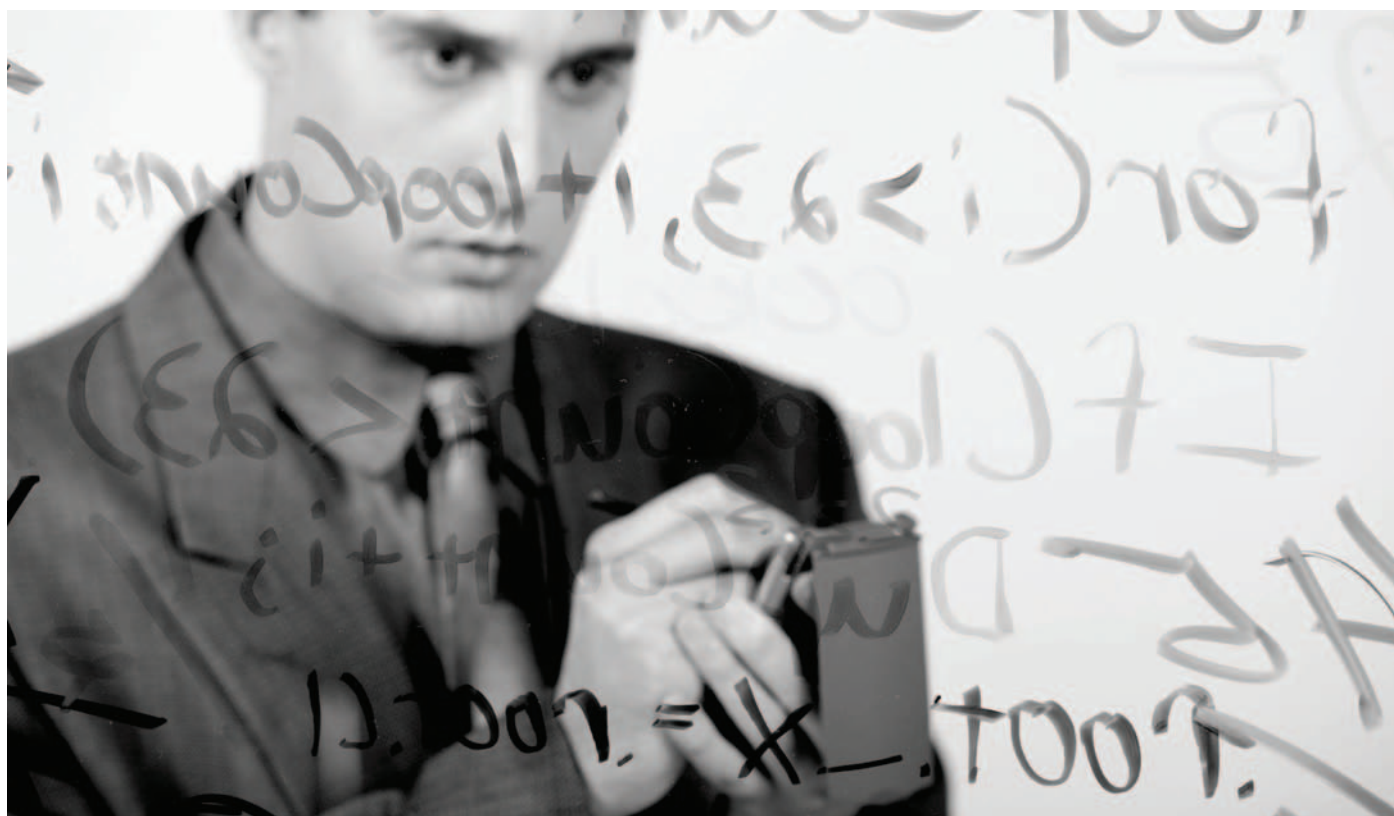
Changing times

Another development concerns the changing customer-base. Payers, and regulatory bodies such as NICE, are taking over the decision-making process. Doctors are being forced down the decision league tables, and may eventually be relegated to deciding on disease codes, which then drive the pharmacist to issue medicines in accordance with formularies or HTA guidelines (Health Technology Assessment).

Additionally, the overall number of new medicines (no more than five years old) being prescribed to British patients is 25% less than in all the major European countries. And the gap is widening. The reason of course is financial. Even when NICE has approved a new drug, PCTs are introducing 'red' lists or formularies of drugs that doctors must not prescribe in a bid to cut costs. And doctors, themselves under pressure to keep within tight budgets, are either refusing patients certain medicines or simply not telling them they are available. Recently the OFT has found that doctors are prescribing brand-name drugs that are up to ten times more expensive than generic products that work just as well. The cost of this is another potential reason drug choice might be removed from the GP.

If we take things to their logical conclusion, GPs may lose control of drug choice to NICE or other regional, national or international HTA bodies. Then currently available technology will not only generate the prescription in the pharmacy, but may prevent the GP from attempting to interfere in drug choice.

Once NICE has directed the choice of medication, and the



diagnostic code and recommended drug has been sent to the pharmacy, it is possible that the pharmacist's role will be to check for interactions, compliance and side-effect issues.

This might, in reality, turn the pharmacist into the prescriber; although working within strict guidelines. If the pharmacist finds the NICE choice of drugs ineffective, she can only send the patient back to the doctor for a diagnosis check. At this point the doctor may wish to swear at NICE or seek help with subtle differences in diagnoses, and the pharmacist may ask for help in deciding when to use the first line treatment, and when the second.

This is likely to force pharma companies to spend time assisting the GP in the disease diagnosis process and more time helping the pharmacist to understand new guidelines and how to work within them for the benefit of patients. All of these areas are either damaging or have the potential to

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damage the pharma/NHS relationship. Some of them have been controlled by the ABPI code, but the temptation to contravene is still there on both sides. Any solution would need to remove the temptation by offering a better system.

So what are pharma companies currently doing to improve their relationships with the NHS? Largely speaking, their approach is fairly traditional.

Knowledge

Probably the greatest positive in the pharma/NHS relationship is the provision of life-saving medicines, techniques and advice. At the moment, however, the GP does not look out of his window at the representative striding across the car park and think 'she's

here to help me save patients' lives'. Perhaps he should.

Education

Educational campaigns can improve the quality of patient care, and are allowed under section 18.4 of the ABPI code. An example of good practice is the unique partnership formed between Ashton, Leigh and Wigan PCT and seven pharmaceutical companies working through the ABPI. The partnership's Learning Development Programme supports the training and development of healthcare professionals with the PCT, as well as undergraduate students from all healthcare disciplines. When referring to these and other community initiatives, the ABPI's president Dr Richard Barker has said "We either pursue a 'more

and cheaper' approach to the NHS, or we get the fundamentals right with lateral thinking and a more comprehensive approach involving more partners and greater courage." He added that "industry needs to be seen as part of the solution, not just part of the problem, as the NHS faces its financial challenges."

Clinical sponsorship

Pharma companies have for a long time been trying to provide value added services to doctors in clinical situations. For example the sponsorship of doctors, nurses or pharmacists.

Next month, we look at the potential impact of maintaining the current approach. If meltdown is to be avoided, is it time for the industry to apply more radical methodology?

Charles Joynson is Managing Director of WaveData, which specialises in commercial pricing data and decision support services for both innovator and generics industries. cjoynson@wavedata.co.uk