The need for a new go-to-market strategy in Europe: How to survive and thrive in the new more complex healthcare marketplace

Received (in revised form): 6th January, 2004

Robert Wadman
is a consultant at Peppers & Rogers Group, Europe. Peppers & Rogers Group is a management consulting firm that specialises in developing and implementing high impact customer-based strategies. Robert has 12 years experience and specialises in the pharmaceuticals marketplace. He holds a joint Masters degree (with honours) from the University of Edinburgh and an MBA from ESCP-EAP in Paris.

Rodrigo Hütt
is a research analyst at Peppers & Rogers Group, Europe. Since joining the firm, Rodrigo has specialised in the Life Sciences Industry and has conducted extensive research on the value and relevance of CRM in the Life Sciences sector. Rodrigo holds a Bachelor's degree in Marketing and Psychology and a Master's degree in Marketing Management from Cranfield University.

Keywords *customer relationship management, European Pharmaceuticals, go-to-market model, key influencers, prescription drugs*

Abstract The European branded pharmaceutical industry is experiencing the most challenging business environment in years. As in other pharma markets in the world, the marketplace is increasingly difficult for the leading players. Generic attacks, parallel imports, meagre pipelines and patent challenges all affect the traditional business model. This paper focuses on the European pharmaceutical market in particular and explores the most recent changes within the regulatory environment that affect pharmaceutical companies. The paper depicts the increasing complexity of the network of influencers and concludes by looking at how pharmaceuticals companies can adapt to the changing conditions through the application of customer-centric interaction strategies. Sales and marketing will no longer be focused on a relatively small (and sceptical) group of customers, but will have to learn how to interact with other stakeholders such as payers, patients, nurses and pharmacists.

INTRODUCTION

Today, the EU branded pharmaceutical industry is entering one of the most challenging periods in its history. In recent years, the worldwide industry has been affected by a number of external forces such as generic competition, parallel imports and patent challenges. Nevertheless, in the European landscape there is a further layer of complexity. Due to recent government efforts, the balance of power between the key stakeholders within the healthcare network is shifting. The new network of players that is taking shape in the larger European markets will be of considerable strategic importance for pharmaceuticals executives.

At the same time, the pharmaceuticals industry is faced with more and more options to reach and influence that network. In other words, the armoury of communication channels is fragmenting.

All in all, this means that pharma companies in Europe are being forced to

Robert Wadman
Consultant,
Peppers & Rogers Group,
Carlson Court,
116 Putney Bridge Road,
London SU15 2NQ, UK
Tel: +44 (0)20 8875 3129
Fax: +44 (0)20 8875 5344
e-mail:
robert.wadman@1to1.com

find a way of re-shaping their go-to-market mix, while remaining cost-effective.

For many years and in most countries, physicians have enjoyed a prescription monopoly. Of course, this has meant that they have been the principal sales target for pharmaceutical companies. The breaking of their prescription monopoly is leading to an increase in complexity in the network of key influencers. Today, pharmaceutical companies have to take account of a broader range of stakeholders, who will not replace the physician *per se*, but will gradually gain a larger decision-making role for themselves. If they are to remain competitive in this fierce market, pharmaceuticals companies must stay alert and adapt accordingly.

Five years ago, the physician was influencer + gatekeeper + decision maker. This meant that life was relatively straightforward for pharmaceutical companies. Once they had the doctors identified and knew their prescription levels, they could aim their firepower in the direction of the most important players, with relatively predictable results. Beyond clinical performance of drugs, only two things mattered: Who had the best trained sales personnel? And who had the biggest sales headcount in each therapeutic area? There was talk of a salesforce arms race between companies; in fact this is still the prevailing mindset in the USA.

Pharmaceutical companies must address the full scope of players ranging from patients through to payers, physicians, nurses and pharmacists. Typically, these sets of stakeholders are looking for a mutual partnership, even though each of these different groups often hold dissimilar aims. Increasingly, physicians do not want to be marketing targets, but partners. They require integrity of care, transparency of information, integration of standards and personal effectiveness. Patients are looking for information, affordability and quality of care. Payers are looking to optimise their spend. Nurses and pharmacists are looking for information and training to enable them to become more effective when it comes to influencing or even prescribing drugs. Given the differences within these key groups, pharmaceuticals companies must be poised to truly understand their needs to become the partner for the years to come.

There is still an emphasis on product-push rather than strategic account management. Audience and channel fragmentation means that it is more important than ever for pharma companies to allocate resources across the go-to-market mix in an objective manner. In a nutshell, pharma companies will have to develop a customer-centric vision to be able to bolster their position in an increasingly complex healthcare sector.

In future, the key issue for a branded pharmaceutical company will be to organise itself to treat different customers differently. Beginning by identifying all customer groups individually and addressably, differentiating customer groups by value and needs, interacting with each individual stakeholder in a cost-effective manner and, finally, using all relevant data to customise the offering and, hence, increase impact and relevance to each of the different customer groups.

A HIGHLY LUCRATIVE INDUSTRY UNDERGOING RAPID CHANGE AND FACING TOUGHER EXTERNAL PRESSURES

As previously mentioned, the worldwide branded pharmaceuticals industry has been faced with a number of pressures. For the purpose of the present piece of research, generic medicines and parallel imports are briefly looked at as two important examples of unwelcome forces on the industry. Most factors like these affect pharmaceuticals markets worldwide.

Nevertheless, our research focuses on Europe, specifically the UK, France, Germany and Spain. The main difference between Europe and the rest of the world can be identified at the government level, given that most governments control the healthcare system.

Generic drugs

Generic drugs raise one of the most pressing issues the Industry is facing today. Generic medicines are drugs that are chemically and biologically equivalent to off-patent, branded drugs; usually priced significantly below the original version.

This makes them attractive to government health ministries because they are generally less expensive than branded medicines. Their manufacturers do not incur the significant risks and costs associated with the research and development of innovative medicines. The Association of British Pharmaceutical Industry (ABPI) confirms that prescribing of generic medicines in Britain is on the increase. It is higher than in many other EU countries; more than 55 per cent of all prescriptions are written generically. This compares with 35 per cent only 15 years ago. In some GP's surgeries, generic prescribing is more than 90 per cent.[1]

Generic drugs are changing the face of the entire Industry. The European Federation of Pharmaceutical Industries and Associations (EFPIA) noted that in 2000 the European Union's generic market was already worth approximately €7bn; that is around 10 per cent of the value of the total European pharmaceutical market at ex-factory prices (Figure 1).[2]

Parallel trade

The export of pharmaceutical products from lower-priced European countries to the higher priced markets has long been the cause of debate and concern in certain markets.

The UK market is said to be one of the most affected markets. The problem is this particular case lies at three levels; first, the Pharmaceutical Price Regulation Scheme (PPRS), which limit the profit levels of drugs, takes an overall approach when looking at the fairness of prices. It does not pay particular attention to specific drugs, which often end at comparatively high prices. Secondly, the UK holds one of the easiest ways of getting international

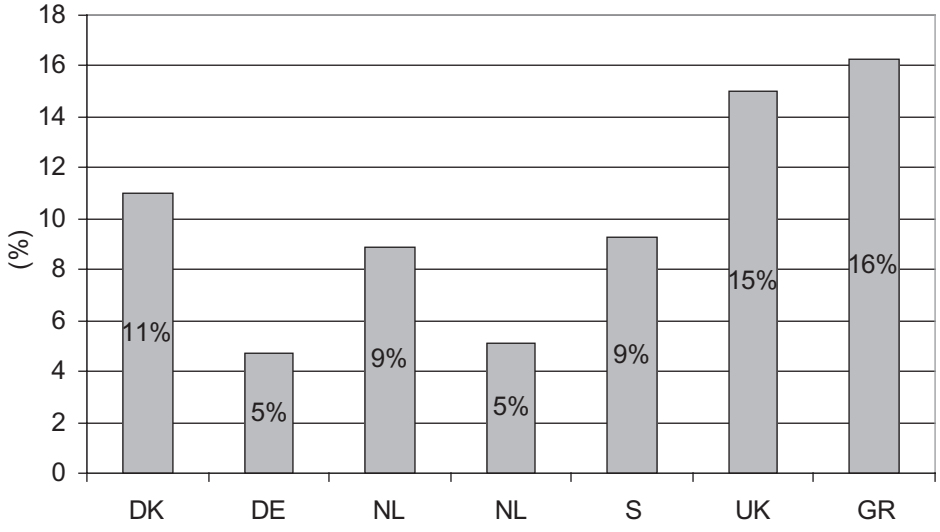

Figure 1: Share of parallel imports in total pharmaceutical market sales in 2001
Source: EFPIA[4]

trading licenses, making it very easy and appealing for importers. Finally, the complex reimbursement system in the NHS produces incentives for full-line wholesalers and independent pharmacists to engage in this type of trading.[3]

The EFPIA claims that parallel imports are now accounting for a significant percentage of market value in some European countries, and although difficult to calculate exactly, it is now estimated to affect sales of about €3.5bn per annum, and could be costing the R&D-based industry approaching €1bn, much of which could have been reinvested in research and innovation. Nor does it save governments or health insurance systems much money because its benefits tend to flow to intermediaries like commercial pharmacy chains.[4]

IN EUROPE, NEW LAWS ARE OPENING NEW DOORS FOR PHARMA COMPANIES

Increasingly, pharmacists can substitute a branded compound with a generic equivalent. This has been the case since 1998 in France and now applies to Spain and Germany as well. Research by a German generic producer found that in Germany today most prescriptions define the compound rather than a specific brand. In the UK, although generic substitution is still not permitted, more than 55 per cent of prescriptions are written generically.[5,6]

Nowadays, certain nurses have prescribing power: District Nurses and Health Visitors in the UK, which number around 23,000, are able to prescribe from an extended formulary a wider range of medicines for a broader range of medical conditions.[7,8] Supplementary prescribing in the UK is defined as a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific Clinical Management Plan with the patient's agreement. According to the Department of Health (DOH) in 2003: 'Amendments on NHS regulations enabled the introduction of supplementary prescribing for first level registered nurses, registered midwives and registered pharmacists from April 2003.

Supplementary prescribing training for nurses began early in 2003, and the first nurse supplementary prescribers are already in place. Pharmacists are expected to begin training shortly with the first pharmacist supplementary prescribers being in place by early in the autumn'.[9] Legislation enables Patient Group Directions (PGDs) to be used for the supply or administration of medicines by nurses, pharmacists, midwives, health visitors, radiographers, physiotherapists and ambulance paramedics). According to the DOH in 2003: 'A Patient Group Direction (PGD) in the UK is defined as a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. It is not a form of prescribing and there is no specific training that health professionals must undertake before supplying medicines in this way'.[10]

THE EXPANDING ROLE OF PAYERS

In Europe, healthcare tends to be planned and controlled by one or more government ministries. The ministry lays down a regulatory framework and controls the financing of the system. Formulary committees (Payers in Europe) have been increasing in importance for some years. In the UK for example, both Primary Care Trusts and Hospital Trusts manage their own budgets and have the autonomy to develop their own formularies. Power has shifted upwards from doctors to these bodies in order to suppress maverick prescribing. What is more, this takes place within a framework managed by bodies of

the Department of Health that controls drugs pricing (PPRS) and, once a drug is in the market, the National Institute of Clinical Excellence (NICE) carries out pharmacoeconomic analysis for the control of cost-effective drugs.

For all of these reasons, governmental healthcare bodies are critically important to pharma companies and they have had to reorganise themselves accordingly. For example, over the last decade in the UK, NHS liaison teams have become a valuable asset for many pharmaceutical companies. According to a recent study from CGEY (2003), payers around Europe do not perceive that they have a true relationship with pharma companies and claim that companies simply do not understand their needs and are more interested in the financial benefits rather than in developing a partnership with them.[11] It is seldom the case that payers in Europe regard pharma companies as true advocates of welfare.

BUT WHAT BROUGHT THESE CHANGES ABOUT?

Two words: budgetary pressure. The vast majority of European healthcare costs are state-funded, whether directly as in the UK or indirectly as in countries like France and Germany. With sluggish economies and the looming demographic time-bomb, the different governments of Europe have woken up to the fact that healthcare costs are soaring and that it is something they must act upon.

The EFPIA claims that in 1950, the median age in Europe was just less than 30 years. Today, it is just short of 40 years and by the middle of the century, Europe's median age will increase to almost 50 years. Projections show that by the year 2050, 60 per cent of all European adults are expected to be over age 65. Germany, Spain and Italy could have more citizens over 80 than under 20 years of age.[12]

As a result, the governments have decided to apply downward pricing pressure on the branded pharmaceuticals industry by breaking the prescription monopoly of doctors and laying the conditions for generic alternatives to flourish.

ON TOP OF EVERYTHING, PATIENTS ARE DEMANDING MORE INFORMATION

In addition to these changes, patients are increasingly empowered by the search for medical information that they find via different channels. They see this information to influence doctors in their prescriptions. New communication channels will allow pharma companies to reach patients and other stakeholders, to interact and to develop rapport at an individual level.

It is clear that patients are increasingly well-informed thanks to faster and wider access to health-related information. This year, the EFPIA released a document depicting the evidence gathered from surveys from Cambridge University Health, 2003 and Consensus Research survey, 2002. It suggests that major benefits of an informed patient accrue to the healthcare system as well as to concerned individuals.[13]

Since 1997, direct to consumer advertising (DTC) has been allowed in the USA and the amount spent on advertising is growing at an astonishing rate. In 1998, it was around US$1.33bn and in 2000 it reached US$2.5bn.[14] A survey carried by *Prevention Magazine*, shows that 95 per cent of respondents questioned could recall having seen a DTC advertisement. Therefore, the clear benefits of DTC advertising lie in encouraging consumers to talk about drugs.[15]

EU health ministers have voted to uphold restrictions on DTC. In 2002 the EU suggested that drug firms should be allowed to give direct to consumer

information (DTCI) to patients with AIDS, asthma and diabetes. The council of ministers rejected the proposals.[16]

Disease Awareness Campaigns (DACs) directed at the general public with a view to providing information, promoting awareness or educating the public on a particular condition or disease are encouraged. Care must be taken, however, when engaging in DACs to ensure that the information provided does not make product claims for the material to remain outside the definition of an 'advertisement' under the regulations. In particular, use of brand names, restricting the range of treatments described in the campaign or drawing attention to the campaign by advertising which is 'likely to lead to the use' of a specific prescription medicine can all lead to a potential violation of the regulations.[17,18]

Some companies are already learning from DACs pilots. Due to the longstanding ban on (DTC) in Europe, some smart companies have proactively responded to patient demands. DACs is more than a branding exercise; it is an information resource that enables companies to connect patients, nurses, physicians and payers in one single place. Best practice DACs includes AstraZeneca with www.LinkMedica.co.uk, Roche Spain with www.xeniplan.com and, GSK with www.right-time.co.uk.

THE BREAKING OF THE PRESCRIPTION MONOPOLY POINTS TOWARDS BROADER SALES AND MARKETING SCOPE

Although different European governments have responded at different speeds in slightly different directions, the overall picture is clear: Branded pharmaceuticals companies now have to contend with far more decision-makers and influencers than ever before.

It is no longer enough for the branded pharmaceuticals players to focus on the doctor or physician alone; there are other players in the decision making process with whom they need to engage (Figure 2).

Of course, this new European market structure has major implications for the branded drugs companies. In the midst of change, smart pharma companies must shift from a doctor-centric to multi-player model. Clearly, this implies a cultural overhaul and an end to the salesforce arms race. Each of the different customer groups are demanding that their needs and wants are met through a variety of media and channels. In order to survive and thrive, pharmaceutical companies will have to work hard to truly understand the 'what, how, when and where' of customer needs.

Pharma companies in Europe must learn to market to a fragmenting audience with a fragmenting armoury of communication/channel tools

With a more complex healthcare environment taking shape, generic pressure mounting and critical launches to get right, there are key challenges facing pharma companies in Europe.

The reality is, pharmaceutical companies can no longer sit on their laurels. Historically, big pharma companies tended to see sales force size as being in direct correlation with market share. Even small and medium sized companies tended to adopt the same 'arms race' mindset.

As they re-shape their go-to-market mix, here are some of the key questions that pharma companies face:

- How to reach the expanded sphere of healthcare influencers without diluting impact?
- Similarly, how to exploit a greater range of channels without losing punch?
- How to allocate resources between different channels and audiences?

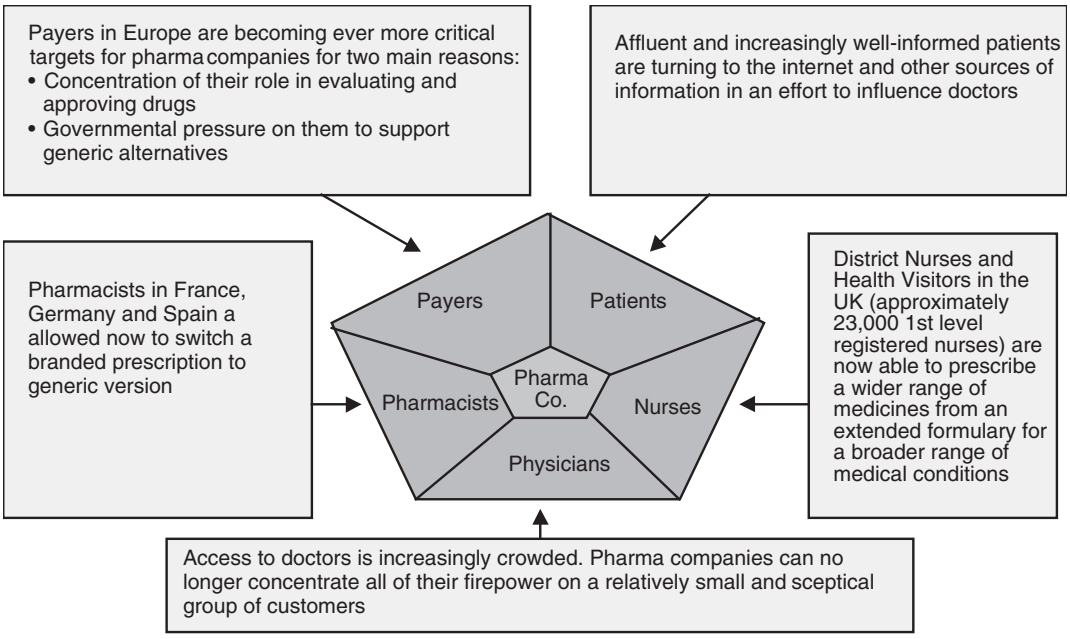

Figure 2: The new face of the European pharmaceutical industry (Peppers & Rogers Group, Europe, own analysis)

- How to go about tailoring messages to the needs of the different audiences?
- How to find new ways to measure the effectiveness of these strategies?

In summary, how can pharma companies re-shape their go-to-market model, while remaining cost-effective?

CONCLUSION AND RECOMMENDATIONS

For many branded pharmaceutical companies, the golden era is at an end. The industry is at a turning point. The pharma business will never be the same again and companies are being compelled to adjust their go to market model.

So how can branded pharmaceutical companies meet this challenge?

As a sound starting point, to avoid being overwhelmed by the recent expansion in the range of contact points in the marketplace, it is necessary to bring a structured view of the marketplace and the players involved. This involves mapping the layers in the therapeutic areas concerned and, at a macro level, pinpointing where the decision-making power lies.

Of course not every customer can, nor should, be treated in the same way. Different actors play different roles in the prescription process and have different levels of importance to the pharmaceuticals companies involved.

A common starting point for customer differentiation is to derive a clear-sighted knowledge of the genuine potential value of stakeholders. This is a sound platform but it is not enough in itself. Looking beyond value, it is necessary to build an understanding of how the different players can be segmented according to groupings with common needs.

There are various types of research approach that will enable companies to uncover the needs-based segments that exist within a customer base. Armed with that knowledge, the next issue is to know how to categorise individual customers on the database. If robust quantitative research has been conducted, this can be done via

one of a range of scoring methods. Alternatively, in cases where customer contact is frequent, it may be possible to drip-feed 'Golden Questions' over time. These are questions within a carefully constructed decision tree format that serve to categorise customers into mutually exclusive, collectively exhaustive groupings (or segments) with common characteristics.

Of course, knowing how to segment the customer base has to be more than an academic exercise. Its purpose is to provide a foundation for differentiation. In other words, to ensure that the marketers know *who* to mass-customise their messages and treatments for. But once a pharmaceutical company has a notion of different customer segments, how does it put in place the mechanisms that allow its salesforce and marketers to detail the right drugs and convey the right messages to the right person at the right time?

The next step is to find a means of balancing the traditional big pharma focus on brand development with a customer portfolio management approach. Over time, a company should ensure that the organisation of its sales and marketing teams reflects portfolios of customers with common needs rather than brands alone. But it is a question of shifting the balance, not erasing the current structures overnight and, as a result, takes time and requires a sensitive approach to change management.

Another gradual shift that needs to take place is in the array of customer-facing treatments that a pharmaceutical company develops. From today's world of one-size-fits-all doctor-centric tools, companies needs to plot a gradual path towards having an armoury of marketing components that can be deployed with business rules according to different customer segments and levels of player within those segments.

The new dynamics and regulations in the healthcare marketplace mean that pharmaceuticals companies have the opportunity to experiment with new types of meaningful, entangled and long-lasting relationships with customers, in particular online offerings to connect patient to doctor to pharma company.

In the long term, there is an opportunity for companies to develop online services as the foundation blocks for integrated disease management programmes (DMPs). Generally focused on chronic diseases, these are integrated programmes to assist in management of an ailment over time, based on ongoing updates to clinical status. Although relatively commonplace in the USA since the early 1990s, today there is still considerable unease among European legislators about the role of a profit-driven industry in the influencing of clinical practice in this way. As the twin pressures of wider patient choice and budget-driven self-care increase, however, DMP is certain to develop further in future in Europe.

Note that relying on gut feeling is no longer enough. The array of actors involved in decisions in the marketplace has expanded to such a degree that system-based analytics of customer value and other characteristics is now necessary to help define priorities, organise territories and build promotional campaigns.

Finally, of course the segment-based, componentised approach that has been outlined above needs to be underpinned by a sound repository of customer data. But the ability of systems to deliver a new customer strategy can easily be exaggerated. The real change that needs to take place gradually, is in the organisation of teams and in the processes that steer them. And that's a far tougher challenge than installing some new software.

References

1 Association of British Pharmaceutical Industry (ABPI) (2001) 'Generic medicines', http://www.abpi.org.uk/publications/briefings/generic.pdf

2 European Federation of Pharmaceutical Industries and Associations (EFPIA) (2000) 'EFPIA's new generics working group will promote generic medicines in a balanced way', http://www.efpia.org/3_press/20000606.htm
3 Bailey, M. (2002) 'Parallel imports', *Pharmaceutical Marketing*, http://www.pmlive.com/index.cfm?showArticle=1&ArticleID=577
4 European Federation of Pharmaceutical Industries and Associations (EFPIA) (2001) 'Parallel trade', http://www.efpia.org/2_indust/Paralleltrade.pdf
5 Association of British Pharmaceutical Industry (ABPI) (2001) *op. cit.*
6 European Federation of Pharmaceutical Industries and Association, (EFPIA) (2000) 'The pharmaceutical industry in figures', http://www.efpia.org/6_publ/Infigures2003.pdf.
7 Department of Health (2000) 'Consultation on proposal to extend nurse prescribing', http://www.doh.gov.uk/pdfs/nurseprescribing.pdf.
8 Department of Health (2003) 'Mechanisms for nurse and pharmacist prescribing', http://www.doh.gov.uk/nurseprescribing/formsofprescribingmay03.pdf
9 Department of Health (2003) *op. cit.*
10 Department of Health (2003) *op. cit.*
11 CGEY & INSEAD (2003) 'Vision and reality survey', www.cgey.com/life/survey/index.shtml
12 European Federation of Pharmaceutical Industries and Associations (EFPIA) (2003) 'Aging population', http://www.efpia.org/2_indust/Healthyageing.pdf
13 European Federation of Pharmaceutical Industries and Associations, (EFPIA) (2003) 'Informed patient: possible ways forward', http://www.efpia.org/4_pos/pharmareview/InfoPatientPolicyPaper.pdf
14 Forrester Research (2001) 'Pharma's detailing overhaul', www.forrester.com
15 Charlish, P. (1999) 'DTC advertising encourages consumers to talk about drugs', *Script*, **84** (November).
16 *Pharmaceutical Marketing* (2003) 'Power to the patient', *Pharmaceutical Marketing*, **15**(2), June.
17 Doonar, J. (2003) 'DTC ahead', *Pharmaceutical Marketing*, **15**(1), June.
18 MHRA (2003) www.mhra.gov.uk