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PATIENT ADHERENCE

The latest global technology and policy issues

Finding the Causes of Non-adherence

One in three patients in England is estimated to be non-adherent. The annual cost to the NHS is around £100 million.

Julian Upton outlines some of the current thinking fueling the fight against non-adherence in the UK.

Given the government's commitment to cutting the NHS in England's spending power by £1 billion (US$1.57 billion) by 2015, it's not surprising there's an increasing focus on new measures aimed at improving patient adherence in the UK.

One device that is generating optimism is the automated pill dispenser. A recently concluded, local authority project in the West Midlands, which provided automated pill dispensers to 250 people across the region, resulted in an average saving for the NHS of over £1,700 ($2660) per person over a six-month period.

But with one in three patients in England estimated to be non-adherent and with the cost to the NHS of disposing of unused drugs at around £100 million annually, it seems increasingly worthwhile to identify the causes of the problem as well as developing initiatives and devices to make adherence easier.

Karl Hewson of the Cambridge Design Partnership speculates that, as far as the patient information leaflets are

concerned, in addition to readability challenges caused by the use of small type, a main source of confusion comes from the use of "complex language" along with the (albeit necessary) medical and legal jargon. Words such as indication and contraindication "are unfamiliar to much of the general population" he writes.

Underscoring this, he points to "a wider cultural predisposition to ignore printed instructions and to try and work things out for oneself, unsurprisingly more common amongst the male population".

This gender-based non-adherence extends (equally unsurprisingly) to using new technology. Back in 2009, a UK call center service called Gadget Helpline found that 64% of its male callers had not read their gadget's relevant instruction manual before calling up for assistance, but only 24% of its female callers had ignored it. The news prompted psychologist Joanna Bawa to assert there was "a gender divide in technology."

"The voices of anonymous peers online can have a stronger influence than medical personnel".

Such research, although fairly light-hearted in this instance, may be usefully employed in future approaches to medicines adherence.

An equally modern (and perhaps more worrying) problem, according Gideon Mantel of Treato.com, is the role of social media in discouraging patients from being adherent. Once patients receive a new prescription, "they take to the privacy of their home computer and that's when the *real* conversation starts," he says.

A study by Mantel's company researching what patients with depression had written in posts that mention their physician revealed that up to 30 per cent of the posts indicated that the patients had decided not to take the physician-recommended medication as a result of information they that they had received online from their peers. Reasons given included resistance to new side effects, unfamiliarity with the new drug, and the drug being too expensive.

The research leads Mantel to the unnerving conclusion that "the voices of anonymous peers online can have a stronger influence than medical personnel".

None of this is perhaps surprising given the way we communicate with each other these days, but it suggests that in the UK (and around the world) pharma/medical device companies and healthcare providers would benefit from an approach to patient adherence that sees beyond the conundrum of how to remind patients of the importance of taking their pills at the right time and in the right quantity. Perhaps the key to tackling non-adherence is by first addressing *patient resistance* — both consciously and subconsciously — to taking their medication.

"Patients take to the privacy of their home computer and that's when the real conversation starts."

Healthcare in Europe
"Failing Patients"

"Delayed and incorrect diagnosis is still far too common — the causes are about competence in primary healthcare.""

A disgruntled patient recently gave the European industry both barrels at an EU event in Dublin. Reflector has some sympathy for what he said.

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Any complacency that the world of healthcare might be feeling about advances in the ability to treat patients suffered a head-on assault in Dublin, Ireland, at a conference organized earlier this year under the auspices of the Irish Presidency of the European Union and featuring a galaxy of Irish and European stars from the worlds of politics, regulation, research, industry and patients. "Crazy," "broken," "failing" and "haphazard" were among the less extreme accusations made.

"Healthcare systems in Europe are failing patients," charged one highly articulate cancer patient.

Failing #1, he claimed, is inadequate data collection. "We are not in a position to analyse what we don't have — and we are told this is an information age!"

"The pharma development model is cracked. Because it is profit driven, commercial opportunism results."

Failing #2 is incompetence. "Delayed and incorrect diagnosis is still far too common — the causes are cultural, structural, and about competence in primary healthcare." Follow-up is "haphazard," "often poorly defined, not really understood, and its value is under-researched." The list went on and on.

"The pharma development model is cracked," he said. "Because it is profit driven, commercial opportunism results. We get competing agents, me-too drugs and protectionist strategies, which hinder medical practice to the dis-benefit of patients." Meanwhile, "costs have risen at every stage in the process, which itself has got longer. There is increased regulation. Pricing has become an art form." And the new emphasis on the search for value is an attempt at something that is "very difficult to define."

Health technology assessment was dismissed as "fractured," because its processes are biased against rare diseases and their treatments at the very time when genetic research is fragmenting the old histological definitions of cancer and providing many more new ones, the aggrieved patient went on. "Every cancer is now rare, every treatment is orphan," he insisted, and "a meaningful randomized clinical trial is sometimes impossible."

"If we fail to take up this last challenge we will create expectations which result in massive dissatisfaction, despair and unhappiness."

The context for drug development was also pilloried. "To compound the problems, academic peer review and journal publishing is also broken," ran the accusations. "The academic process kills patients. They die because evidence does not get published at all, they die while journals decide whether to publish evidence, they die because academic and healthcare regulators prioritise peer reviewed publication and thus preserve a system which builds in delay."

The patient at the forefront of these attacks was Roger Wilson, who founded Sarcoma UK, and who has good reason to know both the merits and the demerits of current treatment regimes. Since he was diagnosed with a soft tissue sarcoma 14 years ago — after initial misdiagnosis — he has experienced multiple operations, chemotherapy, and amputations, and has benefited from successive remissions, but is about to start another round of treatment.

His recommendations ranged across the full area of interventions. In diagnosis, he argued, "genetics changes everything, and we have never had a better chance of improving things." Primary treatment could be "an evolving success story for personalised medicine — built on 200 years of skill development, innovation, new technology and some admirable pragmatism." Follow-up, through risk

modelling, nurse-led clinics, and in primary care, could deliver more benefits if they were taken more seriously. HTA bodies should "use judgement, not rigid processes, and be sensitive to social factors, not dominated by economic factors." He said there was a need for "new systems, which are appropriate for assessing biological treatments, supported with proper use of new technologies."

The right approach, in his view, would be to recognize that "when curative treatments with toxicity and nasty side effects are futile, healthcare systems must provide the symptom control patients need, simple therapies such as morphine." And healthcare systems "must offer good counseling and practical support which helps families address their own needs as well as those of their loved one," he said. "If we fail to take up this last challenge we will create expectations which result in massive dissatisfaction, despair and unhappiness."

His approach to his audience was as direct as his message was harsh: "Let me also remind you that every one of you will die one day, and rather too many of you from cancer; so I suggest you sit up and pay attention."

The Next Step Agenda on Adherence

Colleen McHorney, former Senior Scientist at Merck's US Outcomes Research, talks to Pharm Exec about her long experience — and predictions for the future — of medication adherence.

PharmExec sat down with Colleen A. McHorney, PhD, former Senior Scientist at Merck's U.S. Outcomes Research to review her long record of scientific research on adherence in advance of her retirement last month. McHorney highlights the cyclical nature of engagement on adherence programs, technology's inherent inadequacies, the need to study the provider as well as the patient, and the importance of effective communication practices for providers when prescribing medications.

PE: Do you think the new Prescriptions for a Healthier America coalition of government, industry, and patient groups is going to be effective?

CM: It isn't going to hurt. There have been similar calls to action in the past.

> "In the past 40 years, some 40,000 articles have been published on medication adherence. At this point, I doubt more information is going to solve the problem."

NCPIE, the National Center for Patient Information and Education, published Enhancing Medicines Adherence: A National Action Plan in 2007, but I'm not sure how much it rallied sustained national attention. The National Consumer League also has their Script Your Future national campaign, running since 2011, which is slated to expire next year. We tend to have these cycles of heightened interest in adherence and then it goes away or something else replaces it. Success for these interventions really depends upon how well they are able to mobilize diverse stakeholders and interest groups behind a clear and cogent reform agenda.

PE: There is a focus now on technology to drive adherence. Do you believe that, for instance, dosing reminder apps and flashing pill bottles will be game-changers?

CM: Personally, as a scientist and as a patient myself, I do not think they will. I've spoken to over 2,000 patients in my career in the past six years, and very few people want to get a text message every day saying, "Take your medication." People who have problems remembering are going to appreciate that, but I estimate from Merck's research, as well as others, that only 20% of non-adherence is due to forgetfulness. The other 80% consists of people making intentional decisions about their medications. You can text people all they want and have sirens go off on their pill bottle caps, but unless the patient feels that they need a medication and they don't have concerns about taking it, I don't think technology is going to make the inroads its advocates claim.

PE: A lot of companies are funding and conducting their own studies on adherence. Do you believe that more information will solve the problem?

CM: In the past 40 years, some 40,000 articles have been published on medication adherence. At this point, I doubt more information is going to solve the problem. However, more targeted and theoretically-driven information may have an impact. The research I led at Merck went a long way towards elucidating some of the key drivers of non-adherence. Now it's about meeting patients' informational needs. Knowledge is necessary, but it's not sufficient.

Repeating the same studies on demographics and diagnoses will not get us anywhere. What's going to move the needle is figuring out how and what to effectively message to patients about their medications. How do we communicate to patients exactly what they want to know about their medications in a way that will resonate with them and lay the foundation for their autonomous commitment to therapy? How do we incent providers to spend more than a handful of seconds discussing the rationale for and importance of the medication?

PE: If you were to remain in industry, what would your adherence agenda consist of in the next two years?

CM: I would do basic research to document the fact that patients have different adherence patterns for different medications to continue to underscore the fact that there is no such thing as an "adherent personality" (which many providers erroneously believe). I'm also working on a manuscript now which is documenting the extent of non-adherence at first fill of the prescription, where approximately 25% of patients are gone in the first 30 days. They don't come back for their second fill.

I also have a passion for studying adherence at the physician level. Roughly 95% of all studies on adherence have focused on the patient. We need to start focusing on dyads (i.e., the relationship between provider and patient), and we need to start focusing on providers. One thing I've always wanted to do is aggregate patient-level adherence data up to the physician level and document that there are some physicians who have lots of high adhering patients and some physicians who have lots of low adhering patients. Believe it or not, there have been only two studies conducted on inter-physician variability and adherence rates. We need to understand the attributes of those providers and practices that have higher than average adherence rates. In 40 years of adherence research, we've almost completely ignored the role of the physician in medication adherence? it's the next logical step for researchers to take.

Changing the DNA of Patient Adherence Programs

Grant Corbett argues that many of our assumptions about patient knowledge and health literacy and their critical importance to patient adherence are simply wrong.

Epigenetics is the study of changes in human gene expression, in particular from environmental factors. Pharma is also experiencing epigenetic change. Human genes are formed from DNA, which are instructions much like a blueprint. Similarly, the environment is changing pharmaceutical DNA and how brand marketing is instructed.

For example, pharma's genetic dependence on traditional blueprints (and standard agency recipes), targeting revenue from new molecules in the pipeline, is no longer sufficient for survival. The environment has limited the availability of new blockbuster brands.

Similarly, the environment is changing the DNA of our belief systems. Here I am speaking of the evidence for effectiveness of patient medication adherence interventions. How is this changing the DNA of brand marketing?

> "Do health literacy interventions improve adherence?"

For more than a decade, we have believed that medication non-adherence was the result of patient knowledge and capabilities. This has driven marketing focused on "patient education", "segmentation" to identify profiles of patients based on their "barriers" (or "deficits") and "tailoring" to help customize needed changes in the foregoing.

We have assumed that patient knowledge, of their disease and treatment, and their health literacy capabilities, for example, are critical to patient adherence.

However, the evidence now tells us that our assumptions were wrong. More than 100 published studies show no correlation between a patient's level of knowledge of their disease and treatment, and medication adherence. How many valid studies show a correlation? None of which I am aware. Studies have shown that patient knowledge can be increased, but no increase in medication adherence has resulted.

Similarly, recent systematic reviews show no evidence that health literacy is

associated with medication adherence in adult or pediatric populations. As one of these review papers summarizes:

"A critical element of successful self-management is medication adherence. On this front, the evidence has been mixed.

We have assumed that patient knowledge and their health literacy capabilities, for example, are critical to patient adherence.

Although patients with limited literacy have more trouble understanding primary and precautionary medication label instructions and are less likely to be able to report the name of their medication, there is no consistent finding of worse medication adherence among patients with limited literacy."

In fact, there is evidence that patients with "adequate health literacy are more inclined to purposefully not adhere to their discharge instructions."

Do health literacy interventions improve adherence? A 2011 systematic review found no evidence.

What about the promotion of health literacy programs? Again, a 2011 review reports:

"…current research on health promotion for participants with low health literacy provides insufficient information to conclude whether interventions for health literacy can attract the target population, achieve an effect that is sustainable, or be generalized outside of clinical settings."

"Tailoring" messaging based on patient characteristics has been a proposed as a solution to patient barriers. However, a 2012 review paper, on the efficacy of tailored interventions for self-management outcomes of type 2 diabetes, hypertension or heart disease, concluded:

"Tailored interventions had no impact on self-management activities such as medication adherence, self-monitoring, exercise, smoking, or diet control."

Patients with "adequate health literacy are more inclined to purposefully not adhere to their discharge instructions."

So, there is no peer-reviewed evidence to support developing pharma marketing strategy or tactics based on these assumptions of patient deficits. Money spent in interventions based on these beliefs will produce limited or no ROI, as industry cost-effectiveness evaluations show.

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Japan — Swerving Austerity

National Health Insurance (NHI) and, in particular, innovative medicines still get a good deal in Japan.

Donald Macarthur and Michael LoPresti explain why Japan is the land that cost containment forgot.

The pharmaceutical industry owes much of its success in developed nations outside the US to the post-war emergence of statutory schemes that offer comprehensive, population-wide healthcare on the basis of need, not on ability to pay. The downside is that at times of economic hardship and high unemployment these schemes get squeezed along with all other forms of public expenditure.

Not so in Japan, the second-largest drugs' market in the world. The country might still be suffering from the consequences of the devastating earthquake and tsunami of March 2011, have a national debt in excess of 200% of GDP, seen exports slump and face a rapidly aging, shrinking population, but National Health Insurance

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(NHI) and in particular innovative medicines still get a good deal there.

Government-related approval time has improved substantially over the last several years.

Despite talk of a "drug lag", delays in new drug approval in Japan are no longer due to slower review times. The Pharmaceuticals and Medical Devices Agency (PMDA) distinguishes between manufacturer-related approval time and government-related approval time in their annual overview. Their 2011 overview suggests that government-related approval time has improved substantially over the last several years with the number of review-related staff increasing from 206 persons in 2007 to 415 in 2011. The PMDA estimated the difference in median approval time relative to the US to be about 1.1 years in 2011 — down from 3.4 years in 2007 — and only 0.1 years of that delay was attributed to in-review delays with the rest attributed to pre-submission delays.

An analysis of nearly 400 newly approved drug entities in Japan conducted in 2009 by Kaori Tsuji of Keio University also suggested that the majority of Japan's drug lag can be attributed to delays in the development and submission of new drugs by manufactures — not slower review times. Dr Tsuji's findings showed that many products had not even begun development for Japan at the time of their approval in the US or Europe. Her analysis pointed to two areas where development and submission lags tend to occur: 1) delays due to relatively fewer patients or a smaller market size in Japan and 2) delays due to the lack of a Japan-based office or licensing partner in Japan.

Pricing

So the review time for new drugs in Japan has caught

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up with the US. Moreover, following regulatory approval, reimbursement review normally takes only 60 days (maximum 90 days) — one of the fastest in the world. New drugs are admittedly subject to price controls, but no-one complains about launch prices. These can be higher than those in the US, and much higher than in Europe or elsewhere in Asia-Pacific.

Price reductions, affecting the entire market including patented drugs, occur every second year. The pattern has been repeated for more than 50 years, but results are predictable, without bias and to some extent manageable. Unlike most other countries, where cuts are arbitrary in degree and seemingly random in frequency and timing, Japan's Ministry of Health, Labor and Welfare (MHLW) follows a well announced process to survey actual market prices and bring NHI (reimbursement) prices closer to this level so as to squeeze out the difference, known as the drug price gap (yakka-sa). Some have even pointed out that MHLW doesn't cut prices, companies do by discounting.

Launch prices can be higher than those in the US, and much higher than in Europe or Asia-Pacific.

Repricing of high selling brands takes place at the same time as a general price revision, most commonly after a big new therapeutic indication is approved. The MHLW uses published formulae to arrive at the extent of the cut, which is also subject to a time limit and a cap. Industry might argue this penalises success, but Japan is only doing what payers everywhere practice, linking price with sales volume. One rule change in 2012 promised to lift the threat of repricing products similar to the one whose sales had greatly expanded if they showed clinically relevant differentiating features from it. Unlike, say France, Japan doesn't re-review P&R status after a certain time or with every new indication, only when sales reach double the forecast at the time of first NHI listing and exceed JPY 15 billion/year.

As with downwards price revision, industry has learned to live with repricing. It is also notable even in fast growing classes how relatively few brands are affected. The lessons are clear: Discover how the rules work, and then learn how to work the rules. Any negative price impact can also be mitigated by application of 'correction premiums', awarded to listed products when a new pediatric or orphan indication is added, or when a drug's "true clinical usefulness has been verified after marketing".

An even bigger breathrough came in 2010; a new price premium on a trial basis to promote the creation of new drugs and new indications for existing drugs. This offered to offset in part or in full the biennial downwards revision for qualifying products during their patent life/regulatory re-examination period. It applies to originator brands less than 15 years from first NHI listing with no marketed generics, and with a yakka-sa below the weighted average

Drug pricing in Japan is more transparent than most countries.

yakka-sa of all listed drugs as measured at the most recent price survey. Drugs repriced at the same revision as well as oral fixed-dose combinations are excluded.

At the April 2010 revision, the new premium was applied to 624 presentations (337 ingredients) and at the April 2012 one to 702 presentations (367 ingredients). Almost 77% of eligible products had their pre-revision prices

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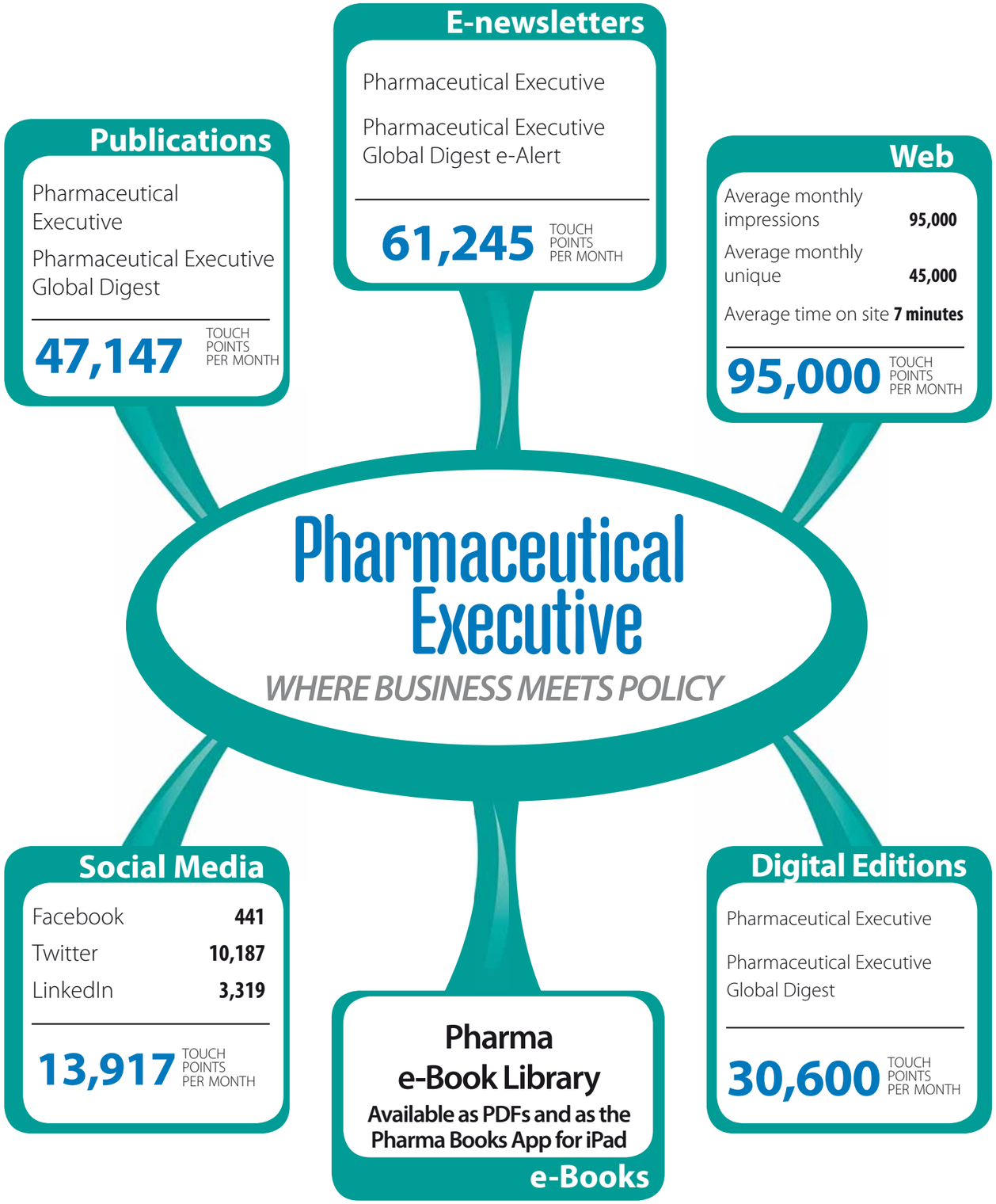

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TOTAL UNIQUE SUBSCRIBERS	**90,929**

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fully maintained last year. Multinationals were the main recipients of premiums; GSK and Pfizer respectively had 51 and 43 presentations that benefited. The total first-year value to companies of retaining higher NHI prices was estimated at JPY 70 billion.

As the title of the new premium indicates, awards are conditional on meeting MHLW requests to individual manufacturers to develop their products/indications for Japan comparable to their status in western countries. While failure to respond adequately is penalised by price cuts to recover premiums plus interest and a ban on any product in the company's portfolio receiving a premium at the next revision, this hasn't happened yet. Furthermore, not all companies in receipt of premiums get development requests, indeed some get requests but no premiums.

Price cuts are only deferred by the new premium. At the revision following launch of the first generic version, the originator's NHI price will be reduced in a single step by the total premium it received during the protected period, in addition to the ordinary biennial price cut. Despite this, industry very much favours the reform and the price stability it brings during patent life. Previously, Japan did not exhibit the "patent cliff" seen elsewhere. An originator brand received a modest 4-6% price penalty after the first generic was launched, though it usually managed to retain sales due to the poor image of generics among Japanese doctors. This is changing, due to a series of pro-generic steps, but generics are starting from a small base, with just 23% volume penetration as recent as 2011, one of the lowest shares of any OECD country.

Conclusion

Japan's drug pricing environment is rules-based, and is more transparent and predictable than most. There is no hint of discrimination against foreign companies. It's future environment can also be forecast with greater confidence than anywhere else.

The rules will continue to be tweaked but the fundamentals will remain. Evolution not revolution is the Japanese way.

Changes that have not already been discussed for months and where consensus is not already close will not take place at the next revision, April 1st 2014. This means, despite earlier suggestions to the contrary, no mandatory cost-effectiveness demands on new drugs and almost certain continuation of the new premium. None of several cost containment techniques widely employed overseas will emerge either: Reference pricing, prescriber budgets, prior authorization, therapeutic substitution, profit control, mandatory discounts to NHI, tiered copays, negative lists, parallel trade, fixed distribution margins, or promotional controls/taxes.

Austerity measures? What are these?

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Drug Patents Under Fire in Brazil

Ryan O' Quinn and Sanya Sukduang outline the implications and complexities of Brazil's newly created agency ANVISA, the country's equivalent of the US Food and Drug Administration.

One of Brazils recent patent "reforms" greatly complicates bio-pharmaceutical patent practice... biopharmaceutical patent practice: a

One of the most promising pharmaceutical markets of the future is Brazil, a nation of nearly 200 million people with a universal healthcare system. Brazil's infamously overloaded patent system has undergone a series of recent reforms. One such "reform," however, greatly complicates biopharmaceutical patent practice: any Brazilian patent application for products affecting "public health" must first be approved by the National Health Surveillance Agency (ANVISA), the Brazilian equivalent of the U.S. Food and Drug Administration, before ever being examined on the merits by the Brazilian Patent Office (known as the "INPI"). This "fourth" prong of patentability threatens the viability of

Gabriel Sperandio/Getty Images

pharmaceutical patent protection in Brazil.

The "Prior Consent" System

Upon Brazil's entry into the World Trade Organization in 1995, TRIPS compliance accompanying WTO membership mandated that Brazil offer pharmaceutical patent protection for the first time. A transitional "pipeline" system was established to permit rapid patent allowance for pharmaceutical products already patented abroad. In response to concerns about safety for a number of these pipeline patents, Brazil's President signed an order in December, 1999 conditioning patentability of pharmaceuticals on "prior consent" by the National Health Surveillance Agency, known by its Portuguese abbreviation, ANVISA.

Nominally, ANVISA would prevent unsafe medicines from entering Brazil, but there were other incentives for implementing prior consent. First, Brazil constitutionally guarantees free medical care for each citizen. Second, Brazil was nurturing its own nascent pharmaceutical industry.

Nominally, ANVISA would prevent unsafe medicines from entering Brazil...

Struggles for Control

ANVISA faced opposition to its prior consent policies both inside and outside Brazil. Brazil has appeared on the annual "Special 301" watch list issued by the Office of the United States Trade Representative each year since 2000, which identifies countries with IP policies that concern the U.S. Government. From 2002–2006, Brazil appeared on the "Priority Watch List," as a country causing the highest level of concern.

Brazil's Attorney General of the Union (AGU) released an official opinion in October, 2009, known popularly as "Opinion 210." Opinion 210 stated that ANVISA was not to determine patentability; instead, its role was solely to consult on technical elements while assisting INPI with its examination. ANVISA, with the support of the Ministry of Health, sought revision or rescission of the opinion. Instead, the AGU issued "final" Opinion in January, 2011, which clearly stated that "ANVISA may not refuse the granting of the prior consent of art. 229-C of IP Law based on patentability requirements." Subsequently, several Brazilian courts ruled against ANVISA in 2011–2012, and limited its review of pharmaceutical patent applications. Since Brazil is a civil law system, however, these decisions are merely persuasive authority.

The Future of Brazilian Pharmaceutical Patents

Although appellate-level judicial decisions and "final" AGU opinions clearly oppose ANVISA's review of pharmaceutical patent applications, those decisions do not bind the agency. At present, it appears only three measures could change the perplexing status quo: new Congressional legislation amending the LPI, a decision by the Brazilian Supreme Court, or international WTO dispute-settlement proceedings predicated on TRIPS violations. Although the stage is set for any or all of the three options, imminent action is unlikely.

At present, it appears only three measures could change the perplexing status quo...

As part of Ordinance 1,065, both ANVISA and INPI were charged with drafting new final rules defining patent examination going forward. ANVISA published a proposed rule on October 16, 2012. The most significant provision was

Art. 4, §1 of the rule, which (translated) states:
It is considered that the patent application is contrary to public health when:

I – The pharmaceutical product or process contained in the patent presents a health risk;

II – The patent application of the pharmaceutical product or process is of interest to the policies regulating the universal access to medicine and pharmaceutical assistance as provided for under SUS — Universal Public Health Care System — and that do not meet the patentability requirements and other criteria as established in the IP Law 9.279/1996.

Among those submitting comments during a 2012 public comment period was the Biotechnology Industry Organization (BIO), which identified several problems with the rule. For example, what defines a "health risk"? What makes patent applications "of interest" to the universal healthcare system? Finally, who determines that applications do not meet patentability requirements?

ANVISA's April 2013 rule update assuages some fears about how prior consent will be implemented going forward,

ANVISA responded to some of these concerns by issuing a revised regulation on April 15, 2013. A "health risk" exists when a pharmaceutical patent application concerns substances banned in Brazil. Applications will be deemed "of interest" to SUS when they claim substances listed on the "strategic products" list for the national health system, or therapeutic purposes associated with the list. ANVISA representatives have stated that applications not triggering the above situations will receive prior consent and will return to INPI for examination.

ANVISA's April 2013 rule update assuages some fears about how prior consent will be implemented going forward, but the pharmaceutical industry should still pay careful attention to ongoing developments.

An expansion of the "strategic products" list for the state-run healthcare system would seem to be all that would be required to deny patent protection to high-profile drugs. This policy may have short-term benefits for Brazilian-based pharmaceutical producers, but dire long-term economic consequences for everyone, as Brazilian citizens are denied cutting-edge therapies and foreign firms are denied significant market presence in one of the world's largest countries. Prior consent may be a temporary speed bump for the pharmaceutical industry, or it may be a canary in the coal mine for future battles in large markets with centralized healthcare systems — perhaps even a large, red-white-and-blue market to Brazil's north.

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Better Sales By Design

Christian Seiffert and George Schmidt explain how taking an innovative approach to commercial model design can serve as a critical growth enabler.

The healthcare marketplace is becoming more complex, spurring the need for innovative approaches to commercial model design. Decision making power is shifting to payers and patients, providers are consolidating, access is shrinking, and local market variances are increasing. Meanwhile, manufacturers and payers face greater cost pressures, shifting focus to quality and outcomes measures. All of this is taking place under the umbrella of changes as a result of healthcare reforms.

As a result of these trends, the traditional marketing and sales model the pharmaceutical industry has relied on for decades is broken, but pharma companies have been reluctant to move away from the traditional face-to-face sales representative model.

Several companies are expanding their efforts to focus on a broader set of actors in the healthcare environment.

Several companies, however, are not only exploring new ways to interact with stakeholders, they are also expanding their efforts to focus on a broader set of actors in the healthcare environment. Companies have achieved varying levels of innovation, but looking across the industry, four key areas stand out:

- Changing the sales interaction
- Broadening customer engagement
- Building partnerships
- Addressing systemic issues

This article will spotlight the pockets of innovation that can be observed in the industry today, as companies begin to reach out and address customer needs across physicians, patients, governments, insurers, advocacy organizations, and other groups.

Changing the Sales Interaction

Pharmaceutical manufacturers need to re-think the physician/rep interaction. Sales representatives are having an increasingly difficult time accessing physicians and engaging them in meaningful conversations about products. Meanwhile, physicians are turning to online sources of information to educate themselves and guide their treatment decisions.

Innovative companies are transforming their commercial model by utilizing a mix of face-to-face and virtual interactions to increase the efficiency of traditional sales forces and deliver better value and personalized experiences to customers.

Merck, for example, has made significant investments in remote ("live" e-detailing) or online interactions ("virtual" e-detailing) with physicians. Genentech, meanwhile, has equipped its sales force with iPhones and a proprietary app that helps reps easily contact experts who can field physicians' questions. More than 8,000 employees use iPhones and a proprietary iTunes-like app to access Genentech information and experts.

Broadening Customer Engagement

Consumer behavior is increasingly influenced by peer-to-peer conversations and user-generated content. Meanwhile, conversations

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about products and services are increasingly taking place in online communities and on social networking sites. Innovative pharmaceutical companies can build stronger connections with healthcare communities and build relationships within physician and patient populations by leveraging existing social media platforms.

Pfizer, for example, partnered with US social network Sermo in 2007 in order to provide Sermo's community of physicians with access to Pfizer's clinical content. On the patient side, J&J has created an online community hosted on Facebook for adults with attention deficit-hyperactivity disorder (ADHD). Branded under McNeil Pediatrics (a division of J&J), the site includes educational information, user polls, and a message board for discussion of topics posted by J&J.

Manufacturers can also promote patient-to-patient connections by investing in word-of-mouth and grassroots patient-to-patient campaigns. Companies can often leverage online platforms to promote crowd-sourcing and other forms of user-generated content. Gilead has made strides in this area by creating the unbranded "B Here" campaign to spark a grassroots patient- and physician-led movement to educate the Asian American community about hepatitis B. The peer-to-peer campaign helps patients, physicians, and other stakeholders meet up, organize events, and share information.

Another way companies can focus on deeper customer engagement is by offering support services. Logistical hassles and the daily burden of complex treatment regimens can lead to patient non-compliance, often resulting in diminished health outcomes and a sub-optimal product experience. In response, companies are increasingly offering suites of services to empower and support patients, especially those using specialty products.

> Pharma companies have been reluctant to move away from the traditional face-to-face sales rep model.

In the Netherlands, Amgen launched "2care service," a cooperative effort with Medizorg Services BV. The program offers reimbursement support, home delivery of products, and drug administration training/support from a staff of field nurses. Eligible patients can either be recovering from chemotherapy or have chronic idiopathic thrombocytopenic purpura or kidney disease to receive treatment. The program is designed to support patients through a team of field nurses, helping them start treatment as soon as possible and learn to administer their own treatments (when appropriate).

Building Partnerships

By focusing on disease prevention and screening, manufacturers can begin building broader partnerships with stakeholders. Chronic diseases such as type II diabetes, hypertension, dyslipidemia, and others are becoming an increasing burden to healthcare systems in emerging as well as developed economies. This trend has heightened the need for disease prevention and early detection, particularly among low-income and rising middle-class populations in the emerging markets. In response, innovative companies are trying to educate patients about disease prevention and are screening at-risk populations to promote access and early detection.

Novo Nordisk, as an example, has launched three mobile clinic programs (Changing Diabetes Bus, IMPROVE Control Mobile Clinic, and NNHF mobile screening) to reach underserved communities in

both developed and developing countries. In the US, Lilly has partnered with Polymer Technology Systems, Kroger, and Vision Racing to offer free diabetes and cholesterol screening at the Indianapolis Motor Speedway. As part of this program, patients also received the free CardioCheck in-home cholesterol reading device and a consultation from a healthcare provider.

Commercial model initiatives can be a critical growth enabler.

Addressing Systemic Issues

Payers and insurance companies are struggling to cope with rising costs while providing access to quality healthcare for patients. Innovative companies are promoting value-based health management to help governments, employers, and insurance companies manage rising costs while maintaining or increasing the quality of care.

For example, GlaxoSmithKline provided an online resource designed to assist employers, health plans, and benefit consultants in improving the health of their workforce/customers while lowering overall healthcare costs by launching their Center for Value-Based Health Management (VBHM) in 2007. The resource was mainly focused on distributing information (e.g., case studies and best practices) and tools (e.g., cost impact models for specific diseases, benchmarking tools).

Conclusion

Whether a company is launching its first product, entering a new therapeutic area, or looking to transform its organization, commercial model initiatives can be a critical growth enabler. An effective new commercial model needs to align with the company's vision, strategy, and culture; be informed by the market, customers, and product portfolio; support local market strategies; and include planned feedback loops and the flexibility to allow for the unknown. Any new approach to commercial model design also needs to include cross-functional analysis to ensure broad input and buy-in and align with and have support from senior management; the training organization; and operational, information technology, human resources, and legal business partners.

You shouldn't look at another company's model and think you have found the answer.

As the healthcare environment changes and becomes more complex, innovative companies like the ones cited in this article are taking fresh approaches to commercial model design. Because every company is unique, however, decision makers should not look at another company's commercial model and think they have found the answer. Instead, considering other organizations' approaches to commercial model design should provide inspiration for the kind of innovative thinking that will be needed to meet the evolving challenges of marketing and selling pharmaceutical products.

About the Authors

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Should Pharma Do Tumblr?

Peter Houston asks, could acquisition by Yahoo make Tumblr more interesting to pharma?

Peter Houston

I'm sure you've heard already — internet geriatric Yahoo just bought six-year old Tumblr for $1.1 billion. The deal, likely to complete in the second half of this year, is almost all cash — reportedly almost all the cash Yahoo had in hand at the close of the first quarter. Why has Yahoo fallen so heavily for Tumblr? Easy, Yahoo is seen by many in the digital world as stodgy, slow and quite possibly past it. Tumblr is cool, nimble and on the up.

The Tumblr blogging platform, founded in 2007, posts some pretty impressive numbers: 300 million unique visitors a month; 17 billion page views monthly; 120,000 signups a day; 900 posts a second; and 24 billion minutes spent on the site every month. The clincher is Tumblr's mobile footprint – more than half its visitors use its mobile app, seven times a day on average.

> "You'll find very few, if any, pharma company Tumblrs"

The bottom line is that a Yahoo-Tumblr combination (Yumblr?) is expected to grow Yahoo's audience by half, giving it more than a billion monthly visitors, with a projected increase in traffic of approximately 20 percent. Yahoo hopes that it can bring its expertise in personalization and search to suck users into its advertising networks.

This could be a problem as the youthful Tumblr user-base, much like its twentysomething founder David Karp, hates internet advertising. As you might expect there has already been a user backlash against the deal, prompting Yahoo CEO to comment, "Don't worry we won't screw it up."

The most likely way for Yahoo not to screw it up is to focus tightly on content marketing or branded content opportunities by bringing its grown-up content management skills to Tumblr's nascent sponsored content offering. And this is the point where pharma marketers should start paying attention.

Given the demographic distance between the average pharma CEO and the average Tumblr user, you have probably never used Tumblr. The easy-to-use blogging platform is used

mainly by a 13 to 25 age group attracted by its "social looseness". Real names are not required on Tumblr, only email addresses, allowing users to present multiple personalities. "Tumblr is, in a way, the anti-Facebook—a social network where you do not have to be friends with your mother," says a recent Economist Explains post.

When you explore Tumblr today, it's not difficult to understand why you'll find very few, if any, pharma company Tumblrs. The content is quirky to say the least, from blogs devoted to photos of the late Kim Jong Il looking at things, to collections of dopey texts we parents send our children. Oh, and there's a fair amount of pornography on there too.

Some major brands and corporations are already on the platform, however. Media — Newsweek, The Boston Globe, Elle Magazine, GQ — was relatively quick to pick up on it, seeing a relatively easy way to distribute a regular stream of highly visual content that would be shared by their audience. Fashion brands like J.Crew and Oscar de La Renta are also taking advantage of the "visual not verbose" ethos

It's worth keeping an eye on what Yahoo does and how the Tumblr audience reponds.

of the site. IBM's Smarter Planet Tumblr is excellent. It features more of a mix of text and images, but the real value is the opportunity to distribute links to the broader network of IBM information elsewhere on the web.

What you will find when you take a closer look at Tumblr is a lot of potential patients. And as pharma marketers get more serious about "customer-centric" and "multi-platform" approaches, maybe the acquisition by Yahoo is as good a time as any to look again at the platform.

Take a look at the diabeticproblems tag on Tumblr. You'll see the occasional 'humorous' picture from people wondering how they're going to cope with a chocolate fountain, but the vast majority of posts are from young people dealing with the day-to day-issues of living with diabetes. Questions about travelling with diabetes, snack recommendations for low blood sugar, pictures of testing kits and insulin pumps and a lot of motivational humor. Do you think a pharma Tumblr offering funny, well-crafted advice and genuine support to this group might get some attention?

I'm not suggesting that anyone switch their social media budget to Tumblr today on the strength of Yahoo's involvement. But it's worth keeping an eye on what Yahoo does and how the Tumblr audience reponds. If they get the content marketing part of the play right and the user base keeps active, Tumblr might just make it into your social media marketing plan.

About the Author

Peter Houston is former Group Content Director for Advanstar pharma Science. He is now an independent media consultant and founder of Flipping Pages.

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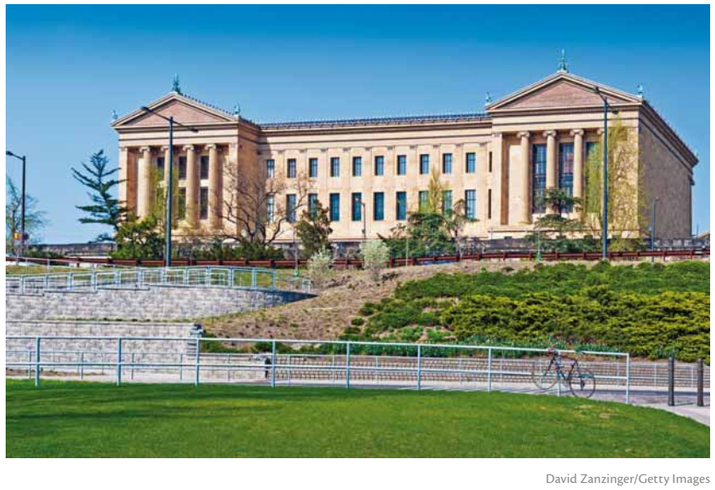

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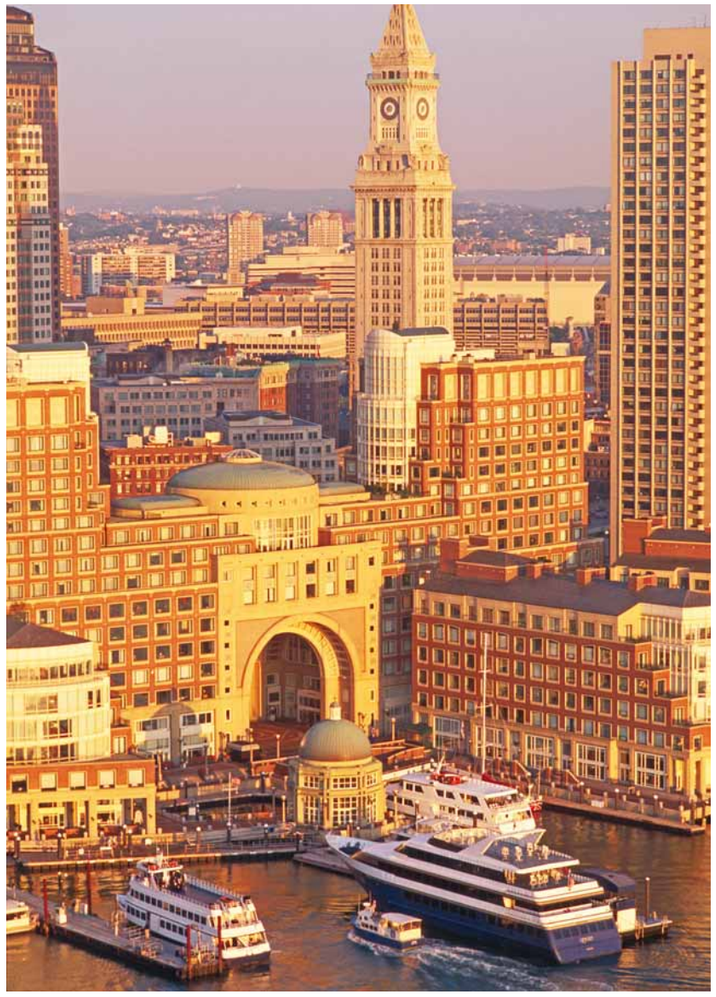

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