ADDING VALUE

With pharma transforming more rapidly than ever, seven industry vets chart a road map for meeting a changed industry's challenges. **James Chase** led the discussion.

James Chase (MM&M) For many years the pharma industry achieved significant business success from a base of rigid organizational structures and risk-averse cultures. Hence, things had been done in basically the same way for decades. A lot has changed in recent years. Through each of your perspectives, what have been the biggest changes you have experienced, and what are the associated challenges?

George Roberts (Janssen): The biggest challenge we've seen is the notion of value as it relates to the acquisition and realization of pharmaceutical products or any other therapeutic. It's about true value that is driving healthcare decisions. We see that from payers, from patients, and from healthcare professionals (HCPs). And because of the nature of what we do, being able to articulate that value is challenging. Our studies upon which all of this is based have been a little bit behind because of the evolution of the market to a value-based model.

Scott Taylor (Scott Taylor Associates): I would say it's also about changing business models—product development, and how companies

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align their regulatory strategy with their marketing strategy and their reimbursement strategy to make sure that things are moving along at the same speed and has the same objectives and goals. This has been challenged by reimbursement cuts almost everywhere, and obviously the ACA is having a huge effect on companies' ability to plan for the future in terms of "What products should I develop?" and "What form should that product be?" and "What patient population am I going to be able to serve?" And then how does that all roll into my business model in terms of providing value to the patient, to the payer and to shareholders? And as a company, how do we remain profitable with all of these different competing elements and constraints?

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And then where it's heading… there's so much ambiguity and uncertainty but I think one of the driving forces is informatics and the ability to digitize information and use that information to develop therapies based on a person's genomics. And then be able to anticipate future diseases this person might develop, prevent them if possible, and then treat with the right drugs at the right times and in the right doses. But how you translate that into a business model is still up in the air. It could take decades for this to happen, if not more.

Patrice Pickering (Braintree Laboratories): I look back and I see the business having been very liberal in the past to it being very constrictive right now. The dynamic has changed, the model has changed, and the regulations associated with the business model have changed drastically. Being a small company, I have the luxury of being able to turn and go down the hall and talk to legal, talk to regulatory affairs, talk to R&D… a lot of companies don't. But the players who have created a marketplace between the manufacturer and the wholesale distributors, I think that layer has caused a lot of the costs to the pharma company and to the end user.

"The mold that was working with blockbuster drugs has been broken up in the last 10 years"

— Frederic Blanquaert, Sanofi

I still take product calls [from patients] because I want to see what the consumer is saying. Most of the time they are complaining about the cost. I got a letter the other day from a woman who said: "Why the hell does your product cost so much when it's a bunch of salts?" And she wants her money back. They don't understand what the process is from beginning to end. For specifically our product and our environment, 95% of patients can be cured of colon cancer. It's an $80 product. It can save your life. Is it worth it? It's a one-shot deal.

Frederic Blanquaert
Head of Global Marketing & Strategy, Musculoskeletal Franchise, Sanofi

Michael McLinden
Partner
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Kathryn Wilson
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My problem with the consumer is there's no personal responsibility anymore. We, as drug companies, have to present a drug to them in the light of all the problems they could possibly have. So when you have a 60-second commercial, you're talking about how bad everything is, not how good everything is. And you talk about the alignment of what consumers and what disease states can best be served by these products – it's very hard to get that messaging across.

So I think it starts with an inability for us to deliver products in a cost-efficient manner that the consumer would like to see, and which the government would also like to see, especially with everything that is happening with the Affordable Care Act. I just think a lot of layers were created that didn't need to be created. Somebody found a niche in the marketplace and created a space that doesn't necessarily need to be there.

"It's almost like you're not selling to the physician anymore, you're selling to that end user"

— Patrice Pickering, Braintree Laboratories

I also just think that the government has gone in the wrong direction in what they're doing with healthcare. They could have done a much better job. I also think that pharmaceutical companies who represented us at the table could have done a much better job. So I think there's a lot of problems going forward and I think a lot of people are going to lose their jobs. I think there's going to be a big change in the environment.

Frederic Blanquaert (Sanofi): I think a big trend is the mold that was working with the blockbuster drugs has been broken up in the last 10 years, and there are a couple of reasons for that. The first one is the drying up of the pipelines. The way we have successfully researched products in the last 10 years, whether devices or drugs, is not working, and new approaches like personalized medicine that are more efficient have not broken through yet. The complementary part is that there is a huge increase in the population with demand for care. So at the end of the day, from a pure numbers point of view, there is a huge increase in the number of people that are in demand for care, and that creates new trends of expenditure which the payer has to find ways to meet.

The pharma world was very simplistic in the past: it was basically saying, "I have a drug, it's good enough, I've made my case with the payers and I've made my case with the physician." With those two, your product can win. That was good and fine pending that you had this value that was sufficient. Now the problem is you don't get that and you have a shift of the payment decision that is going to lose patients. But these boundaries that existed, where the main actors were the physician that could speak to the patient, and where payers were establishing the rules of the game, this is completely shifting. And so, like it or not, we have to think of better ways to create that relationship with the patient. And you're right, you can't do everything for everyone. Patients are not all the same. As an industry, that very significant piece of the equation that now is becoming critical and we have to learn how we can break out and reach out. The ACA creates a new parameter. We are just now hearing about the mess of changing healthcare plans and this is just the beginning. So now we have to wait and see what the fallout will be. But that will multiply the situation that I am sure you are now faced with, that's the big transformation we have to deal with.

Pickering: It's almost like you're not selling to the physician anymore, you are selling to that end user.

Blanquaert: Well one part of this industry that has been epitomized early on has been the sales force and the sales rep. They were the strength behind the success of those products, in good ways and bad ways, too. But at the end of the day, companies can't just rely on those forces because they were one vehicle that was driven solely towards the physician. And while that relationship is still critical to maintain, it cannot be the only channel that you use to play with all stakeholders.

Kathryn Wilson (Mc|K Healthcare): When I started in this industry 15 years ago we were at the end of the heyday. The sales rep was going in and really had a good relationship with the doctor, and because of that relationship they were able to really talk about what that product was and the value that had been added. The thing that I heard the first year that I started was that a patient feels that a doctor visit has been successful if they go in and come out with a script. And then five years or so passed and it changed. Instead, it was that a patient feels the visit was successful if they went in and got the script that they had specifically asked for… Like, "I want Ambien." OK,

pick your product. So the decision maker had changed.

We fast-forward again and the decision maker has changed again. Now it's managed care. So the sales rep and the doctor no longer have that same relationship. Because… well, why would they? I mean, if I'm a doctor, [the payer] is going to tell me what I can prescribe anyway. So you have to factor in managed care, and then you have the doctor who doesn't want to talk to the sales reps, so that's broken down also. And then you have the consumer who's hearing about a lot of side effects, but not the efficacy message about your the product. So who are you talking to and how are you bringing that back around? When I started 15 years ago, I start with "this person" and I was talking to "that person." I'm not always sure who I'm even talking to anymore. So I think that's the biggest shift that makes that communication, and having that dialogue, so difficult.

Kyle Roderick (WebMD): The first part is how do you bring drugs to market that have value? And now it's not just about value to the patient, but also to the payers. Your product has to be at least better than the ones that are currently out there, or cheaper. But once you do have that product – and I think we do ourselves a disservice if we don't say that the industry has been working diligently to try to bring these drugs to market. But to Kathryn's point, how do we know that a drug is going to win, once it gets (FDA) approval. We see so many examples of drugs that gain approval but then can't get sold.

But the other side of that is, okay, once you've developed that value, how do you go and communicate it? Certainly from my perspective that's really where the world has changed. And are we keeping up with the ways the world has been consuming information? Previously, I was a rep, and so I did have personal relationships with all these physicians. And managed care comes in, tells them what they can and cannot write in black and white, and it becomes much more difficult. And so when you think outside our industry, the last Blockbuster store finally just gave up, right? People just don't have time to go to Blockbuster and get a videotape anymore. And then return it, no less. And you think about how Amazon is challenging all the brick-and-mortar retailers. I don't have time to keep driving to the store to pick things up. So if something is available on Amazon for the same price, or maybe even a little cheaper, then that's the way I want to go because Amazon will deliver it to my door in two days. That's the way I think we have to go.

When we look at healthcare consumers (both patients and physicians), we ask "How are they consuming information?" The patients are walking into physicians' offices a lot more heavily armed than they used to be with information about all of the drugs they could possibly take. Oftentimes they think they know what their diagnosis is, whether it's actually correct or not. For WebMD I think we see around 138 million unique visits a month – that's a third of the US population. That's crazy. And so are we fully leveraging the different ways that people are consuming information now? Probably in the past 18 months the biggest trend that we've seen, both on the patient and HCP sides, has been the rise of mobile. But desktops, laptops, tablets and phones do different things.

So once we have created value, and we have the right value proposition, how do we then communicate it and make it a more cohesive story. And furthermore, how do we arm reps to be different? They are on the front lines, and I don't think there'll ever be a replacement for an intelligent rep who can have a dialogue when they get access. But are we empowering reps for – not just the doctor/rep conversation – but also the practice manager to talk about, say, billing. Do reps know those sorts of attributes? Even if they do, are we finding ways within the med-legal system to empower them to be able to have those conversations – like a sort of problem solver, but with roots on the ground. I'd argue that, at least in my experience, we didn't find that solution necessarily. Are we arming them with resources for the whole team? Because a single doctor probably has two nurses under his practitioner, three secretaries and a practice manager. How are we talking to that whole group?

"I don't think there'll ever be a replacement for an intelligent rep who can have a dialogue "

— Kyle Roderick, WebMD

Mike McLinden (Mc|K Healthcare): We're using a few words that have come up over and over, such as value, access, responsibility, relationships… these are common themes. I think what emerges is that when we look back, certainly to when I started in the industry, I don't think we realized at the time that we were in this business that had this godly complexity and obscurity to it, almost like the public's opinion of the old Catholic Church. We didn't realize it at the time, and it didn't matter, because it worked. At the end of the day, the patients felt like they were in a good place, and so did

the doctors. But what's happened over the last couple of years is that the tide has gone out, and everybody's staring at each other in our bathing suits, which alone is a scary thing. And nobody really knows what to do in that role. So then you're clinging to some very narrow, single dimensional ideas. On one side you have people who are clinging to price. "We're going to look at managing to the lowest dollar price." Not value, but dollar price. Then there are people who are clinging to regulatory orthodoxy, where it's all about the discipline of the label. And then you have the people that just don't know what to do. And they're taking 11% of all the "value" in our business off the table and nobody even knows who these people are. A patient doesn't know. The people that are complaining about the price of pharmaceuticals don't know that 11% of it is going to process and handling.

"The trick is going to be figuring out how we change this environment so that we're all interacting again"

— Michael McLinden, Mc|K Healthcare

So right now a lot of people are working in a way that's not very organized and not very effective. We have this opportunity to think very powerfully about what this transition is going to be – because it's got to be different than it is right now. As we go forward, you have to ask: "Is the patient being served well by this?" Probably not.

We are still trying to figure out where physicians fit into this whole thing. But there are other high-value people, such as nurses, physical therapists and occupational therapists. I do a lot of work in Parkinson's disease, and if you look at any of the major Parkinson's drugs, similar results can be achieved by exercise programs or by physical therapy. But we can't talk about that right now. We can't say, "This is how our drug works if you have physical therapy and a diet, and if we monitor these other things …" because we're not allowed to connect those dots. The trick is going to be figuring out how we change this environment so that we're all talking and interacting again as effectively as we did when it was the Catholic Church and we knew when to kneel, when to stand up and when to bless ourselves. We all knew that. Now we have to figure out what to do now that we're all atheists. We've got to go out and just live in the world and figure out what our roles are. ■