

# Marketing Strategy

## The need for new promotional models

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**Abstract** The increasing pressure on the pharmaceutical industry is widely described and attributed to constantly rising R&D-costs, decreasing R&D-productivity, increased generic competition and healthcare reforms in almost all Western countries trying to enforce price cuts and restrictions in reimbursement. With the changing healthcare environment, the focus in Pharma marketing needs to adapt to new stakeholders needs as payers and patients are becoming more actively involved and are requesting a higher health outcome. We believe that, given the increasing complexity due to the changing healthcare environment, a broader perspective on ROI helps to cope with rising uncertainty and propose a simple, illustrative formula to visualise the effects of the different actions that can be taken into account. We discuss the effects of targeted therapies, health education programmes and early commercialisation.

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### THE CASE FOR CHANGE

It sounds like the broken record that nobody wants to hear anymore when we talk about the ever-increasing pressure for the pharmaceutical industry but the facts cannot be denied: constantly rising R&D-costs, decreasing R&D-productivity and increased generic competition have slowed down the innovation motor of the drug industry. Often quoted are average development costs of about \$800m<sup>1</sup> and approximately 12 years to develop and launch a new drug. While the annual

amount of new molecular entities approved by the FDA was decreasing from their historical peak of 49 approvals in 1996, they are now in the range of the long-term mean value of about 22 per annum. Furthermore, many block buster drugs will loose patent protection and exclusivity periods are drastically declining. While a few years ago, branded drugs coming off-patent used to maintain a reasonable level of sales for one year after introduction of the first generic alternative, it now takes just a few weeks or days to see sales

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volumes of originator drugs plunge by 80 per cent. Alessandro Banchi, Head of the Board of Boehringer Ingelheim, even stated that it took just 40h for their pain killer drug Mobic to lose the majority of sales in the US to generics manufacturers after patent protection ended.<sup>2</sup>

In addition to such industry-internal pressure, healthcare reforms in almost all Western countries try to enforce price cuts and restrictions in reimbursement. The recent announcement of new pricing regulations in the UK or decisions of the German Institute for Quality and Efficiency in Healthcare (IQWiG) regarding reimbursement of innovative drugs such as insulin analogue are two prominent examples but probably just the tip of the ice berg in a long-term melt-down of drug margins.

In addition, payers will become more proactive managers of health in the future. The objectives are, obviously, to reduce costs but, more importantly, to emphasise health outcomes. The survey results of Capgemini's Vision & Reality study in 2005<sup>3</sup> showed that over 80 per cent of payers believe that their role will change towards a more proactive role in managing patients' health. The payers will look to implement a variety of programmes like prevention programmes, chronic care management, patient compliance and disease management programmes.

Furthermore, patients are becoming better educated and more demanding. Patients, while still the weakest of all stakeholder groups, can become really powerful if they get organised as the recent case of Tysabri has shown. Due to safety concerns, Biogen Idec voluntarily withdrew the drug from the market after two serious adverse events in clinical trials. An alliance of multiple sclerosis patients, however, forced Biogen to re-launch the drug. While this might be an extreme case, patients will get more and more involved in the economic decision making of

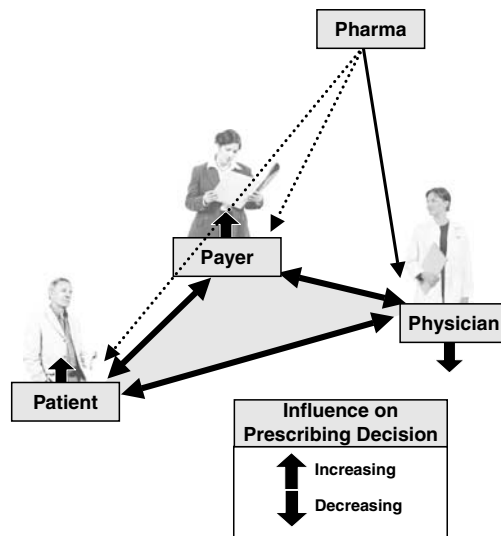
prescriptions. The 2006 Nobel Peace Prize Laureate, Professor Muhammad Yunus, argued in his opening address to the World Health Care Congress in Barcelona in March that patients should pay part of their healthcare services themselves. In countries with solidarity-funded health systems, many politicians and lobbyists still argue this would be unsocial. We, however, strongly believe that it would not only lead to a better allocation of resources but it would also contribute to solving the burning healthcare financing crisis. About 90 per cent of the respondents in the above-mentioned 2005 Vision & Reality study wanted to have complete transparency of their treatment costs.

Whereas more than 60 per cent of the respondents expected an increase of co-payments by the patients, 50 per cent of the respondents believed that their direct cost will grow by up to 25 per cent or more in the next few years.

Patients are also exerting their power by suing pharmaceutical companies. The risk of litigations increased strongly as seen with the rising number of class-action lawsuits, for example, with Vioxx. These lawsuits not only have an immediate and high-negative impact on market capitalisation (Merck's share price dropped about 30 per cent in the month after the withdrawal of Vioxx), and a negative financial impact on the company due to settlements or compensatory or punitive damages, but also on the company's reputation, whose effects can hardly be quantified.

## **A NEED FOR NEW MARKETING RECIPES**

With the changing healthcare environment, the focus in pharma marketing needs to adapt to new stakeholders needs. Figure 1 shows the changing role of key stakeholders in the healthcare environment. We observe an increasing influence of payers and patients



**Figure 1:** Key players' relationships within healthcare

on prescribing decision whereas physician's influence is decreasing. Marketing recipes that worked in the past will not guarantee future success — patient centricity and focus on health outcomes need to be at the heart of the pharma value proposition in the future. Direct interactions between pharmaceutical companies and payers will open the door for further market mechanisms. For instance, the latest healthcare reform in Germany allows now direct negotiations between drug manufacturers and payers. While this will initially benefit generic drugs, we believe that this will also lead to further price and value differentiation for patent-protected drugs; for example, when companies negotiate volume discounts on their late-lifecycle medications if payer organisations at the same time promote highly innovative treatments. Those companies who manage to successfully negotiate commercial terms across their portfolio of drugs will lead the race. Individual selling at the GP-level will then lose its relative importance.

The industry is already reacting to these pressures by adapting their sales forces and re-shuffling their commercial organisations.

Whether it was pure cost pressure or adaptation to future market change does not really matter. At latest, when Pfizer announced the end of the 'sales force race' by trimming their worldwide sales and marketing staff by 20 per cent and Astra Zeneca followed shortly with a 10 per cent cut of their US sales force, the search for new promotional models and new recipes to sell drugs was on. We feel that a stronger orientation around therapeutic areas goes into the right direction. Companies like Roche, reshaping their organisation around disease areas, which will have the overall control of R&D, marketing and also to some extent M&A seem to explore new ways in getting more patient and health outcomes focussed.

Let's be clear: the fundamental objective of any pharmaceutical company is to make money by providing treatments that ease patients' life. As the innovation machine is not providing the same output as in the past and as traditional marketing and sales efforts are yielding diminishing returns, new recipes are needed so that shareholders continue to provide financial funds to the industry.

The question remains, however, if there are additional facets that should be taken into account to produce better health outcomes and help to overcome the short-term issues that the industry is faced with, while new technologies, for example, personalised medicines or stem cell therapies are still a long way out.

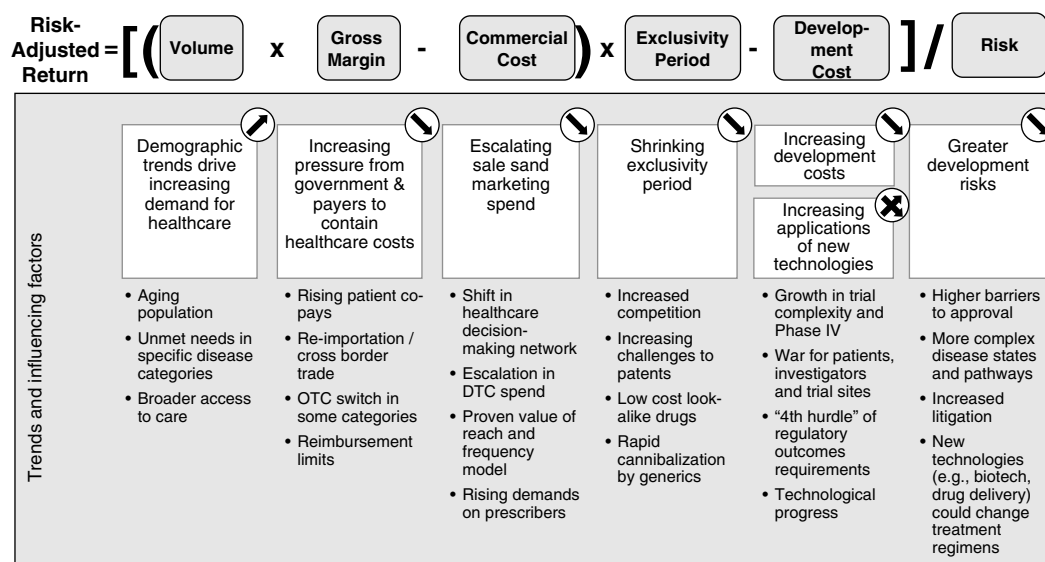
## FRAMEWORK FOR LONG-TERM COMMERCIAL SUCCESS

Many pharmaceutical executives agree that there are a variety of initiatives that would help to produce better health outcomes, for example, prevention and screening programmes or health education at school. Investing in such initiatives is, however, hard to justify for a CEO facing his

shareholders who expect higher returns every quarter. The fundamental and often long-term effect of strategic change in healthcare is difficult to justify in an industry that is so dependent on political decision making and regulation. Again, take the example of companies like Pfizer or Novo Nordisk investing millions in easing the life of diabetic patients and realising only years later that patient convenience is not of sufficient value to payers to reimburse analogue or inhalable insulin. Hence, senior management in pharmaceutical companies sees it as difficult to prioritise long-term strategic initiatives, especially if short-sighted initiatives such as cost-cutting or ‘the last month sales race’ provide a higher and more immediate ROI. We believe that, given the increasing complexity due to the changing healthcare environment, a broader perspective on ROI helps to cope with rising uncertainty. To discuss the impact of different factors we use the formula in Figure 2. (Please note that this formula is not used in a mathematical sense but rather as a tool to visualise the impact of various long-term initiatives.)

First lessons in business administration tell that profit (or return) equals sales minus cost (or, in simple terms: output minus input). Similarly in our case, risk-adjusted return is dependent on the output minus input, corrected by a risk factor. More specifically, we take the volume of the drugs sold calculated at their individual gross margin, minus the commercial costs for promoting and selling them, over their exclusivity period. From this we deduct the development costs and we assess the risk associated not only with development but also with, for example, litigations after market launch (in case of adverse side effects of the drugs). The most important drivers are shown in the figure; some of them are elaborated below.

Sales volume is generally growing due to an aging population needing more and longer medical treatment. In addition, we expect that the future will see breakthrough applications of modern technologies like genomics, proteomics, or rational drug design that will bring out new drugs for disease areas with so far unmet medical needs.



**Figure 2:** Framework for long-term commercial success  
 Source: Capgemini Life Sciences

A negative impact on return is expected from decreasing gross margins. In the short-term, we expect this to result from increasing government and payer pressure to contain healthcare costs. Several payers are already putting limits on reimbursement, for example, lately the National Institute for Health and Clinical Excellence (NICE) published the final guidance on bevacizumab and cetuximab for the treatment of metastatic colorectal cancer and stated that these new treatments do not balance their additional therapeutic benefit against their cost.<sup>4</sup> Several other monoclonal antibodies were also regarded as a not good use of NHS resources. A longer-term effect on gross margin can be expected as more market mechanisms in line with future healthcare reforms will gradually come into effect. The rising amount of co-payment by the patients will shift to lower priced and more effective drugs because the patients will be more demanding and look more carefully on their direct spent.

The commercial costs, esp. sales and marketing costs are escalating. Even if the race for the higher share of voice in the physician's office seems to have reached its peak, spend for DTC advertisements has grown tremendously and in countries like the US, the pharmaceutical industry is the largest spender for TV advertising. While we do not want to suggest that TV advertising is the most effective use of funds in marketing prescription drugs, it is clear that the shift in the healthcare decision-making network (Figure 1) needs more funds to address the information needs of patients and payers. Well-targeted and high-quality information will require pharma marketers to learn from other industries. Legal hurdles that still exist in many countries are expected to gradually be reduced if pharma takes a proactive approach to more transparency and patient-centricity.

Development costs are expected to rise due to the use of new technologies which allow addressing new, but so far unknown targets where the biology of the disease has to be understood. While regulatory requirements are rising, trial complexity is growing and in some indications like cancer the enrolment of patients and also investigators is getting very competitive. The new technologies, however, enable targeted therapies and therefore, clinical effectiveness can be improved by identifying and addressing specific patient groups in comparison to broad patient groups which react diversely to the drug. While reducing the potential market a higher clinical outcome can lead to a better justification for higher prices.

## PRACTICAL APPLICATION

Theory is one thing but in business life, practical application of concepts is what counts. So let's take a few examples of different initiatives and see how the framework for commercial success can be used in real life.

The development of new approaches for diagnosis, for example, molecular diagnostics, leads to targeted therapies where patient groups can be identified showing a positive response to the drug. Others which do not show a positive response will be excluded from treatment. It is inherent to such 'personalised' medicine that the number of potential patients is much lower than with traditional 'one size fits all'-drugs. In consequence, volumes will be lower. Given an overall higher clinical effectiveness, higher prices should be, however, justifiable. Development costs could be higher because of the additional research to identify the right patient group. But, in turn, the overall development risk could be reduced if the right target group is defined because the higher specificity should have a positive impact on clinical effectiveness or on the

safety profile. Hence, market authorisation should be easier due to a much more targeted approach. And, with a better safety profile and much closer patient-monitoring the risk of litigations due to adverse side effects should be lower.

Health education programmes like prevention initiatives or patient campaigns will not show a short-term ROI for a drug manufacturer (if an ROI can be calculated at all). They could, however, help to increase the reputation of a company and help to become or stay a recognised leader in a specific indication. For example, Novo Nordisk as a leader in the field of diabetes has invested since a long time in ‘changing diabetes’ which is also their marketing claim. They have introduced the insulin pen in 1985 making life with diabetes easier and were instrumental in developing rapid-acting insulin analogues. In our view, it is vital and it supports the value proposition of a drug manufacturer in a therapeutic area, if the company also engages in supporting patient associations that run health education programmes. Transparency and clear governance principles need to be established. In this way, Novo Nordisk supports the World Diabetes Foundation, which is dedicated to supporting prevention and treatment of diabetes in developing countries.

Disease management initiatives as payer/provider collaborations will also not show an immediate ROI for a pharmaceutical company. At first sight, pharma’s commercial costs will rise because of the additional marketing efforts to engage payers and patients in these programmes. If the companies are, however, able to show the payers that overall healthcare costs can be reduced by a more stringent patient compliance, volumes and prices could increase.

In similar ways, patient management can be seen. For an international pharmaceutical company, we developed a

patient management concept for innovative treatments of chronic diseases. Seeing the world through the eyes of the patient, we defined three patient phases ‘disease awareness’, ‘treatment’ and ‘recovery’. For each of the phases, we developed aligned and coordinated services that address patient phase-specific needs. For example, targeted awareness creation helped to raise disease awareness and direct patients to seek the advice of a doctor. Specific patient–physician communication material eased the communication between doctors and patients and thus served the information need of the patient and their relatives. And specific services involving the physician’s assistant helped to raise treatment compliance and also to maintain a relationship to patients during the symptom-free recovery phase. All these services and patient data were systematically collected by an external agency and stored in a patient database. This database was then used to continuously improve patient segmentation and tailor services that met the needs of customers even better.

## **ADAPTING THROUGHOUT THE PHARMACEUTICAL VALUE CHAIN — EXAMPLE: EARLY COMMERCIALISATION**

At the end, it all boils down to the fact that health outcome will be much more important in the future. And pharma companies need to embrace the concept early on and align all their activities around producing better balance between input and output. How can the companies address health outcome early enough? Combining the scientific innovation engine with a patient and customer perspective from the beginning?

One approach is early commercialisation whose aspects we analysed in the 6th Edition of our Vision & Reality study.<sup>5</sup> Pharmaceutical companies need to

reconsider their indication development model and expand it to a ‘customer centric product development model’ (Figure 3). Hence, looking for new promotional models starts as early as in Phase II of the product development chain (if we neglect that the strategic choice of the therapeutic areas has occurred even before that).

We focus here on how early commercialisation can help to anticipate payers’ questions of a drug’s value and refer to the study for the other aspects. In the past, pharmaceutical companies attempted to circumvent payers’ influence by using sheer commercial muscle to make sure that the provider and, where DTC advertising is allowed, to some extent also the patient are demanding the drug. Now, payers have a very specific perception of value, and pharmaceutical companies must be able to argue that their price levels are appropriate. If not, market success can never be seen as observed with Amevive in 2003, Biogen’s biologic for psoriasis, which was priced at a significant cost premium over Amgen’s Enbrel. Because this price premium was never justified with pharmacoeconomic arguments, many payers refused to add Amevive to their preferred formularies,

and doctors who did use the drug were not always reimbursed for their purchase. As a consequence, Amevive’s launch was stillborn. The lesson learned is that pharmaceutical companies need health economic and health outcome studies to justify prices. The strategies for the setup of these studies should be planned even before the clinical trials start. Furthermore, price differentials across different countries should be considered as well. In summary, customer-centricity is about payers’ and patients’ needs, already during R&D.

### OUTLOOK

When it comes to new promotional models, we do not expect to see a ‘one size fits all’. Pharma companies need to think more about their value proposition and how they can provide value to all customers, that is, patients, healthcare professionals and payers. This value proposition drives the pharma brand and needs to be communicated appropriately. This goes far beyond sales reps detailing drugs to physicians. And the marketing message will be very different from one drug class to another and from one company to another, even in the same drug class and indication area. It will need

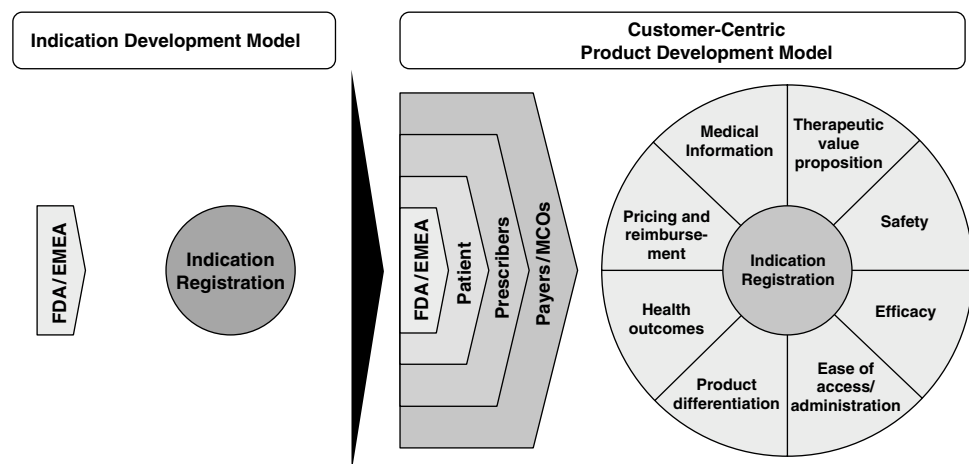


Figure 3: Customer-centric product development model

a multitude of different channels tailored to the needs of each customer.

The risk-adjusted return framework provides a simple but strategic framework that will help pharma executives to cut through the ever more complex marketing jungle. The difficulty will not be to identify the right initiatives but to change from the current model to a new one. It involves trying new avenues and thus bears risk of failure. This is why we do not believe in a Big Bang approach but a long phase of trial and error. Piloting new promotional models in a variety of areas and learning from mistakes will be required. But is not this how all industries have developed and hence brought better products at cheaper prices? It will be up to the adaptive companies to reap the

benefits of the changing healthcare environment.

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