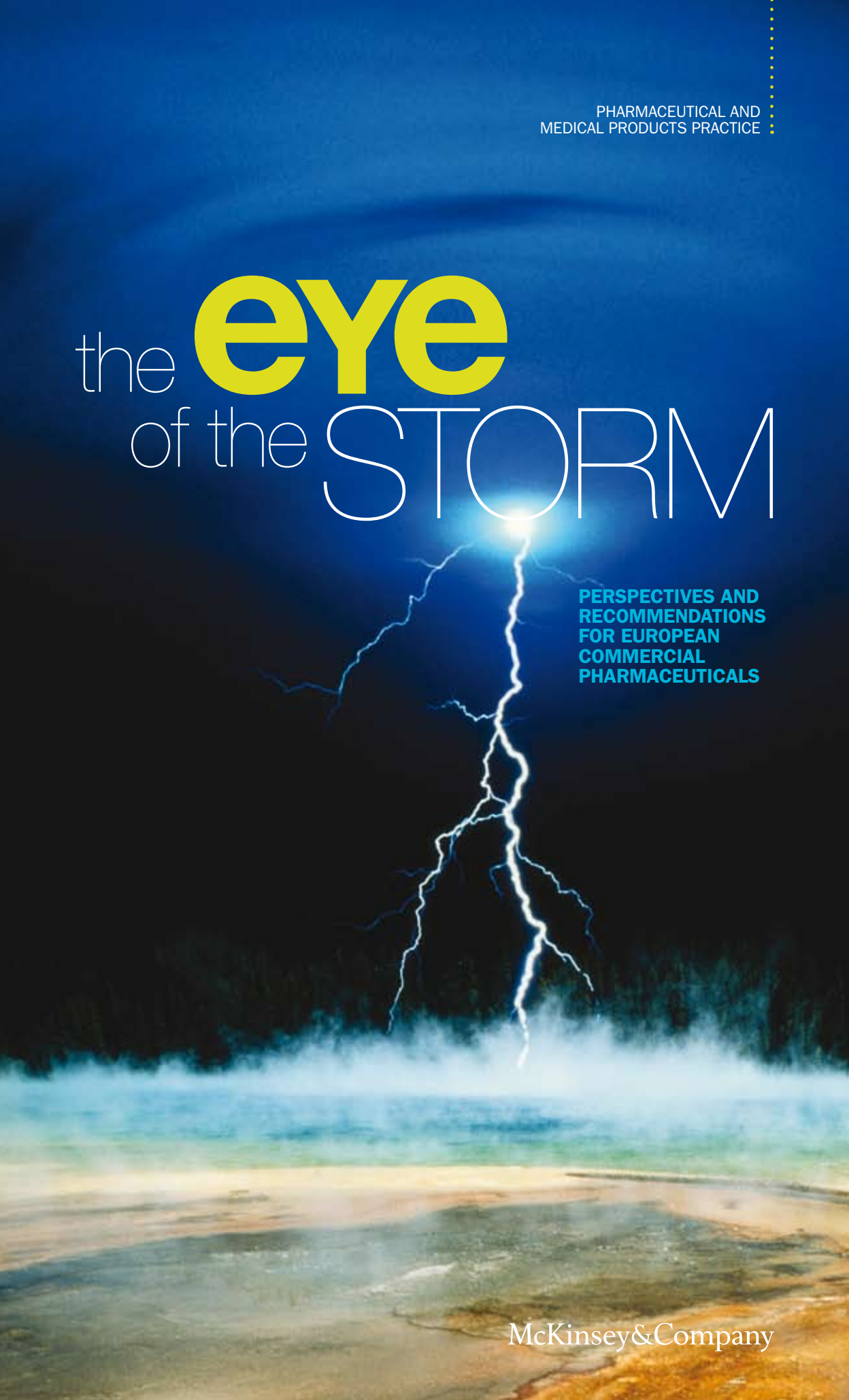
PHARMACEUTICAL AND
MEDICAL PRODUCTS PRACTICE

the eye of the STORM



PERSPECTIVES AND RECOMMENDATIONS FOR EUROPEAN COMMERCIAL PHARMACEUTICALS

McKinsey&Company

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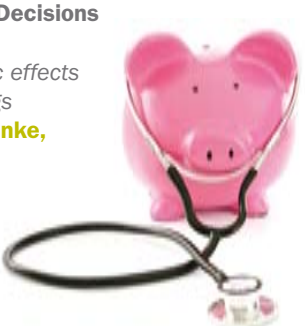
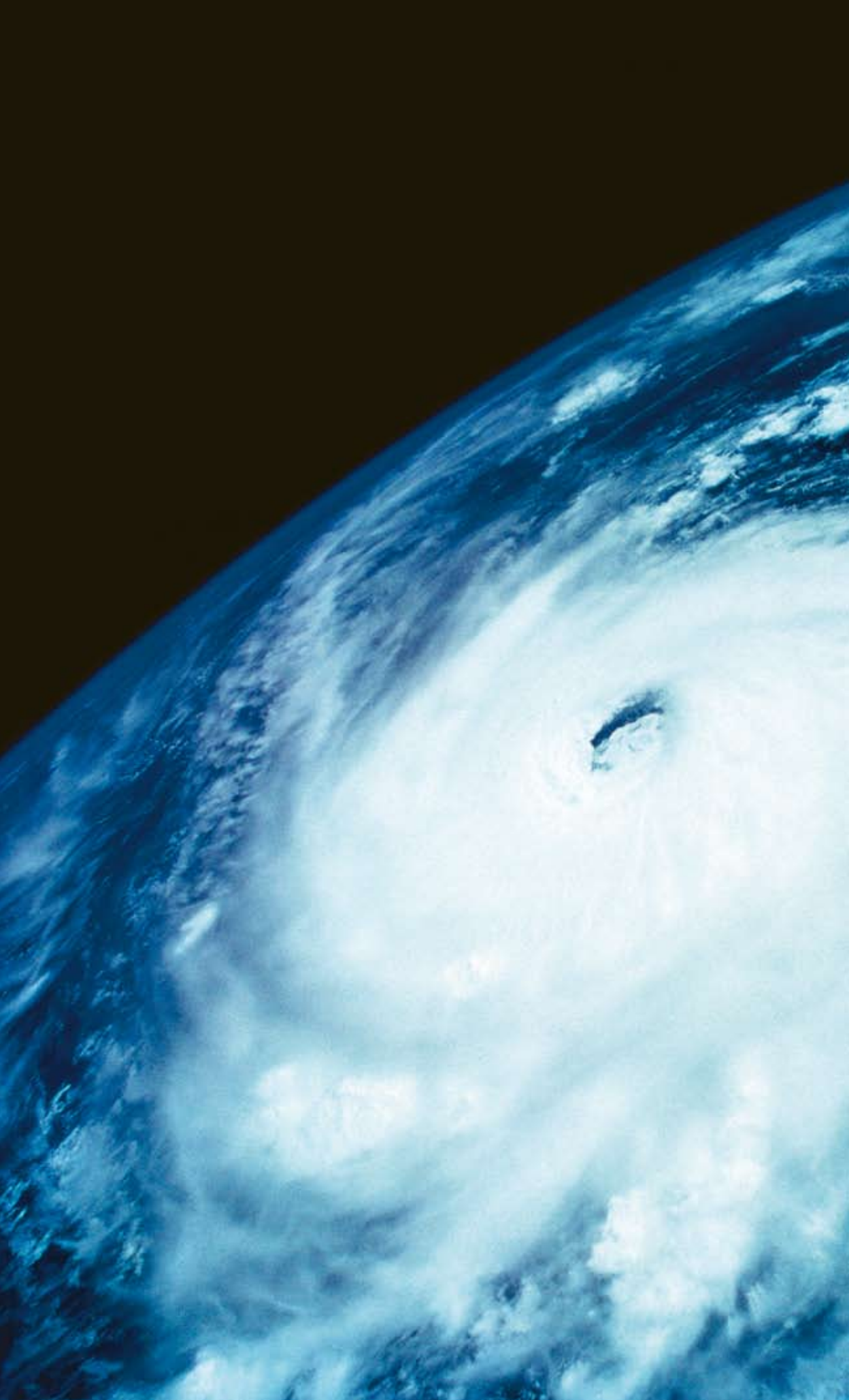
CONTENTS

The coming storm

Market access diplomacy



Front-line sales and marketing excellence



the eye of the STORM

PERSPECTIVES AND RECOMMENDATIONS FOR EUROPEAN COMMERCIAL PHARMACEUTICALS

VIVIAN HUNT
MAGNUS TYREMAN

INTRODUCTION

The pharmaceutical industry is approaching a tipping point as both external changes (in the evolution of the customer landscape) and internal changes (in the development of companies' own portfolios and capabilities) place increasing pressure on the traditional commercial model. So far, pharmaceutical companies have responded – with some success – by focusing on improving productivity without fundamentally changing the sales model. These improvements, however, are unlikely to be enough to meet the challenges ahead.

The coming storm

The first article in this compendium, "Mastering Complexity with New Commercial models", shares our perspectives on more radical moves that may be required. While exploring portfolio alternatives is certainly a strategic choice for companies to consider, optimising the commercial model for primary care will be the most important challenge in the near term, as all large pharmaceutical companies will retain a substantial interest in primary care for the next ten years. As the current sales model becomes increasingly unsustainable, the article considers the new insights, capabilities, and processes companies will need to bolster them for the future.

Meanwhile, the battlefield in the war for talent has also shifted. As the pharmaceutical market environment has changed, so have the skills required for key commercial roles. Furthermore, Generation Y employees require different approaches from those used with Generation X employees before them. We highlight the new challenges pharmaceutical companies face in leadership and talent management and suggest steps they can take to address these issues.

The articles which follow describe in depth new methods available to pharmaceutical companies to master the subtleties of market access diplomacy and front-line sales and marketing excellence in today's complex environment.

Market access diplomacy

As governments, regulators, and payors scrutinise the economic value of drugs more and more closely, market access is becoming an increasingly important issue for pharmaceutical companies. The article "Unlocking Market Access in Europe" shares our perspectives on the vital actions that companies need to take to improve their access to the market in this constrained environment. These actions include demonstrating the economic value of their drugs, and we adopt the term "Market Access Minded Development" to describe how pharmaceutical companies can apply a smart approach from the start of development and transform potential "me-too drugs" into "me-better drugs".

Beyond the development stage, the article "Real-Life Health Care Economics: A Better Basis for Treatment Decisions" proposes a clear, practical approach, gathering real-life data from hospitals and GP practices to supplement the data derived from the controlled environment of clinical trials.

Sales and marketing excellence

As access to markets become increasingly restricted and competitive intensity increases, adopting customer-centric mindsets will be a key success factor for pharmaceutical companies. The pharmaceutical industry can look to the highly competitive technology and consumer goods industry for inspiration in developing customer insights and tailoring global brands to local needs. Getting this right can mean the difference between a blockbuster and a mediocre market performer.

Based on our experience across industries, we have identified four core components of marketing excellence in pharmaceuticals and medical products: 1) defining the market; 2) designing the brand proposition and marketing plan; 3) delivering the plan in the marketplace; and 4) driving the organisation to support these activities.

Within each of these components, a number of skills and capabilities are required to deliver excellence. No one excels at all of them. The goal is to identify which capabilities have the greatest impact on your business and where you have the greatest gaps compared with best practice.

The first three articles in this section describe some of the initiatives leading pharmaceutical players are taking to bolster their marketing performance:

- "Building a Differentiated Brand Positioning" shares a systematic approach to defining the market and also to designing and delivering the brand proposition.
- "Customer Insight: Crucial to Growth in Competitive Markets" outlines our perspectives on what it takes for companies to generate superior customer insight.
- "Optimizing Marketing Spend: Moving Beyond ROI to Quality" provides an innovative, holistic approach to assessing and reallocating spend that overcomes many of the limitations of traditional ROI analyses by factoring quality.

The final article, "Ten Ideas to Improve the Front Line", turns the spotlight on the sales model, and proposes ten suggestions for companies to consider as they experiment and innovate.

CONCLUSION

While this compendium does not attempt to cover all commercial capabilities, it highlights a few that we think are particularly critical and uses tangible examples and thought starters to illustrate some ways of tackling the industry's pressing issues. We hope that you find this informative and useful on your journey to commercial excellence.

mastering complexity with new commercial MODELS

JONATHAN DOOGAN
VIVIAN HUNT

As the customer landscape and their own product portfolios both become more complex, pharmaceutical companies need to pick their battlegrounds more carefully, and to master the subtleties of market access diplomacy at regional, national and local levels. To succeed in the new environment, primary care players must urgently overhaul their commercial models, and incorporate some of the strengths of generics and specialty businesses into the remodeling.

COMPLEXITY ON THE PLAYING FIELD AND CLOSER TO HOME

The commercial model in ethical pharmaceuticals has been based on the same, simple conventions for decades: bag-carrying sales representatives delivering their messages to GPs in three-product details, in five to ten minute slots. It was the proliferation of drug representatives and their increasingly aggressive tactics in the 1990s that first gave rise to the term "pharmaceutical arms race". The expression does not suggest that companies have been bothering much about focus, subtlety or precision in their campaigning. And why would they? The industry has been among the most profitable in the world for decades, physicians have dutifully responded to new innovations, education and exposure by writing prescriptions and portfolios have been constantly refreshed by a steady stream of blockbuster drugs.

Times are changing. New pressures, both external (in the evolution of the customer landscape) and internal (in the development of the companies' own portfolios and capabilities) are already reducing the effectiveness of this model. As the world order continues to change and the heavy artillery loses its firepower, it will be consigned to history. Meanwhile, the battlefield in the war for talent has also shifted – as the pharmaceutical market environment has changed, so have the skills required for key commercial roles. Furthermore, Generation Y employees require different approaches from those used with Generation X employees before them. We highlight the new challenges pharmaceutical companies face in talent management and suggest steps they can take to address these issues.

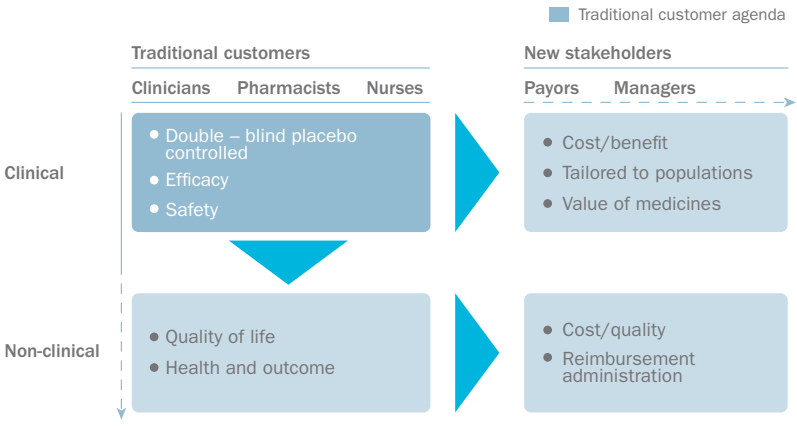
The articles which follow describe in depth new methods available to pharmaceutical companies to master the subtleties of market access diplomacy and front-line sales and marketing excellence in tomorrow's complex environment.

External complexity: proliferating customers and the cost agenda

- **Drug pricing and reimbursement are under increasing scrutiny**, as governments in many countries try to tackle the mounting burden of healthcare costs in part by reducing drug costs and decentralising the burden of payment.
- **New customer and stakeholder groups are emerging**, many of them outside the surgery or hospital ward – namely, managers, payors, and health economists. In conjunction, customer agendas and the relevant end points for engagement have shifted away from purely clinical considerations towards questions of value.
- **Prescribing guidelines are being tightened** because the payors and managers who have wrested control from physicians over some prescribing decisions are less concerned with drug efficacy and safety alone and more interested in value, measured in terms of both cost:benefit and overall value. In many cases, pharmacists are being incentivised to streamline hospital formularies and substitute generics for branded products.
- **Access to physicians is increasingly restricted** as their work burdens, as well as new regulatory policies, tend to exclude representatives from the surgery. So, as conventional sales forces struggle to remain effective in the changing environment, their difficulties are exacerbated by a breakdown in their traditional channels of communication. Alternatives, such as peer advocacy and the internet, contribute to greater channel complexity, which the traditional commercial model is not designed to accommodate.

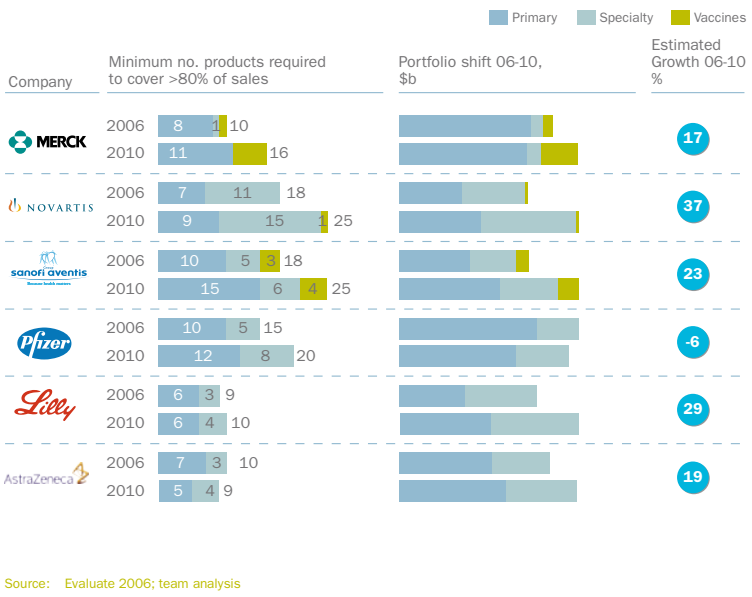
In short, the traditional, "push" approach to primary care sales and marketing is no longer adequate because it does not communicate well differentiated value propositions to customers who are demanding demonstrated medical value in terms of both health outcome and health economics *(Exhibit 1)*.

exhibit 1



Source: McKinsey

exhibit 2a



Source: Evaluate 2006; team analysis

Internal complexity: proliferation within portfolios

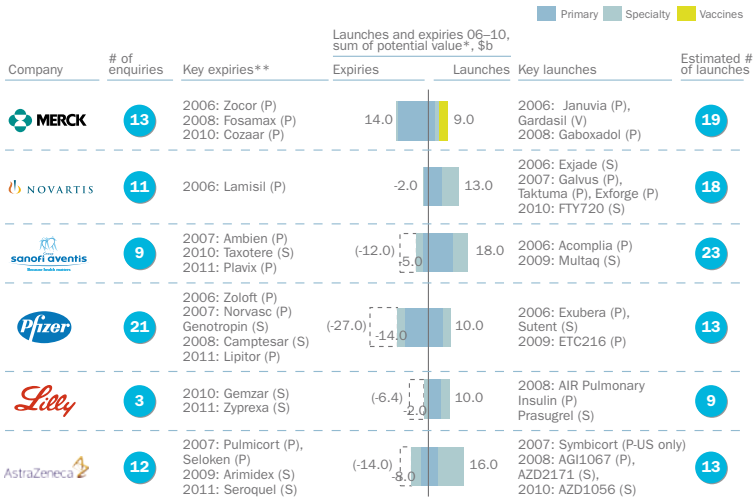
While most managers are only too well aware of the complexity arising from changes in the external environment, they are generally less conscious of a similar development closer to home. In most large companies, the product portfolio is becoming more complex as it evolves.

- **Portfolios are fragmenting** to such an extent that the typical primary care portfolio of 2017 is likely to look very different from that of today. As blockbuster patents expire, companies are generally making up for lost revenues by launching a larger number of small and medium-sized products. For example, it will take 16 products to constitute 80% of one pharma major's total revenues by 2010, compared to ten in 2006 – and similar fragmentation can be seen in the portfolios of some of the largest players *(Exhibit 2a)*. Commercialising a larger number of smaller products inevitably increases the number of product teams required to promote the portfolio, and the managerial complexity of the sales and marketing remit.
- **Portfolios are shifting** across the borders between settings and the dominance of primary care, in terms of revenue share, is diminishing in the prescription drug sector as a whole in favour of specialty and vaccines. This trend is most pronounced at some of the largest players *(Exhibit 2a)*. But the traffic is not all one way; specialty players are expanding their footprints into primary care. Managing a portfolio more evenly spread across several settings broadens the range of potential customer types and therefore increases the range of front-line roles required.

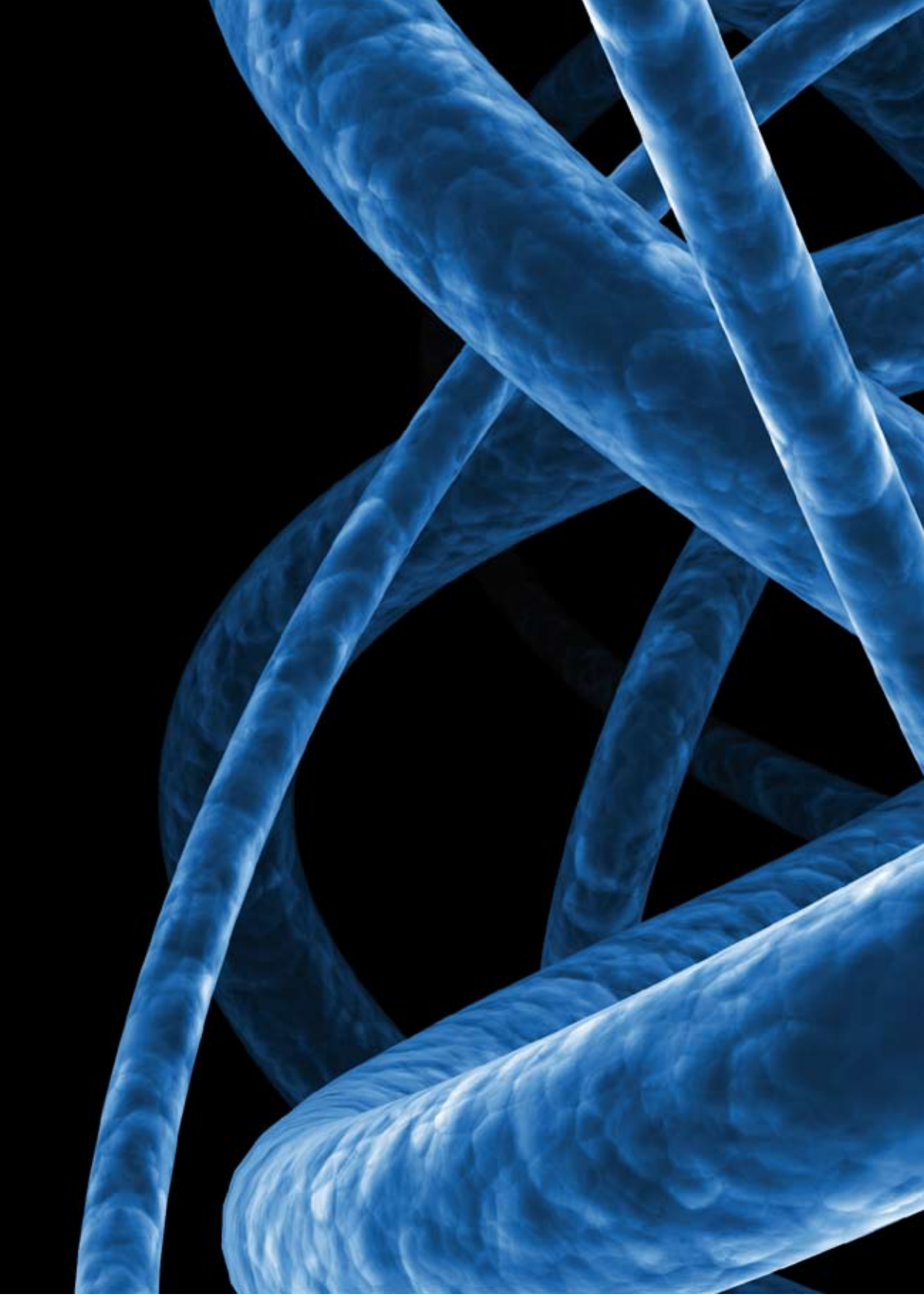
- **Levels of product differentiation are becoming more polarised.** As the white spaces of unmet need shrink, differentiation in primary care is becoming increasingly marginal and hard to attain. In search of rewards for innovation, companies are supplementing their core businesses by tackling areas of unmet need outside primary care. This diversification makes their overall portfolio value propositions less internally consistent, and splits their portfolios across a broader range of clinical settings and therapeutic areas.
- **Launches and expirations are happening more frequently.** Most companies are experiencing a dynamic period of product expiries. The simultaneous launch and expiration of products not only creates margin pressure through short-term revenue decline – it also turns the management of field force resource into an ongoing challenge. Questions such as when and how to scale down, whether to re-allocate resources and, if so, where and how, can be hard to judge correctly. They involve considering, for example, the extent to which primary care representatives can be re-assigned to specialty products and vaccines – which would require them to adapt to new customers, interaction styles and commercial approaches.

These factors relating to products and portfolios are far more complex, more intricate and harder to manage than those which major companies in the blockbuster era had to face. Combined with the external complications and increasing pressure on profitability described earlier, they make the legacy commercial model anachronistic. As customer groups and their agendas proliferate, with more stakeholders demanding to debate different points, pharmaceutical companies are dealing with a significantly more complex purchasing environment. This has significant implications for the commercial roles companies require, and the types of people they need to fill them, in order to be competitive. In addition, market access and marketing efforts are both becoming more onerous, requiring weightier evidence and broader value propositions to support their products. In the new world, novel parity will not open the door; proof of outcomes across populations is the required entry ticket for commercialisation.

exhibit 2b



* Potential value = value of peak sales of product
** Does not account for line extension (e.g., extended release formulations)
Source: Evaluate 2006; team analysis



In our work with clients, we see returns on traditional sales and marketing efforts diminishing all the time. A hundred visits, for example, may lead to as few as twelve product details being recalled by physicians. Most primary care executives admit that significant waste in the current system is destroying value. Those with foresight are starting to realise that the time has come to rethink their commercial models.

ARCHETYPES AND STRATEGIC CHOICES

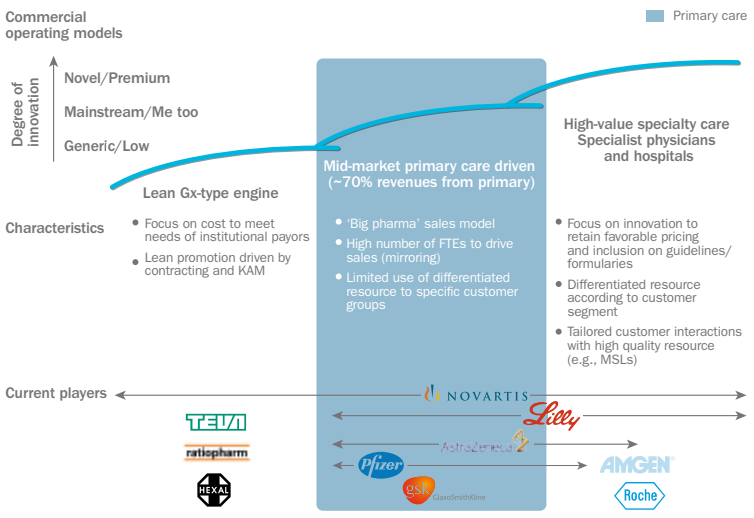
The loss of scope to innovate in primary care puts at risk the traditional levels of profitability enjoyed by large pharmaceutical companies, as authorities have become increasingly intolerant of paying for a stream of "me-too" products, one after another. To defend the high returns to which they are accustomed, companies will have to broaden their commercial footprints beyond primary care, at the same time as optimising their primary care businesses.

The evolution of the portfolio, and therefore the commercial model, is not solely the result of pipeline or patent life determinism. Managers need to be more active in their choices about strategic direction in determining the commercial footprint – asking themselves which are the right spaces to compete in and how the company should organise to compete effectively in the spaces it selects.

Commercial archetypes

There are three commercial archetypes at the core of the pharmaceutical industry (excluding consumer health and vaccines): the lean generics player, the high value specialty player, and the primary care player *(Exhibit 3)*.

exhibit 3



Source: Annual reports 2006; team analysis

Generics players need a broad portfolio of low-cost medicines to foster relationships with a small number of key decision makers for whom cost is the most important purchasing criterion. Payors in most markets favour substitution of generics whenever this can be justified, so these players are pushing against an open door. However, there is little left if they fail to be first or second to market. So the factors which drive resourcing and shape the commercial model are speed (with a regulatory function that can guarantee rapid licensing to ensure first mover advantage), the need to drive costs down as low as possible, and the ability to manage effectively a small number of key accounts (purchasing managers and lead pharmacists). This is exactly what we see if we examine the commercial approaches of the emerging leaders in generics.

At the other end of the spectrum of innovation, success for high value specialty players depends on innovative outcomes, quality and peer-to-peer interaction, rather than on scale. The commercial model here is based on scientific excellence and intimacy with key opinion leaders (KOLs). Reputation as therapeutic category leader is a critical lever in developing network credibility to smooth market access, so high value specialty players need to focus on Research and Development (R&D) in select therapeutic areas as the engine of future value. They need to integrate KOLs into their development processes in order to ensure the support of key stakeholders for the smooth transition of their products from pipeline to market. Established specialty players illustrate this model nicely.

Despite their obvious differences, these two archetypes share a common requirement for excellent account management. Both types of player must tailor their value propositions to meet customer needs – at one end by paying attention to tendering and cost, at the other by focusing on science and quality.

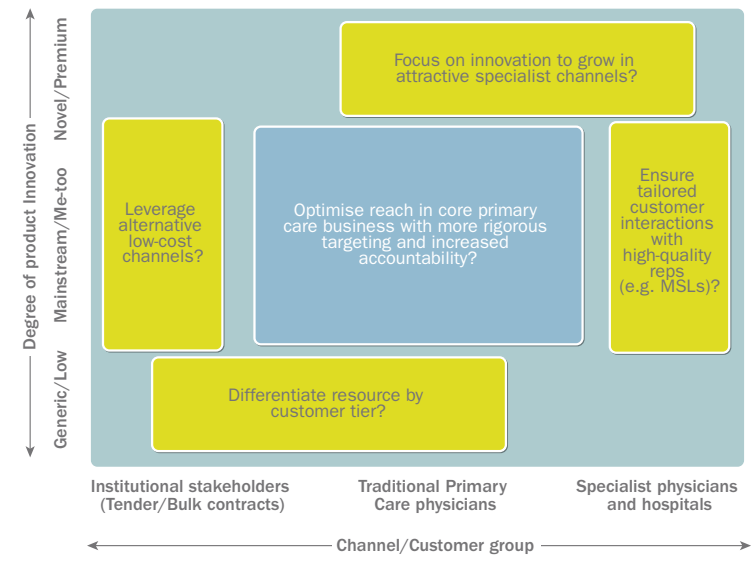
The third archetype is the primary care company we have already described, fighting on the familiar battlefield.

Strategic choices – deciding where to play

If the evolution of the portfolio is to be actively determined by strategic choice, for a primary care player, there are three basic choices *(Exhibit 4)*:

- **To focus on primary care and optimise the business**. This means aligning R&D and business development around therapeutic categories where the company can drive competitive advantage through differentiation at the brand level and the customer interface.

exhibit 4



Source: McKinsey

- **To migrate into other clinical settings** where innovation and optimisation of the commercial approach provide potential sources of sustainable advantage. Migration is usually into specialty care, where volumes may be lower but the basis of competition is more clinically defined and differentiation may be easier to attain. Examples include GSK's move into oncology, Astra Zeneca into biologics or Novartis's into haematology. Migration into generics is less common, but Novartis continues to operate the Sandoz generics business very successfully, and migration into generics or other unbranded/unpatented strategies can offset the risk of prescription medicines coming under further attack by payors. It also allows expiring products to be transferred into a lower cost, contract-based commercial environment. Companies are increasingly competing right across the spectrum. Migration into new therapeutic paradigms, such as vaccines or biologics, provides opportunities in businesses where the traditional sales force driven model is less relevant and innovation is more fertile.
- **To dramatically reduce dependence on primary care** and focus on other settings, perhaps diversifying through partnerships or "swapping out". This type of migration may become an attractive option for some companies in future.

Strategic choices about the shape of a company's footprint should be guided by its existing strengths and assets *(Exhibit 5)*:

- ***Portfolio and pipeline assets.*** The evolution of the product mix and how the products meet the white spaces of clinical need – if they do so at all.
- ***Customer relationships*** – both clinical and non-clinical – that represent a source of preference and competitive advantage.
- ***Functional competencies*** which represent sources of advantage within the organisation (such as distinctive science, R&D, business development, licensing, customer insight, or marketing and sales).

exhibit 5

Source: McKinsey

The multi-model company

In practice, few large companies will resemble a single archetype – the commercial footprint represents a balance of different archetypes. We have already described how some are increasingly competing right across the innovation spectrum and beyond it. Most companies compete on multiple fronts – consumer, vaccines, generics, general medicine, and specialty/oncology. Such diversified portfolios will require several commercial models to cohabit within a single company.

To flourish, cohabiting commercial models will require the appropriate balance of separation and integration, both organisational and cultural. The optimal organisational model does not follow a single blueprint.

Whatever choices they make, for the next ten years all large ethical pharmaceutical companies will retain a substantial interest in primary care. Indeed, in the next four to five years, most will continue to earn the majority of their revenues from primary care. For this reason, optimising the commercial model in the middle ground remains one of the most important challenges.

WINNING IN PRIMARY CARE WITH A MORE ADVANCED MODEL

How can managers defend the primary care business, the middle ground in the commercial footprint? The short answer is that the current primary care model needs to harness elements of both the generics and specialty models to optimise customer reach, cost-to-serve, quality of interaction with stakeholders and resourcing flexibility. We believe that four over-arching themes should govern the model's development to address the forces of complexity outlined in this article.

1. Sales forces will need to become leaner.

Scaling back on wasteful numbers of representatives and unfocused calls and interactions is a "no brainer". There can be little question that the current sales forces of large primary care players need to be reduced to eliminate waste and enhance focus and accountability. Calls by several representatives on the same physician diminish accountability and performance transparency, and this is causing managers to question the wisdom of the mirrored approach. Recent reductions by Wyeth, Merck and Pfizer demonstrate that some companies are already flexing their commercial models. The size of sales territories is also under scrutiny for similar reasons. One pharmaceutical company, for example, is defining smaller "micro-territories" in the US to sharpen the focus of its sales force there. Finally, there will likely be sharper differentiation and coordination between commercial sales efforts and scientific or peer-to-peer interaction.

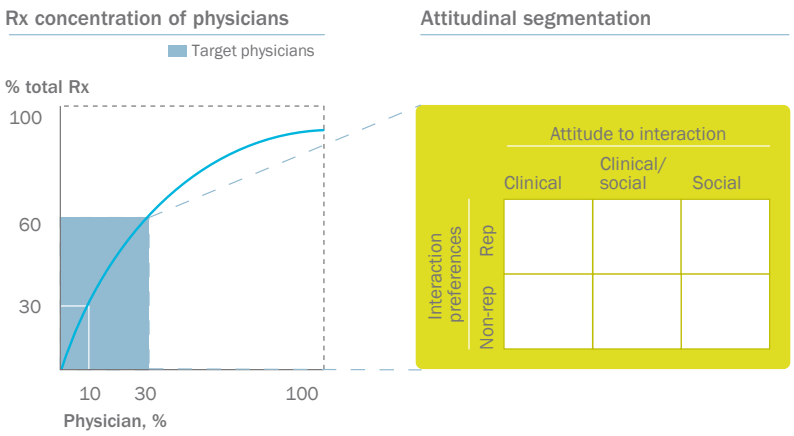
2. Targeting must be more effective, with resources allocated more ruthlessly according to customer value.

A leaner sales force calls for sharper judgments about the customer base. A reduction in physician prescribing across all therapeutic categories has not prevented many large players from trying to reach an unnecessarily broad GP universe. The marginal return from applying field force resource (the most expensive lever available) to a physician in the 8th, 9th or 10th decile even once (let alone four or five times in a quarter) is close to zero. A more ruthless approach to "cutting the tail" based on physician prescribing data is critical to free up time for customers with higher potential.

Current assumptions about coverage and frequency are open to challenge – including the assumption that all customers should be seen by sales representatives. To win with more products but fewer sales representatives, companies will have to allocate a more diverse range of resources with far greater precision. This is likely to mean more cross-functional planning more continuously than under current annual or bi-annual planning cycles.

A corollary of value-based targeting is to analyse segment-based interaction preferences to ensure that high value customers are addressed in a tailored and effective fashion. For example, a significant minority of high prescribing physicians prefer the advocacy of their peers to that of a sales representative as a source of new information about products. The sequencing of interactions can be a powerful variable in determining the optimal mix. Overlaying value-based target lists with needs-based segmentation (including interaction preferences) is a potent way of optimising the allocation of resources ***(Exhibit 6)***.

exhibit 6



Source: McKinsey

3. For top tier physicians and other key stakeholders, quality of interaction is a key differentiator.

Preference among top tier practitioners is a critical driver of sales in most therapeutic areas, and preference cannot be achieved without investment in high quality resources. A few specialty players set new standards in developing peer-to-peer relationships with oncologists by investing in high quality front-line resources to drive innovative products like Herceptin. For top tier customers, particularly where launch and early lifecycle products are concerned, peer-to-peer interactions can be conducted like clinical account management. Creating these relationships will demand new talents and capabilities within primary care companies.

Gaining market access at national and local levels will require leadership and talent to upgrade the quality of non-clinical interactions as well. Understanding the public health agenda and linking product benefits to economic end points will mean employing more expert stakeholder influencers to enable front-line representatives.

4. A leaner model under more complex conditions will require much more flexibility.

A fundamental lack of flexibility and long planning cycles have been defining features of the traditional primary care model – the legacy is a one-size-fits-all promotional approach which disregards differences in products, customers and territories. Managers now need to instill a dynamic approach, one which enables resources to be optimally deployed and investments to be pulsed up and pulsed down, as commercial and competitive considerations change.

Evidence of renewed commitment to contract sales partnerships amongst a number of the largest players, shows a desire not just to reduce headcount but also to manipulate the promotional mix so that it fits more precisely the requirements of particular products in particular places at particular times.

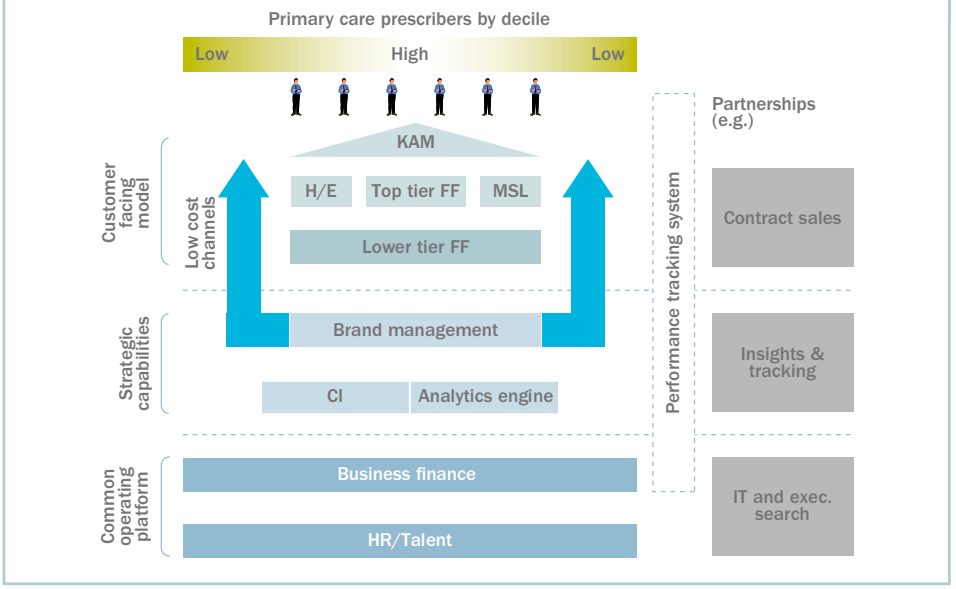
Contract sales will support the higher quality full-time employees by addressing the lower value customer base. In addition, alternative marketing channels such as direct mail, e-Detailing and other low cost yet targeted levers can further supplement the more targeted and tiered in-house resource.

NEW CAPABILITIES AND CORE PROCESSES TO SUPPORT THE NEW MODEL

A commercial model which is leaner and more targeted, more focused on quality of interaction and more flexible will require companies to build or upgrade their core capabilities, processes and systems. Strategic capabilities, such as those in front-line sales and centralised marketing, including consumer insights and brand translation, need to be supported by operational capabilities, such as performance tracking systems and talent management *(Exhibit 7)*.

Attaining the optimal balance between up-skilling and down-scaling is the ultimate management challenge. It would be illogical to pursue a lean model and then bolt expensive new capabilities on to it: some existing capabilities will need to be scaled down or replaced.

exhibit 7



1. Customer facing capabilities

Success in primary care will increasingly depend on deep relationships with top tier physicians. This implies extra investment in people who can conduct peer-to-peer relationships (akin to those in medical science liaison). The trade-off will be to reduce the number of conventional field force representatives and replace them with lower cost channels, contract sales or lower paid "sample-drop reps" where permitted.

Primary care players will also need to master key account management (KAM). This will involve developing next generation processes, such as drawing up account plans for key surgeries, primary care trusts and regional bodies and building a KAM database – the most important source of insights for the development of value and service propositions. The pharmaceutical industry has much to learn about prioritising top accounts from world-class executives in medical devices and computing, like Philips and Cisco, and about managing key accounts in tiers based on value. Among pharmaceutical companies, a few specialty players are good examples of those emulating this approach, particularly with top tier oncologists.

2. Specialist expertise

To ensure access and supplement front-line activity, companies will also need to invest in people who can talk the language of healthcare economics and public health management. Addressing the cost:benefit agenda and coming up with solutions tailored to local requirements will be crucial drivers of the value proposition. So integrating employees with these capabilities into cohesive teams will be key to managing local and regional networks effectively.

Key account managers will not only need to manage customers in an integrated way but will need to act as hubs in the co-ordination and deployment of a range of specialists, including health economists and medical science specialists. Responsibility for the management of key customer groups will be collective, rather than individual, and judgements about resourcing will be devolved to the front line. This shift will require customer-facing gatekeepers of the right calibre and mindset for an entrepreneurial, business management approach.

3. Customer insights and brand capabilities

Primary care companies will need customer insights which are both deeper (into top-tier physicians) and broader (into the whole set of stakeholders) to inform the way they position their products and the way they deploy resources.

Recruiting professionals with deep expertise in the generation of customer insights, able to use innovative qualitative and quantitative techniques as well as secondary sources, should be a high priority. Market research is all too seldom run by strategic business thinkers who understand the value of systematic segmentation, targeting and brand positioning. The role of business intelligence or customer insights management will need to be elevated to attract and retain the requisite calibre of individuals. By forming strategic partnerships with global agencies and outsourcing the more operational aspects of research design and copy generation, a relatively small number of internal managers should be able to run this function and spend time analysing data and pursuing the proprietary “insights” which underpin sustainable brand growth.

A broader set of marketing levers must be employed to align cost-to-serve with customer value, and to address interaction preferences segment by segment. A&P allocation and lower cost channels will be required to free up resource for the critical top tier, support a leaner sales force and form part of a more effective model. Companies will need to get better at leveraging the internet and e-channels, for example, both to address lower value deciles and to supplement representative activity in addressing higher value deciles.

4. Commercial support and core processes

The commercial capabilities outlined above will need to be supported by a more intensive and sophisticated set of core processes, which enable greater control over execution and greater flexibility in resourcing.

The current cycle of strategy execution and resource planning where marketing interacts with sales is annual in most companies – bi-annual or quarterly in others. Once promotional direction is set and budgets are allocated, the usual attitude is, “job done” until the next cyclic interaction. This norm will increasingly fail to meet the standards of quality and lean operation. Planning cycles need to get shorter to enable more real-time allocation and re-allocation of resources and even adjustment of the campaign itself. Companies will need to invest more to track precisely the effectiveness of commercial inputs into the market, with business intelligence roles dedicated to their active monitoring.

Such aspirations will only be feasible in practice in organisations sufficiently flexible to allow managers or KAMs to make continuous resourcing adjustments at front-line level. The KAM system needs to create the conditions for entrepreneurial decision making by assisting risk management. This means controls over levers that could affect profitability, namely budgeting and (where relevant) pricing, must be embedded in it. The KAM system should provide core input to business intelligence for the overall management of the commercial operating system.

It naturally falls to HR and talent management to fulfil the requirement for the right calibre people to fill key roles and to make work meaningful for them on a sustainable basis, using incentives to drive performance and recognition, and rotation to drive stability by retaining the best human capital. Incentives need to be aligned to a balanced selection of key business drivers – not only to the commercial outputs of sales and market share but also to a few priority lead indicators, such as message tracking to measure brand equity, and to validated behaviours, such as influencing formularies through projects, forums and other initiatives.

5. Shared operating systems

Most pharmaceutical companies, unlike global consumer goods companies and retailers, currently lack the "analytic engine" they need to support the new way of working. The workload involved in acquiring and leveraging a fact base on customers, influencers, prescribers and market access conditions will be significant. This data will need to be integrated, analysed and interpreted to supply both marketing and sales with core insights to direct their activities, resourcing and investment. The system should integrate customer insights, business intelligence and key account plans and activity reports. It should also process key performance indicators, acting as the nerve centre of performance management.

A new level of management focus and system integration will be required to apply front-line capability across the broader range of roles and allocate the right weight and mix of marketing investment to the customer base, on the basis of cost-to-serve principles. Marketers and sales managers or KAMs will need an increasingly finance-orientated mindset to evaluate return on investment, and appropriate monitoring systems to support such investment evaluation.

General managers or business unit heads will require visibility across the systems, linked to commercial performance. A well-prioritised executive level dashboard should be constructed with much consideration so that it delivers real-time transparency and supports effective challenge to brand and sales teams.

6. Integrated decision making

Decision making across the organisation at all levels, from general managers to the front line, needs to become more integrated. Integration is relatively natural at the top of the organisation; the challenge is to drive it down to brand and customer-focused teams by changing both practices and mindsets. While organisational transformation of this nature may be hard to achieve in the short term, the identification of natural overlaps in commercial functions will help managers at operational levels to learn new behaviours. Greater accountability of marketing managers for the profitability of their brands, rather than just market share, for example, necessitates a new way of working. This will include greater coordination across product performance (or other) teams, countries and regional/global teams and more overlap and debate with finance and business development. The same principle could apply equally to sales and key account management. The inextricable overlap of local market access and sales now means that braver decisions need to be made about substituting public-health and market access focused roles to replace traditional commercial resourcing until profitable access for the sales force can be attained – key account managers need to integrate commercial and regulatory decision making.

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The relative profitability of the pharmaceutical sector has, to some extent, insulated it from the burning platform of change which has already shaken up sales and marketing in other industries but external and internal indicators are now signalling that the old commercial model has had its day. Fundamentally, the commercial mind-shift must move away from big-is-beautiful thinking, hooked on market share.

Companies need to broaden their commercial footprints into clinical settings and therapeutic areas where they can optimise the combination of their developing product portfolios and customer relationships. The commercial models they operate in different parts of the footprint will require appropriate degrees of organisational and cultural separation to flourish.

The centre ground of primary care is the arena where change is most urgent and where there is the most room for improvement – but also, therefore, the greatest potential. Companies can adapt and improve the primary care model both by adopting the lean principles inherent in the generics model and by replicating the quality focus currently reserved for high value specialty products. To achieve his transformation, they will have to get better at targeting and tiering resources, and they will need to overhaul their commercial capabilities and core processes. They will need a model with flexibility built into its fabric. Their leaders should be looking for inspiration from both their customers and industries well beyond traditional, outside "big pharma".

Our appreciation to several clients and our colleagues including Sven Dethlefs, Jason Hoffe, Olof Mathé, Carlo Rizzuto, and Magnus Tyreman for their assistance.

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the talent management CHALLENGE

EMILY LAWSON

The McKinsey Quarterly survey asked nearly 10,000 global business executives in 2005 what their biggest managerial challenge would be over the next five years. The most common answer was “finding talent”. As acutely as companies in any other industry, pharmaceutical companies in Europe are now confronting this issue: finding, hiring and retaining staff with the right skills has never been harder.

The large sales force that has been the driving force in pharmaceutical sales, along with a high demand for research scientists, means that the pharmaceutical industry has always needed to recruit large numbers of staff. Despite experimentation with new sales models, that requirement has not changed materially over the last five years. The McKinsey Global Institute expects employment in the pharmaceutical industry globally to grow at approximately 3% annually over the period 2003-2008, the increase being driven by increased sales, and held back by efficiency improvements and (gradually increasing) outsourcing and off-shoring.

Given this rate of growth, the skills shortage in Europe is just that – a shortage of experience and combinations of expertise, as opposed to a shortage of available people. As the market environment has shifted, the skills required for key commercial roles in pharmaceutical companies have also changed. For example, the sales function no longer demands purely entrepreneurial, hard-hitting sales skills but also calls for strong interpersonal skills to achieve a more balanced focus on patient advocacy and relationship building with physicians. In marketing, as companies have become more global, the need for senior managers who can manage people in complex organisational structures has made it difficult to fill senior roles. At the same time, as the external stakeholder environment has become more complex, little thought has been devoted to strategic deployment of the targeted group of pharmaceutical employees who have experience in complex customer management issues to interface with the critical stakeholder groups.

The challenge is compounded by the new demands of those just entering middle management now – the so-called "Generation Y". To this group in particular, jobs need to be more than just jobs: they need to provide meaning, and a sense of contributing to a better world, along with a high level of autonomy and clear development potential. Challenges to the pharmaceutical industry's reputation, such as the perceived safety issues and huge public debate over the cost of drugs, have led to a public perception of pharmaceutical companies as big businesses that don't care about the public. For Generation Y, issues involving reputation are important and big pharmaceutical has become a low priority destination for this group. In addition, Generation Y staff are significantly less loyal even than the Generation X employees who came before them – they are likely to move between jobs and industries many times during their careers. Together, these factors mean that emerging talent is in short supply for the industry as a whole.

Until now, European pharmaceutical companies have done little to address these issues. Traditional job routes, working up through sales to senior sales roles or through marketing to senior marketing roles, still tend to be the norm. A recent InPharm survey in the UK showed that the lack of career opportunities was a major factor in staff dissatisfaction in these companies.[1]

So what is to be done? The challenges ahead are substantial, but a series of concrete steps can help to overcome them, beginning with talent planning.

The starting point is to develop talent strategies based on clear analysis of the skills needed to drive the business, including new capabilities which will be required to meet changing market situations. Critical roles and current gaps both need to be identified. As part of these talent strategies, we expect that companies will need to plan for higher staff turnover by tapping new recruiting sources and by working hard to develop tailored employee value propositions (EVPs) for specific groups.

To find people with the right skills and experience to fill some of the new roles required to manage the changing stakeholder environment, pharmaceutical companies may need to look outside the industry more than they do at present. Creativity in hiring may mean, for example, finding new marketing skills in the insurance and airline industries, complex stakeholder management skills in the defence industry, or government liaison skills in the oil industry.

While we haven't seen this happen yet in pharma, companies in other industries have segmented their staff requirements into target groups and developed tailored EVPs. Tesco in the UK, for example, advertises opportunities for retired people who want to work limited hours, and offers a fast track to management for ambitious graduates.

Another important step is to create attractive careers through internal rotations between functions and between businesses. The industry has great potential to offer more systematically varied career paths, but the opportunities are rarely made transparent to entry-level staff, let alone middle managers. Companies in other industries have differentiated themselves by offering development paths towards either general management or senior technical leadership. Participants may move between different functions and geographic territories, or they may move up within a specific function, depending on the career path they choose.

"While we haven't seen this happen yet in pharma, companies in other industries have segmented their staff requirements into target groups and developed tailored EVPs."

[1] www.inpharm.com/view/MjU4OC9wZkFydGljbGUvMi9udWxs/recruitmentArticle.html

unlocking market access in EUROPE

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MARTIN DEWHURST
MATTHIAS EVERS

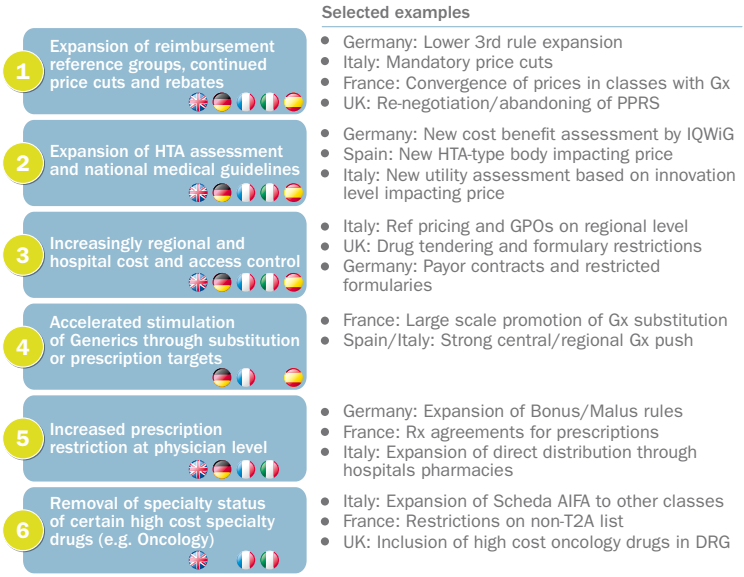
As regulators, payors and providers focus on drugs in their efforts to contain costs, the European pharmaceutical industry faces increasing restrictions on market access. To rise to the challenge, companies must develop insights into the stakeholders who matter, create product offerings that prove the economic value of their drugs, and strengthen and integrate their market access organisations.

SIX TRENDS RESTRICTING MARKET ACCESS

All is not lost: demographic changes, new technologies and rising patient and consumer expectations continue to drive positive, long-term prospects for the pharmaceutical industry in Europe. In the short to medium term, however, these positive developments are counterbalanced by increasing restrictions on market access. Six trends are making market access increasingly difficult for pharmaceutical companies ***(Exhibit 1)***.

Taken together, we estimate that these trends put 15 to 30% of projected revenues at risk in the European pharmaceutical market as a whole over the next five years, with some leading companies having more than 70% of their revenues at risk. The size of this threat should make unlocking market access a top priority throughout the industry. While several companies have made some efforts in this direction by piloting new organisational and service models, few, if any, have yet come up with a solution to overcome the whole range of external challenges.

exhibit 1



Source: Press clippings, interviews

THREE ACTIONS REQUIRED TO UNLOCK MARKET ACCESS

A company needs to do three things to improve its access to the market in this constrained environment. The first is to improve its understanding of the needs and incentives of stakeholders who matter. The second is to develop pilot and then scale up new product offerings that prove the economic value of its drugs. The third is to strengthen its market access organisation and integrate it with marketing and sales *(Exhibit 2)*.

Understand the needs and incentives of important stakeholders

Pharmaceutical companies are responding to the proliferation of stakeholders in the healthcare landscape (including regional payors, providers, guideline bodies, purchasing organisations and policy makers) by starting to map out the main institutions and identify the influencers in each market so that they know whom to approach and how best to address their needs.

Only a few, however, have adopted a systematic approach to creating insights. Such an approach involves prioritising and segmenting stakeholders according to their importance, identifying the key individuals who play both formal and informal roles in making market access decisions for the company's brands, understanding their needs, incentives and economics, and tailoring messages, offerings and interactions to meet their needs and preferences *(Exhibit 3)*.

Even the leading pharmaceutical companies in this field still fall far behind cross-industry "best in class" companies in creating insights into stakeholders and consumers (such as Coke, Diageo and P&G) and in mining and leveraging complex customer data (where credit card companies are the top performers).

Without deep insights into the needs, incentives and economic considerations of the key individual stakeholders in their markets, pharmacos will be unable to establish the collaborations and develop the new offerings that will unlock market access.

exhibit 2

World Class Market Access Programme

1

Stakeholder insight

- Which stakeholders matter and what is on their agenda?

2

Compelling offerings

- What can we offer to improve access?

3

New delivery model

- How to create new interaction model and organization?

exhibit 3

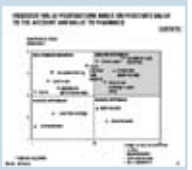
Prioritization/ targeting

- **Prioritization of** stakeholders based on importance
- **Identification of individuals** within accounts to target

Customer insights/ segmentation

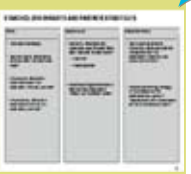
- **Several** market research **techniques** To unlock needs including
  - *Medical/clinical*
  - *Support*
  - *Financial/ economic*
  - *Political*
  - *Professional*

Messages/ offering



- Joint development and prioritization of **solutions** that realize value for payor/provider while improving sales for pharmaco

Channels/ execution



- **Mix of channels**
  - *Meetings*
  - *Joint projects*
  - *Peer-to-peer sessions*
  - *Advisory boards*
  - *PR/Media*
  - *Others...*

Pilot and scale up new product offerings

The second challenge is to identify, pilot and scale up new product offerings that convince payors, providers and guideline bodies not only of their clinical value but also of their economic value. Identifying and developing offerings that achieve this will be a source of competitive advantage.

Exhibit 4 shows ten product offerings that have proven to work in practice to unlock market access. In practice, they need to be tailored to specific product and payor needs. In the following paragraphs, we describe six of them in detail. In each case, we suggest how an offering can meet a specific need or solve a specific problem for a particular stakeholder group.

1. Establish value-based pricing for products with partial outcome evidence at launch

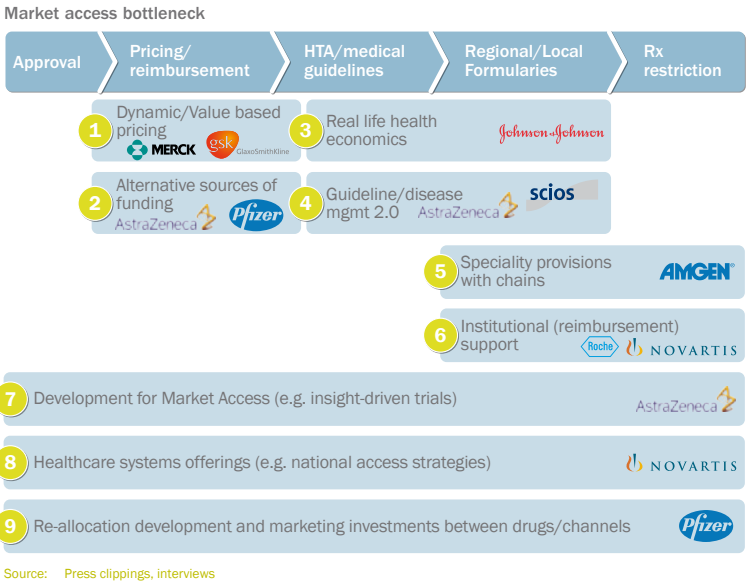
Insight: Regulation dictates that drug price is set at launch when least is known about the product, its outcomes and total cost to society. Inevitably, this leads to suppliers demanding the highest possible price at launch and governments demanding the lowest possible.

Offering: Establish flexible, value-based pricing agreements, which allow prices to go up or down in response to new evidence emerging or which link prices to outcomes. This is especially relevant for drugs that require usage or trials involving large populations or long timescales to prove their benefits (treatments for chronic diseases, for example) and for drugs that have a narrow but expanding indication when they are launched like oncology or central nervous system (CNS). *Exhibit 5* shows alternative pricing strategies that companies have successfully pursued to unlock market access.

2. Provide arguments based on real-life healthcare economics

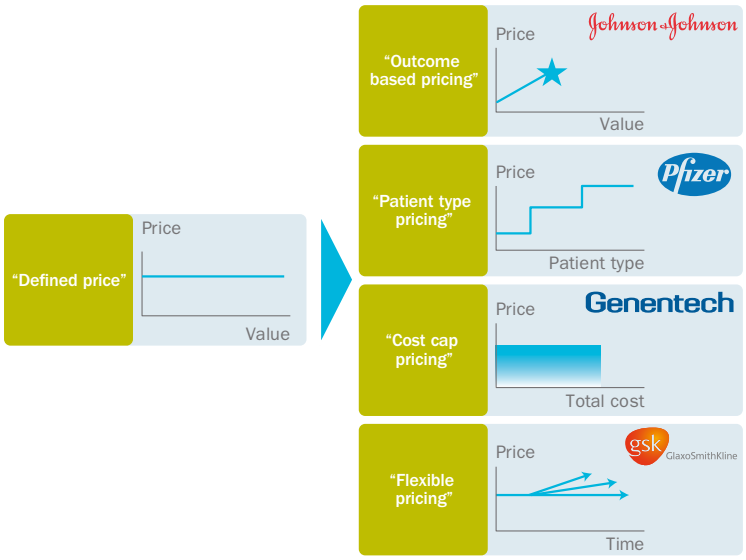
Insight: Payors and providers do not have full visibility of the economic impact of drugs in use on the ground and frequently have low confidence in data generated by pharmaceutical companies. A more collaborative approach could pay high dividends.

exhibit 4



Source: Press clippings, interviews

exhibit 5



Source: Press clippings, industry interviews

Offering: Develop real-life healthcare economics by working together with payors and providers to monitor drug usage in hospitals or surgeries, and assess the impact on total costs of switching between drug regimes. This is especially relevant for drugs with significant sales potential, those that place a high cost burden on the healthcare system, and those that risk failing cost effectiveness assessments. (Examples include several anti-coagulation products and supportive and therapeutic oncology drugs.)

Case example: A major company had conducted payor research that identified cost effectiveness as a potential barrier facing one of its products at launch. It decided to work together with a leading hospital to assess all the drugs used for the indication, together with the full associated treatment cost of each. Compelling findings demonstrated that, while the hospital and payors believed introducing the new product would increase cost per patient significantly, its real impact was a cost reduction because it reduced high off-label use of another, high cost drug and also reduced associated out-patient cost. The company now intends to roll out this research throughout Europe and use the findings in negotiations with national guideline bodies and regional payors (please see the "Real-Life Healthcare Economics" article on page 34 for details).

4. Provide administrative support for products with local reimbursement hurdles

Insight: Reimbursement barriers at hospital and physician levels are rapidly increasing. Various EU restrictions require reimbursement approval to be decided on a case by case basis (examples include Scheda AIFA in Italy, and electronic prescription approval in Germany). Applications for reimbursement in some cases take up 20-30% of the time spent by the physician on that case, and this limits prescribing, both because it is a disincentive in itself and because physicians know that many applications are rejected.

Offering: Provide administrative support for hospitals and prescribers when drugs require complex or case by case reimbursement approval.

Case example: one company identified local reimbursement restrictions as a major hurdle for several of its oncology drugs. To unlock access, it decided to provide systematic support to oncologists in the form of denials and appeals, coding and billing questions, alternative funding searches, patient assistance programmes, information requests and letters of medical necessity to local payors.

5. Embrace market access focused clinical development

Insight: Despite recent improvements in their understanding of stakeholders, companies preparing to launch products tend to focus narrowly on providing the clinical evidence required by regulators. To achieve optimal decisions on pricing, reimbursement, and listing, they need different types of data to demonstrate the differentiation of their products in standard of care and economic effectiveness.

Offering: Design fact based trials to substantiate claims about products that will be valuable in opening up access to the market, and align decision making accordingly. This requires high levels of cross-functional thinking, as well as creative thinking in the clinic, to determine the right parameters for patient selection, endpoint selection, and efficient trial design.

Case Example: A European company upgraded its clinical trial program for Phase II GI compound after analysing stakeholder insights and prioritising claims about the product. It discovered that regulatory endpoints (such as healing rates), while crucial for getting approval, were insufficient to demonstrate whether the compound could satisfy unmet medical needs and differentiate the compound from the established gold standard (please see the "Market Access Minded Development" article on page 31 for details).

6. Work with stakeholders to shape healthcare strategies in areas of national priority

Insight: All major healthcare systems identify five to ten major priorities for society. There are many high profile examples of the extent to which these areas of national priority can drive changes in healthcare systems. In the UK, for example, obesity and cancer care have been selected and the government has appointed a "cancer czar" to develop a strategy to improve outcomes. Companies could align themselves more closely with stakeholders in therapeutic areas which are national priorities and which match their portfolios.

Offering: Develop a coalition of key stakeholders, and work out how to provide the group with comprehensive healthcare inputs. Inputs may include experience of patients and clinical pathways, as well as funding trials or developing pilots to share guidelines and influence practice either at system, region or hospital level.

Case examples: Novo Nordisk's work on diabetes in India is one of several examples in emerging markets. The contribution of two pharma majors to GINA guidelines is one in a developed market. We believe there will be many opportunities to shape treatment guidelines for dread and complex diseases with interaction between primary and secondary care (chronic illnesses with poor compliance, for example) and also treatment guidelines in areas which are poorly understood or novel (such as erectile dysfunction and attention deficiency disorder).

Strengthen the market access organisation and integrate it into sales and marketing

Traditionally, market access has usually been managed by small government affairs or market access teams, working semi-independently from the rest of the commercial organisation. This is no longer acceptable.

To create insights, manage an increasing number of stakeholders and develop new product offerings, companies will need to beef up their market access organisations and, even more importantly, integrate them properly into the rest of their commercial organisations.

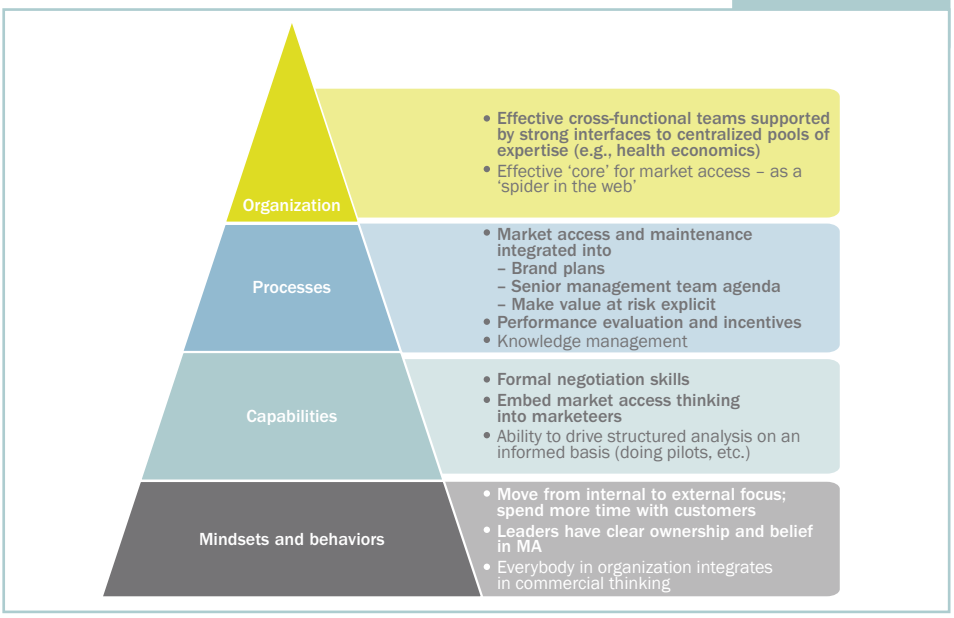
In our experience, the required ingredients are: cross-functional market access teams, supported by a centralised pool of experts; processes that provide customer plans and link them in with marketing and sales and budgetary planning; and specific capabilities, including negotiating and contracting skills, which may need to be hired in. There is also a fundamental need to shift mindsets and behaviors throughout the commercial organisation so that the importance of market access is recognised and the focus is on spending time with new customers *(Exhibit 6)*.

Few managers would disagree that market access is becoming an increasingly important issue, and most would probably concur with the broad-brush solutions suggested in this article: developing insights into the stakeholders who matter, creating product offerings that prove the economic value of their drugs, and strengthening and integrating their market access organisations.

The key challenges lie in the tactical decisions and the practicalities of implementation: when, where and how to make changes? The timing and speed of transition are critically important: the first mover advantage from rapid actions must be balanced against the risk of premature disruption and loss of focus.

It is important not to generalise too broadly – markets are evolving in different ways, with some, such as the UK, Germany, Sweden and the Netherlands already undergoing fundamental change. There is no universal panacea to solve the access problem – specific solutions will differ by market – and even within individual territories there are no instant cures. Leaders in the industry will have to invest in creating distinctive insights in their markets, pilot portfolios of initiatives, and watch out for "tipping points" where incremental change is no longer sufficient, and fundamentally different ways of working are required.

exhibit 6



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market access minded

DEVELOPMENT

MATTHIAS EVERS

Recent research shows that clinical differentiation against the standard of care is the best indicator for the future success of a drug in the marketplace.[1] This finding is borne out by high-profile failures of products identified as "me-too drugs" or as cost inefficient options by institutions such as the Institute for Quality and Efficiency in Health Care (IQWIG) or The National Institute for Clinical Excellence (NICE) or by Managed Care organisations. To win both regulatory approval and market acceptance, pharmacos must develop "me-better drugs" with compelling value propositions and conduct trials which demonstrate their value convincingly.

We have coined the term "market access minded development" to describe a new way of crafting clinical strategies and designing trials. The crucial difference is that, as early as the beginning of Phase 2, clinical teams start thinking beyond end points, patient segments and study designs relevant to approval, and focus on value as well. They embrace the need to profile drugs on their most valuable claims – claims that show differentiation against the standard of care and, ideally, provide initial lessons on cost efficiency.

Characteristics of this new approach to development

Market minded clinical development is likely to include some or all of the following four characteristics:

More strategic and value-focused – Clinicians and their teams move beyond the target product profile (TPP) to achieve an in-depth understanding of what the most valuable claims are, by thinking through the real needs of patients, physicians and other stakeholders needs. For example, delivering a specified efficacy after four weeks of treatment might be the right end point to choose for approval. However, if the resulting efficacy figure does not differentiate the drug against the (future) standard of care, it will not help to ensure success of the drug in the marketplace.

Clinical teams will need to think in new and unconventional ways to design trials that will reveal what value the drug can deliver.

More targeted – The teams apply economic/cost-efficiency milestones early in the development process, before initiating more expensive late-stage trials. Just as scientific key opinion leaders (KOLs) are currently involved early in the development process, "health-economics KOLs" (health economists from academic institutions, for example) are brought in to assess and communicate the cost effectiveness of a new drug.

More rigorous – Instead of relying on a tiny group of senior experts who "just know" by experience what trial designs to pursue, market minded clinical development is more rigorous and systematic. It is structured in four steps: (i) define the most valuable claims to prove, (ii) identify the most suitable patients, (iii) define the most relevant end points, and (iv) deploy the most cost-efficient design.

More cross-functional – Clinical strategy and trial design are often considered the home turf of the senior brand clinician. In the new world, however, clinical strategy and trial design will become a much more cross-functional effort by a broader group of experts. The composition of the clinical project team will increasingly need to reflect this. It will involve, for example: pricing/reimbursement experts, customer and payor insights, health economics/outcomes researchers to come up with cost efficiency end-points, strategic marketing experts to contribute customer insights, and modeling and simulation specialists and biostatisticians to determine the most suitable patients for trials and the most cost-efficient designs.

Obstacles which tend to get in the way

It is challenging to start a broad transformation of the development function, shifting its focus from achieving approvals towards value and marketable labels. One major barrier is the scarcity of people who excel at clinical strategy and trial design. Even the major pharmacos rely on a very small group of experts whose skills are based on experience and pattern recognition. So far, their abilities have not been codified in a rigorous approach that would support less experienced associates. There is little or no training to turn potential into proficiency, and too much reliance on copying and pasting supposedly proven designs instead of learning from mistakes and experimenting with more innovative designs.

Other barriers are cultural and organisational. They include an ingrained habit of focusing on clinical parameters rather than value, risk aversion (it is easier to replicate trials with end points that have led to registration in the past than to work on new designs) and functional silos or a poor interface between development and commercial functions. Reluctance of clinicians to accept that cross-functional efforts are now essential and a shortage of capabilities in emerging disciplines, such as health economics, outcomes research, and capturing payor insights, are also inhibiting factors.

There are no instant solutions: the development leadership team needs to think systematically about all the functions and departments at the development/commercial interface, and ask what needs to change to shift the company's approach from a focus on approval to a focus on value.

The importance of pilots or winning hearts and minds

Convincing in-house success stories help to break the mould. We urge managers to start working on market access minded development by conducting pilots with selected project teams. When high-profile teams embrace market access as an additional challenge and demonstrate the substantial benefits of the new approach, it becomes easier to initiate more fundamental and widespread change.

"We have coined the term "market access minded development" to describe a new way of crafting clinical strategies and designing trials."

[1] Source: Gordian et al., in vivo, April 2006

real-life healthcare ECONOMICS

a better basis for treatment decisions

MARTIN DEWHURST
NICOLAUS HENKE
RAFAEL NATANEK

In this article we argue that payors, providers and pharmaceutical companies could all make better treatment decisions if they based their economic evaluations of drugs on real-life data from hospitals and GP practices, in addition to data derived from the controlled environments of clinical trials.

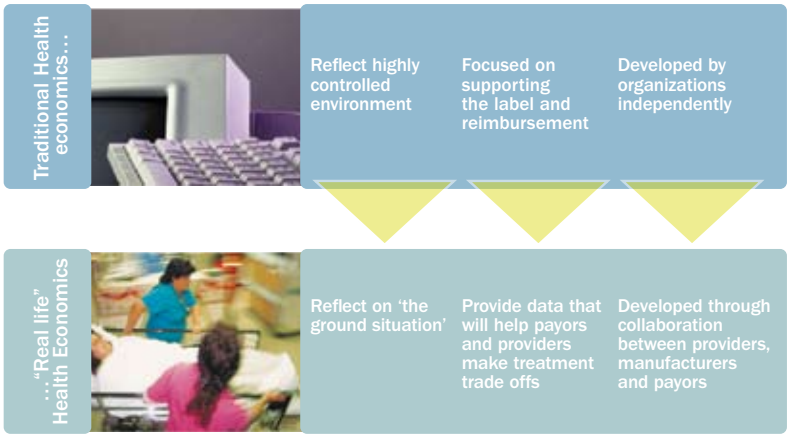
Economic evaluations are proliferating and playing a major role in drug access

Under intense pressure to control healthcare costs, European countries are applying an increasing number of economic evaluations at national, regional and local levels when making drug access decisions and selecting treatment options (please see broader article on market access on page 24).

Health technology assessment programmes (HTAs), which define and publish medical guidelines based on cost effectiveness, are spreading throughout Europe, at both national and regional levels. HTAs are run by the National Institute for Clinical Excellence (NICE) in the UK and the Institute for Quality and Efficiency in Healthcare (IQWIG) in Germany, for example, and used to strengthen regional cost and access control in the UK, Spain and Italy.

Individual hospitals across Europe are also applying stricter formulary usage, with drug and therapy committees taking into account both clinical value and cost effectiveness when selecting drugs. A survey we have conducted at more than 200 hospitals in Germany and the UK indicates that over 50% of their managers now consider the power of economic decision makers in the hospital to be “strong”, thanks to formularies and financial decisions.

exhibit 1



Source: Team analyses, hospital data, clinical trial data

Real-life Healthcare Economics (RLHE) is a new and practical way to improve cost and value measurement as a basis for decision making

Real-life Healthcare Economics (RLHE) aims to provide information on the value and cost of drugs to enable people to make informed decisions, and choices between treatment options, based on actual situations in hospital wards and doctors' practices.

The concept differs from traditional pharmaceutical economics (TPhE) in three important respects ***(Exhibit 1)***.

Firstly, while TPhE relies on models based on the highly controlled environments prevailing in clinical trials, the models used in RLHE are based on situations "on the ground" in hospitals and GP practices. This enables them to reflect costs and assess value more accurately.

Secondly, TPhE is often used to prepare dossiers and submissions in order to support the labelling and reimbursement of a drug, whereas the intention of RLHE is to provide data which payors need to make trade-offs. For example, it may help to forecast the impact on budget of a switch from one oncology protocol to another in a particular hospital, or to determine what diabetic services can be cut if a new product is introduced and achieves better results.

Thirdly, TPhE is usually developed by a team of health economists working in an isolated unit, either in the medical or health department of a pharmaceutical company, or within a payor or guideline body. RLHE, on the other hand, is developed through collaboration between providers, manufacturers and often payors. As well as ensuring the inclusion of appropriate data and assumptions from all the sources, this helps to strengthen relationships between the parties working together, on clinical trials and pathway development, for example.

Traditional studies provide valuable information, but because they do not reflect the situation on the ground they can lead to sub-optimal treatment decisions

TPhE studies currently play an important role in guiding healthcare resource allocation in a standardised and scientifically grounded manner at various stages of the clinical development and market approval processes as well as in guiding national reimbursement and HTAs.

In addition, recognising that the value of drugs is not fully transparent to regional and local payors and providers, some pharmaceutical companies are experimenting with tailoring global study results and adapting them to local conditions using budget impact models. These take into account, for example, the number of patients or the cost of doctors and nurses in a particular hospital or region in assessing the budget impact of a product.

However, TPhE and the budget impact models that are built on them often lead to sub-optimal treatment decisions because they do not allow for the differences between highly controlled trial environments and the real conditions on the ground.

Instead of measuring the total cost difference between treatment options, traditional economic assessment often measures only the difference in drug prices, without adjusting for differences in side effect profiles, testing, nurse and doctor time or dispensing costs. Factors such as these can often change the relative economics of treatment options completely.

The treatment actually given to patients often differs from the treatment tested during clinical trials because doctors tend to use a combination of drugs and other treatments for their patients, especially in fields such as psychiatry and oncology.

The criteria used to select patients for clinical studies lead to biases. These can skew the results of economic evaluations which influence treatment decisions, and therefore treatment costs. For example, excluding patients with brain metastasis from clinical trials for breast cancer drugs leads to disregarding the additional costs of monitoring and treating this patient group.

Delivery costs are often artificially low in clinical trials because the highly controlled treatment provision cuts out waste and inefficiencies. For example, at one hospital where we assessed the actual delivery times of oncology drugs, chair times for delivery were utilised at half the estimated rate used in trials, and this lower throughput doubled the cost of administration, skewing the relative cost of infusion drugs compared with oral ones.

Many studies fail to build in realistic local cost levels for employees, infrastructure, and drugs after discount and dispensing. While some budget models do make adjustments for these local factors, they are generally considered to be inflexible enough for variations to be disregarded or perceived as bias to benefit the pharmaceutical company.

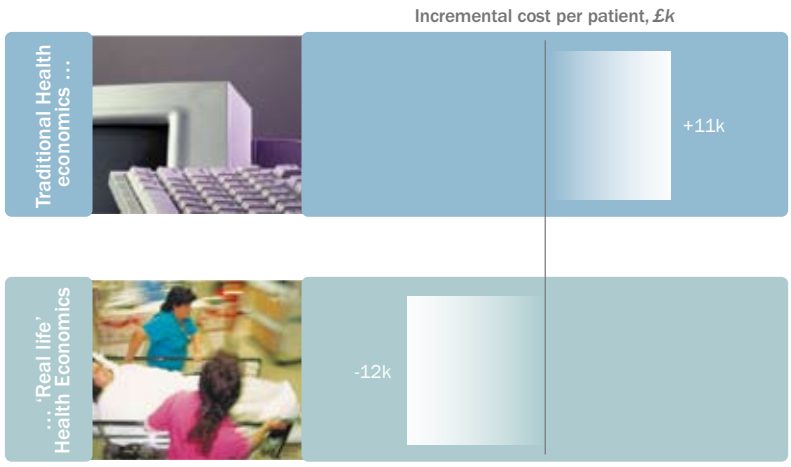
RLHE could help address these issues and bring benefits to all parties in the healthcare system, including payors, providers and pharmaceutical companies

Benefits to payors/regulators. The main value of RLHE to payors is the ability it gives them to issue formularies, guidelines and practices based on the true budget impact of different treatment decisions. For example, one assessment of a hospital drug showed that the real cost per patient to the payor was five and half times lower than the theoretical cost predicted using economic modeling based on global clinical trials because of differences in treatment regimes and patient populations. Another important benefit to payors is that performing and supporting RLHE studies enables payors to gather information on the treatments providers deliver and how they deliver them, which can support enforcement of guidelines as well as helping to improve pathways.

Benefits to providers. The greatest benefit of RLHE to providers, as to payors, is the transparency it provides, enabling proper comparisons of the true costs, profits and capacity requirements of different drug treatments. For example, one hospital performed a RLHE study together with a pharmaceutical company to evaluate two equivalent oncology drugs, one oral and the other injectable. They found that, taking into account reimbursement levels, administrative costs and capacity utilisation (of chairs and nurses, for example), shifting to an oral drug would free up significant capacity to treat more patients. However, if this capacity could not be utilised by the hospital referral network, the hospital would lose 30% of the surplus within its oncology service line as a result of shifting to the oral drug. Secondary benefits to providers include opportunities to create closer collaboration with pharmaceutical companies on clinical research and to foster better understanding of the importance of economic considerations among clinical employees.

Benefits to pharmaceutical companies. Suppliers can use RLHE for their pipeline and in-market assets to prove the economic advantages of their drugs in HTA applications and in discussions with local payors and providers before and after launch. This is especially relevant for drugs with significant sales potential or cost burden to the system, and those at risk of failing cost:benefit assessments (including several anti-coagulation and supportive/therapeutic oncology drugs, for example). Payor research in one case indicated that cost effectiveness would be a potential barrier at launch of an oncology drug. The manufacturer worked together with a leading hospital to assess the drugs used for the indication and compare the full treatment cost associated with each of the alternatives. Although the hospital and payors believed the introduction of the new drug would lead to a significant increase in cost per patient, the assessment found that the actual impact was a cost decrease because the product reduced the formerly high off-label use of another expensive drug, as well as associated out-patient cost *(Exhibit 2)*.

exhibit 2



Source: Team analyses, hospital data, clinical trial data

HOW TO GET GOING

We believe that the first step for all parties, whether pharmacos, payors or providers, should be to identify the specific disease areas or drugs which are the most appropriate for pilot studies using RLHE.

If you are a company: The right starting point may be to assess which drug is facing or likely to face market access issues because of the economic or budget concerns of payors, providers or guideline bodies in particular countries, then engage in discussions about the disease that the drug is designed to treat with one or two key payors and treatment centres in each country. The next steps would be to build a real-life economic model for that disease and to perform a study in each centre, taking into consideration the full cost of treatment, as well as patient types. In our experience, this is likely to take between 5 and 12 weeks per centre, depending on the availability of data and synergies with existing analytic tools and expertise. Finally, you would synthesise the results and use them to build a flexible real-life budget model to use with other payors and providers and for submissions to national bodies.

If you are a Payor: The best way forward may be to identify key areas of treatment where costs are high (such as oncology and CV) or disease classes where you believe there is over-spending, whether because of non-compliance with guidelines, discrepancy between reimbursement levels and actual cost to providers, or poor pathways. In these areas, you would work with a provider (or two or three providers) to develop a model to assess real-life treatment costs, which you could subsequently roll out across all providers. You could then use the findings from this assessment to inform reimbursement decisions and improve pathways.

If you are a Provider: You need to decide which area would benefit most from more transparent service line economics. This is often an area with complex treatment pathways, capacity constraints and several reimbursement levels (such as oncology or orthopedics). In this area, you would develop a detailed model of the service line, including reimbursement levels, true cost per activity and patient log of treatment provided. You would then be able to use the findings from this study to make treatment decisions based on clinical, cost and capacity considerations.

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RLHE is a powerful approach to evaluating the true economic effects of both new and in-market drugs. If widely adopted, it could revolutionise the way assessments are made and benefit all stakeholders. Payors, providers and pharmaceutical companies should all be examining the drugs and diseases within their respective remits with a view to piloting this approach in the areas where it is likely to have most impact.

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building a differentiated brand POSITIONING

DAVE ELZINGA
LIZ RODGERS

INTRODUCTION

As product categories become more crowded and marketing budgets come under greater scrutiny, many marketers are rethinking their approach to brand positioning. The traditional focus on functional benefits is no longer sufficient. Creating a compelling, relevant, and differentiated brand positioning can often mean the difference between blockbuster and blasé market performance.

Take the proton pump inhibitor category as an example. In a category with arguably little product differentiation, Nexium and Protonix have grown share while others like AcipHex and Prevacid remain flat. Nexium targeted physicians and patients with an emotional message focused on healing; Protonix targeted payors with attractive contracts and rebates. With Nexium and Protonix clearly staking out territory in the premium and value ends of the market respectively, AcipHex[1] and Prevacid were left to battle over a disappearing middle.

The question is, then, how does a company build a Nexium rather than an AcipHex? In our experience, building a powerful, differentiated brand positioning requires marketers to answer three core questions:

- How do you **define the market** in a way that helps you identify who you are targeting (i.e., which physicians) and what their frame of reference is (i.e., for which patients do they feel your product is most appropriate and what other products are competing for that space)?
- How should you **design the brand proposition** so that it clearly communicates to physicians your point of difference relative to others? How do you ensure that the point of difference you are talking about is both relevant and compelling to your target?
- How do you align the organization to **deliver the brand positioning** you desire to your target segments?

[1] www.aciphex.com

Our definition of positioning incorporates deep insight into customer needs, a clearly defined target, an understanding of the appropriate frame of reference, and a distinct point of differentiation. These elements are reflected in a succinct description that captures the benefits the brand delivers (including both functional and emotional components), the supporting "facts" that provide a reason for customers to believe that the brand is capable of delivering the benefit and the identity of the brand that supports the desired emotional connection with the customer.

DEFINING THE MARKET

Segmentation is at the core of defining the market. We believe that needs-based segmentation is the most insightful approach for building powerful brands. Demographic and behavioral (e.g., prescriptions written) segmentations do an excellent job of telling you who is doing what, but they don't explain why. A needs-based approach also explains more of the variance in brand perceptions and behaviors than traditional demographic cuts ***(Exhibit 1)*** leading to more distinct segments. Understanding the reasons behind the behaviors is critical to motivating brand loyalty over time.

Within needs-based segmentation, there are several ways we can look at the market: by customer (physician or patient) attitudes, by situation or patient types, or by a combination of both attitudes and situations ***(Exhibit 2)***. An attitudinal approach groups physicians by their beliefs and values about themselves as prescribers, their patients, and the specific therapeutic area. How knowledgeable they are about a therapeutic area, how cost-conscious they are, how involved they are with their patient's care, etc., all factor into an attitudinal segmentation and can often explain the brand and treatment choices physicians make. As you would expect, we find similarities and differences across therapeutic areas. In some categories, physicians believe that lifestyle choices have lead to the patient's situation and that it is "their fault". Ultimately, the objective is to figure out whom you are building the brand for and what patient types are most appropriate for your product in the eyes of physicians.

exhibit 1

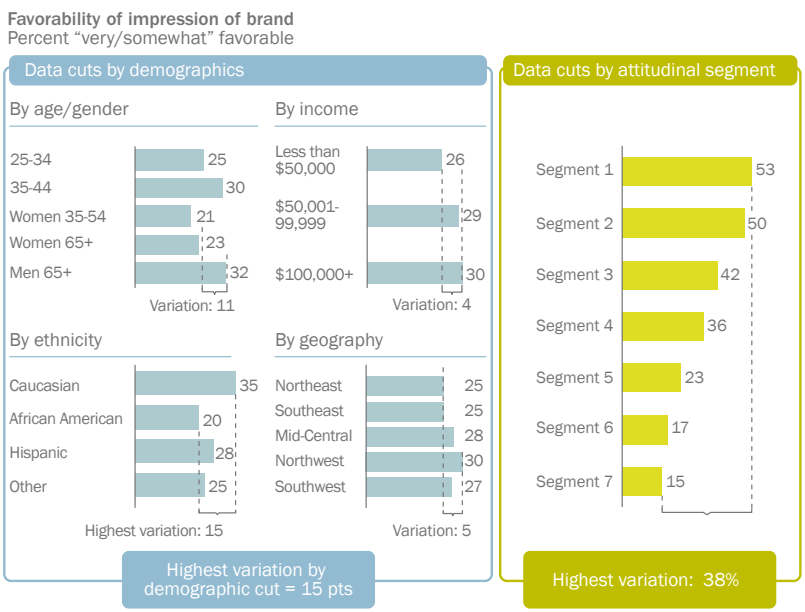
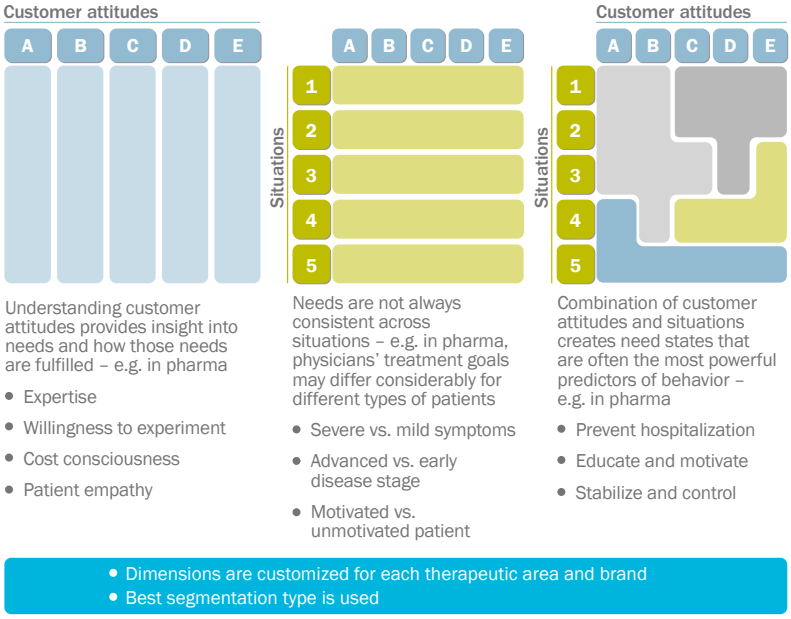


exhibit 2



With the segments defined, the next step is to select a target. In an environment of proliferating stakeholders, we are often asked who the target should be and whether or not multiple stakeholders require multiple positionings. While brands can have different targets for communication and marketing activities, positioning requires selecting a primary target. In addition to economics and volumetrics, there are several factors to consider when deciding who the target should be including the stage in the brand's lifecycle, level of product differentiation, role of patient vs. physician in treatment and the level of complexity/risk associated with the product and therapeutic area.

Implementing a segmentation strategy often ignites heated debates between sales and marketing functions. Marketing favors a needs-based approach that yields more insight, but results in segments that are more challenging to identify in the market place. The sales team, which is tasked with finding these targets and delivering the messages, places greater emphasis on the ease of identification that a demographic or behavioral approach yield. The solution is to be very clear on why you are segmenting so you can have a sophisticated answer where it helps (e.g. message development) and greater simplicity where it is critical (e.g. message delivery). While needs-state segmentation may point to several potential target customers, it is critical to implement based on sales force capabilities. For most, a single message approach is best. For companies with more sophisticated sales forces, multiple messages may provide incremental impact if executed effectively as they better meet customer needs.

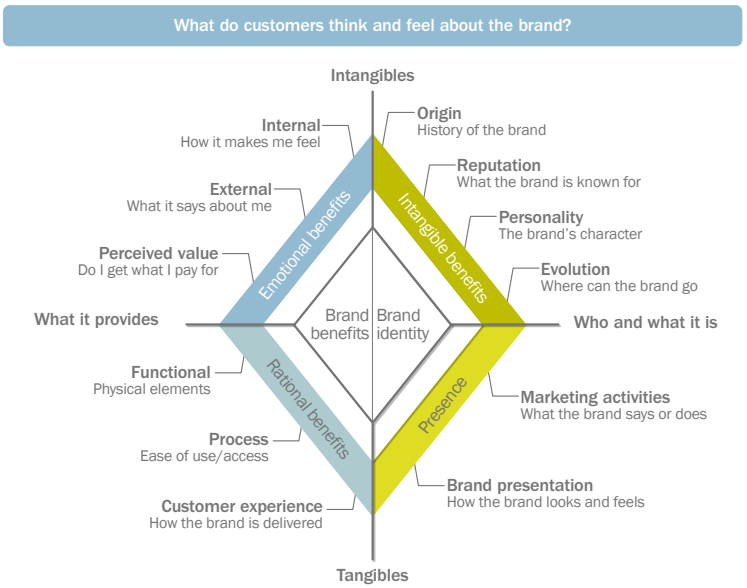
DESIGNING THE BRAND PROPOSITION

Once it is clear which target segment you are developing the brand for, the next challenge is to determine what they want and what you can deliver. Understanding brand equity is key to identifying which attributes and characteristics of your product will prompt brand choice and inspire loyalty. We use two core frameworks to assess brand equity: the ***brand equity diamond*** which helps you ascertain what people are saying about your brand and the ***asset-liabilities matrix*** which identifies those attributes and associations that really matter.

The Brand Equity Diamond

The ***brand equity diamond*** ***(Exhibit 3)*** is used to dimensionalize brands. It is a holistic approach that incorporates both brand benefits (what the brand offers) and brand identity (who the brand is). Both are critical to develop as you build your brand in the marketplace. The left side of the diamond displays brand benefits, which are both rational and emotional. The right side displays brand identity, which includes both what you do in the market (lower right) and the reputation you build (upper right). At launch, marketers are primarily working on the bottom part of the diamond (rational, functional benefits, and presence), which are the tangible dimensions you can control. Ultimately, the goal is to build the intangible dimensions on the brand, since these are the things you can own over time.

exhibit 3

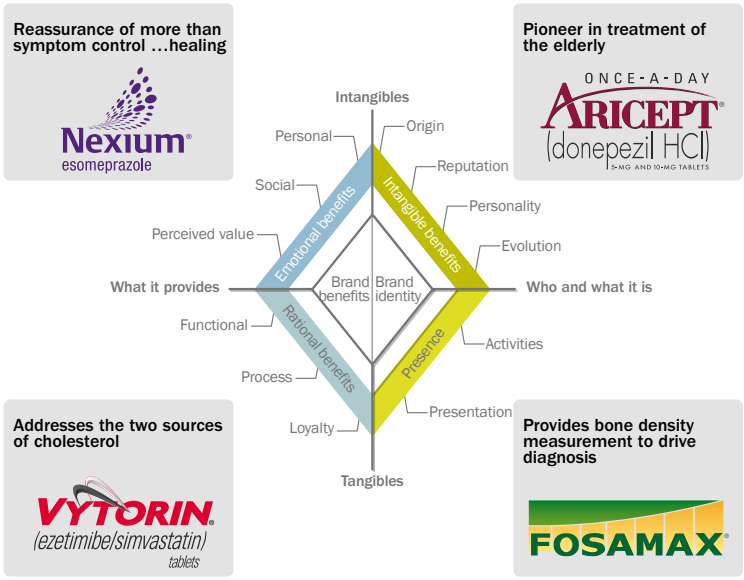


Brands can leverage any quadrant of the brand diamond to differentiate themselves ***(Exhibit 4)***. Aricept is a good example of a product that has effectively positioned itself in the minds of both physicians and caregivers as the best thing you can do for an elderly person. Aricept has focused on activities like patient education that help create their reputation as a leader in the category. In contrast, Ortho-Evra has focused on the emotional dimension of the brand diamond. Rather than focus on the product's functional benefits, Ortho-Evra positioned itself to both physicians and patients as the brand that delivers peace of mind ("take birth control off your mind").

Asset-liabilities Matrix

The second framework we use is the ***asset-liabilities matrix*** ***(Exhibit 5, page 45)***. This tool helps identify which benefits are differentiating for you and competitors. If a benefit is currently well delivered by both you and your competitors, it is an ante, or an expectation of a company in this space. Antes should be maintained, since they are necessary for consideration, or redefined in such way that "raises the stakes" but they are not the focus of the brand proposition. If it is a benefit that you are strong on and others are not, it is a driver of brand choice for you. Drivers are benefits that you should protect and continue to own. Benefits that are important but are not strongly associated with any brand are considered opportunities. These are unmet category needs that should be selectively developed and invested in to establish ownership.

exhibit 4



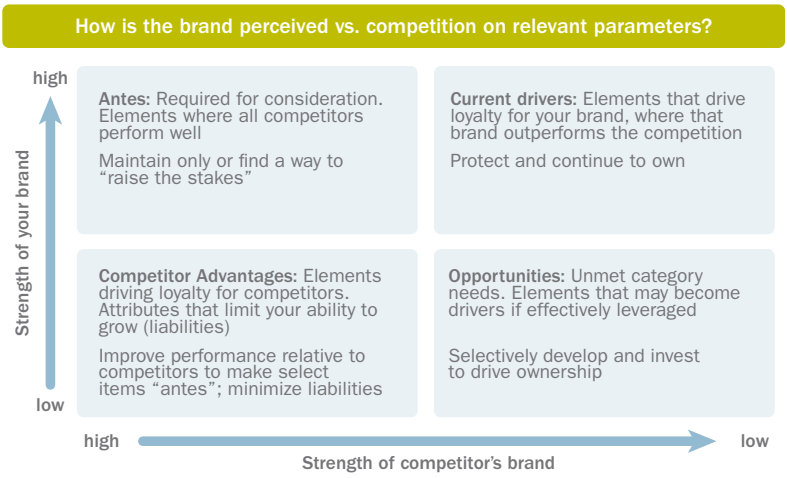
Source: McKinsey marketing practice, brand websites

pressure testing your positioning

A good brand positioning specifies a clear target, defines what the product is and does, and provides a distinctive reason to believe the benefit is true. Beyond this, you should consider the following questions:

- *Is it relevant to target customers? Will customers care? Could you have a conversation with the customer on the subject that they would find interesting?*
- *Is it credible for the brand? Would a customer agree that the brand can say this today or be able to gather the proof to say it in the future?*
- *Is it distinctive from competitors? A customer must not be able to replace your brand name with a competitor's in the statement and find it equally true.*
- *Does it leverage brand strengths and address weaknesses (e.g., side effect)?*
- *Does it provides clear direction for all brand-related activities including communications, sales force activities, product development, and pricing?*
- *Is the positioning aspirational enough that it will take 3 to 5 years to fully achieve and enable the brand to achieve its growth objectives?*
- *Is it consistent with the organization's core competencies and can it be effectively executed?*

exhibit 5



Last, the matrix allows you to capture competitive advantages. These are elements that are driving the brand choice of competitors and may be brand liabilities for you (i.e., are reasons why customers would avoid a brand). These are attributes where you need to improve performance relative to competition to make select items 'antes' if at all possible. Constructing the asset-liabilities matrix for multiple brands in the category provides insight into competitive strengths and weaknesses and may suggest how competitors might expand or migrate their brand over time (e.g. opportunities).

Brand equity is not static. Over time a brand's equity changes due to changes in the marketplace (e.g., new entrants, changes in treatment protocols) and the actions taken by the brand team. Both the brand diamond and the asset-liabilities matrix are powerful tools for tracking those changes and measuring the impact your marketing efforts are having on shaping your brand's equity.

The approach we use to develop differentiated brand positionings has been successfully applied across industries as well as across therapeutic areas within pharmaceuticals.

In addition to creating a strong, enduring brand positioning, this process ensures marketers avoid several of the most common positioning pitfalls:

- **Selling the antes:** Often marketers chose to focus on functional product attributes that are important to the category, true of their product, but not differentiating versus competition. We call these attributes "antes." These are the qualities and characteristics patients and physicians expect of any product in their consideration set. They are necessary, but not sufficient to drive brand choice. AcipHex provides a good example of a product whose positioning focuses on selling the antes. The key benefits – "managing the effects of acid reflux disease" and "helps keep the burn out of your esophagus" is very functional and could be applied to any proton pump inhibitor. If you can put any brand name in to your product's positioning statement and have it still be true, you are selling antes.

- **Failing to refresh:** Over time, differentiated brand benefits can become category antes, as competitors expand their indications and new players enter the market. Brands need to regularly track how their core attributes (functional and emotional) resonate in the marketplace so they can migrate their positioning as needed. For example, when Johnson & Johnson (J&J) recently purchased the over the counter (OTC) rights to the allergy medication, Zyrtec, they recognized that the brand's "indoor/outdoor" positioning was no longer as unique as it once was. J&J has since evolved the positioning to focus on the product's speed of action – a more differentiating benefit. In addition, the "works two hours faster" claim links to the powerful emotional value of getting time back for yourself.
- **Letting competitors do your work for you:** In highly competitive markets, unsuspecting marketers may find that the competition has defined their brand for them. By using your brand as a foil, others can position your product unfavorably or just too narrowly. For example, Apple Computer's current advertising campaign – "See all the reasons why you'll love a Mac"– portrays PCs as geeky, outdated and unwieldy compared to the smooth, stylish, fully integrated Apple.

DELIVERING THE BRAND POSITIONING

With the target defined and the product benefits designed, the final step in developing a differentiated brand positioning focuses on bringing the positioning to life. How do you align the organization so that all elements of the commercial mix support and reinforce the ideal positioning concept for your target customer? Successfully executing a brand positioning requires the full commitment and drive of the entire organization. Without a shared understanding of what the brand could be and the underlying insights, execution falls off and by the following year marketers are conceiving a new and equally brilliant positioning, wondering again where last year's approach went wrong.

Companies that have been successful in executing their brand positioning have several things in common which ensure a high level of organizational commitment to the strategy. There are three key steps to driving brand positioning through to the front line: aligning the organization, balancing global and local positioning, and measuring, tracking and adjusting.

Aligning the Organization: For a brand positioning to be embraced and executed, it must be intricately linked to overall performance, and should be one of the performance indicators used to evaluate the overall state of the organization. Varying degrees of organizational change may make sense, from simply rethinking reports and incentives, to broader based changes to the organizational design. Each situation is likely to be different, and requires managers to think about exactly what elements of the organization are most critical to align in support of the end goal.

Balancing Local and Global Positioning: A healthy tension exists between global and local or regional marketers as they struggle to find the right balance between global consistency and local tailoring. One brand positioning is often not appropriate for all markets due to differences in physician education, diagnostic techniques, cultural norms, etc. On the other hand, having multiple brand messages is both confusing for an increasingly mobile audience and more costly (e.g. no efficiencies in materials, training, etc.). To resolve this issue, companies must decide which elements of their brand positioning (both benefits and brand identity) are core and cannot be altered across markets and which can be changed to reflect the specific market conditions.

fine points of positioning

Q. Does it ever make sense to have more than one positioning for a Brand?

- Across markets?
- Across indications?
- Across customer types (HCP, Consumer)?

A. A brand should have **one** positioning:

Markets: Markets may differ in how that positioning is communicated, but the positioning should be the same across markets to prevent customer confusion. A brand may be more developed in some markets than in others, which affects what is communicated to customers and how/when it is communicated, but the positioning that all markets aspire to achieve (the positioning journey) should be the same.

Indications: A brand may span indications (e.g., asthma and COPD, or schizophrenia and bipolar disorder), but the positioning should not differ by indication – it should be broad enough to encompass both indications. Different elements may be emphasized to support the positioning for different indications, but the overarching positioning should be the same. For example, if the positioning promises that the brand "helps you maximize your patients' progress," this may mean maintaining productive work and family relationships for a bipolar patient, whereas for a schizophrenia patient, progress may mean reducing hospitalizations – thus, the reasons to believe the promise may differ by indication, but the positioning does not. If the new indication is extremely unrelated to the current indication, a new brand name should be considered (e.g., Zyban for smoking cessation vs. Wellbutrin for depression).

Customer types: AA brand's positioning should be consistent for both healthcare providers and consumers, since a brand cannot effectively stand for two different things. The articulation of the positioning (messaging) and the reasons to believe may differ for providers and consumers, but they should not be in conflict with each other.

Q. What signals indicate it is time to change (or at least examine) brand positioning?

A. A brand positioning generally has a shelf life of three to five years. By that time, changes in the marketplace have reduced the effectiveness of the current positioning – for example, competitors have entered or left the market, brands have gone generic, activities by you and your competitors have changed the way physicians view the competitive landscape, etc. In very mature categories, where change occurs slowly, a positioning may be effective somewhat longer than five years. In newer categories, changes may occur rapidly and the positioning may need to be refreshed more frequently than every three years.

Events that may trigger a reworking of the positioning include:

- New indication
- Entry of a new competitor (branded and generic)
- Treatment advances that prompt physicians to change the way they think about the disease/condition and/or their treatment approach
- Physician or patient feedback that suggests lack of differentiation
- Internal confusion about the future direction of a brand (across geographies or functions)
- Inconsistent activities that are sending conflicting messages to target customers
- Inability of all associated with a brand to state main reasons why the target should choose the brand.

Measuring, Tracking and Adjusting: As the McKinsey "Insights to Actions" marketing survey highlights, pharmaceutical companies rate themselves poorly on their ability to measure impact. Yet measuring impact is critical to assessing how well an organization is delivering the brand positioning. In addition to tracking brand performance, marketers must monitor brand identity to see how their tangible actions are influencing the brand's intangible benefits and associations. Tracking these intanglible attributes can serve as a powerful early indicator of when a brand needs to update or migrate its positioning.

CONCLUSION

Building a differentiated brand positioning is a cornerstone of success in today's increasingly competitive marketplace. Doing so requires a clear definition of the target for whom you are building the brand and the bundle of benefits that will drive their brand choice. With these questions answered, marketers can focus their limited resources on delivering the functional and emotional attributes that engender customer loyalty.

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customer INSIGHT

crucial to growth in competitive markets

AUNIA GROGAN
VICKI SMITH
JOHN FORSYTH

INTRODUCTION

Superior customer insight is a key success factor for pharmaceutical companies, to identify and leverage growth opportunities and to defend against market share erosion as access to markets becomes more restricted and competitive intensity increases.

Excellence in customer insight requires companies to adopt a customer-centric philosophy, set clear priorities among customer groups, and ensure they have talented marketers and market researchers working in partnership and using the best available tools and techniques for generating insights.

WHAT DO WE MEAN BY CUSTOMER INSIGHT?

Customer insight is the discovery of something fundamental about a customer's needs, which marketing strategies and tactics can address to create customer value and competitive advantage. An insight should:

- Be anchored in a broad and deep understanding of the market – the disease, customers, competitors, and the broader healthcare environment
- Go beyond facts to explain the "why" behind the "who and what" of customer behavior
- Bring a new understanding to bear on issues and challenge existing beliefs to reveal new ideas/territories to exploit, linking insights to the economics of the organization
- Be forward looking, built on connecting multiple, innovative sources of information
- Be relevant and lead to action; otherwise, it is not insight, just information.

GETTING IT RIGHT CREATES GROWTH

Moving beyond common beliefs about customers can be a powerful source of profitable growth. In the highly competitive Consumer Packaged Goods (CPG) arena, the importance of insights in keeping pace with competitors and creating competitive differentiation has been heard and accepted. High-performing CPG[1] companies believe insights to be fundamental to their success. In a recent survey, 100 percent of CPG high performers agreed with the statement, "Insights are the foundation of the culture, working approach, and go-to-market strategy of the organization".[2] In interviews we conducted with 40 Chief Marketing Officers (CMOs) around the globe, capturing and leveraging actionable customer insights was the second most frequently cited challenge for successful marketing, behind driving higher marketing return on investment.

IN THE PHARMACEUTICAL CONTEXT, INSIGHT MAY BE EVEN MORE IMPORTANT

We believe that in the pharmaceutical environment the need for customer insight is an even more pressing issue. The market context is inherently more complex than CPG, requiring insight into the multiple perspectives of multiple customers, including primary and specialist physicians, key opinion leaders, legislators, payors, pharmacists, patients and in some contexts, caregivers.

From this already complex starting point, physicians' control over the brand choice is being reduced. At one end of the value chain, payors and providers are increasingly exerting influence over the treatment choices and therapies available to physicians. At the other end, "activist patients" are emerging in many markets, exerting influence on the treatment they receive. For example, in a study we conducted with consumers in Germany, U.K., and Italy in 2001, 26 percent claimed to request a specific treatment, compared with 21 percent five years before, an increase of 24 percent.[3]

In the U.S., investigations into the impact of direct to consumer (DTC) advertising have demonstrated the impact of increased patient awareness and direct brand requests on prescribing behavior. Kravitz et al demonstrated the influence of patient requests on physician behavior in the antidepressant market.[4] Ninety percent of patients who had made a specific brand request were likely to be offered further treatment or a script, compared to only 56 percent of those making no request. In Europe, where pharmaceutical DTC does not currently exist, increasing patient power is also evident. For example, in the U.K. the growing calls for Herceptin for breast cancer patients has been largely led by patients and the media. Thus, the patient – while not always the primary decision maker – is not a trivial part of brand decision.

In parallel with this erosion of the physician's traditional sphere of decision making, the tools available to pharmaceutical companies to influence that decision are being constrained. For example, sales reps are still the dominant tool used by pharmaceutical companies, and they now operate under far tighter controls than ever before. As the sales and marketing teams' freedom to manoeuvre decreases, their efficacy must increase, something that can only be achieved by underpinning activity with superior insights.

Pharmaceutical companies are becoming aware of the need to build their customer insight capabilities. For example, Sanofi Aventis has publicly stated its belief in the importance of understanding customers as a key driver of its marketing efforts in the future:

> *"(Lack of customer understanding is) a threat to our revenues and to our health. We need to understand customer value and do it better than our competition"*
>
> *– Corinne Le Goof, VP CNS Marketing, Sanofi Aventis*[5]

Some pharmaceutical companies are already developing capabilities to understand this complex set of stakeholders and influencers, and successfully leveraging it to business advantage. Cialis was launched in Europe in February 2003, behind Viagra (August 1998) and slightly ahead of Levitra (August 2003). It gained FDA approval in November of 2003. Cialis had a slower onset of action than its competitors (45 minutes versus about 30 minutes), but also had a longer half life, which physicians viewed as a disadvantage because the medication stayed in patients' systems longer. In the course of their research to discover how best to position Cialis, Lilly discovered a key insight – erectile dysfunction is not just about male performance, it is about couples and their intimacy.[2] Couples want the freedom to choose when they get intimate; they do not want to be forced into a time slot. Cialis translated this insight into the big idea of "spontaneity" and freedom to choose the right time, which is now deeply embedded in the brand strategy and positioning.

With this positioning, Lilly accomplished two important goals: 1) it effectively differentiated Cialis from Viagra and Levitra, both of which had been positioned as solutions to male performance problems, and 2) it turned the perceived disadvantage of a longer half life into a benefit that both patients and physicians value.

As a result of this positioning, Cialis became the best-performing erectile dysfunction brand in 2003 and 2004, with 25 to 35 percent market share, and the top position in new prescriptions[3]. The positioning continues to be used in adverting and media today; contrasting with the approach Viagra and Levitra continue to take – much more focused on the male and his sexual performance.

WHAT DOES IT TAKE TO ACHIEVE EXCELLENCE IN CUSTOMER INSIGHT?

To generate and capture the value of superior customer insight, an organization must:

- Have the right ***philosophy*** about the importance of insight and customers
- Be focused on the right ***priority*** customers
- Have the right ***people*** to generate and leverage superior insight
- Have the right ***processes*** in place to generate and leverage insights.

Philosophy

A corporate philosophy that is truly customer-centric is critical. Nothing shows senior management commitment to this philosophy more effectively than public statements of the importance of in-depth customer understanding for business decision making and planning.

> *"I encourage marketers to invest a great deal of time observing consumers. A few years ago, we spent four hours a month with consumers. It's at least triple that now."*
>
> *– J. Stengel, CMO Procter & Gamble*[6]

Public statements are essential, but rarely sufficient to generate change. Hardwiring the need for insights into the organization's decision making DNA creates pull from decision makers for insight. Increasingly, manufacturers are following the lead of best-in-class packaged goods players and mandating the need for customer insights in key business decisions.

> *"All development activities within the group are now based on research into how consumers think, feel, and behave when they use our products, as well as which problems they experience."*[7]
>
> *– Hans Strâberg, President and CEO of the Electrolux Group*

A minority of organizations have taken a structural approach to embedding a customer-centric philosophy. For example, Procter & Gamble (P&G) installs specialists from its Consumer and Shopper Insights department on its brand teams. More commonly, companies employ a mixture of conducting formal training on insights for broader marketing teams and mandating insights for key marketing processes, such as the annual planning cycle or new product development program, which establishes the right corporate mindset. Embedding the customer-centric philosophy can be as simple as having senior managers consistently ask, "What is the insight (rather than the belief) on which this recommendation is based?" and agreeing only to recommendations based on insights.

Priorities

Setting customer priorities is critical to ensuring that marketing and sales activities are efficient and effective. Because of the complexity of the pharmaceutical environment, it is important to make clear and explicit decisions about how resources of both time and money will be allocated across physicians, KOLs, legislators, payors, pharmacists, patients, and caregivers. For most prescription drugs, the primary customers will be the physicians – they ultimately make the choice of which therapy to use, so it is critical to understand their needs and correctly position the brand to meet those needs. However, in some therapy areas it may be important to understand the needs of the patients and how they are manifested to the physician. For example, in a recent client study we found that a key barrier to the adoption of a new type of therapy was the deep emotional attachment patients had to their existing therapy, a bond that would need to be addressed if their behavior was to be modified in any meaningful way.

The importance of other stakeholder groups, and therefore the deployment of resources against them, will depend on the therapeutic area and the life stage of the drug. Setting and frequently reviewing customer priorities is a key step in the planning process, as the type of insight needed varies considerably across customer groups. Even within a customer group like physicians, priorities must be set. Historically pharmaceutical companies, as other industries in the early stages of their development, tried to do business with all physicians; targeting only a subset of the physician base was perceived as giving up too much volume. However, it is now well established that physicians, as customers in other markets, are not created equal:

- Physicians differ in what they need from therapies and what motivates them to prescribe
- A brand cannot meet the needs of all physicians, and trying to do so results in "plain vanilla" brand propositions that do not do a good job of meeting anyone's needs.

It is thus important for companies to focus their marketing and sales efforts on highest priority customer segments, building higher brand loyalty through better addressing their needs. Segmentation creates a clear, customer-centric view of the marketplace that enables these core customers and their needs to be identified.

People

Investing in the right people for generating insights is challenging but essential. Success in this context is often defined as a "T-shaped" skill set: a deep area of specialization coupled with broad business skills to create connections across the business. Specifically, a company needs people with the traditional researcher's core competence of data analysis, underpinned by a natural curiosity or problem-solving mentality, and interpretation skills for taking business imperatives into account. Typically this requires capability in three areas:

- Developing a picture of the customer's world based on hard and soft data streams – for example sales data, qualitative insight on the consideration process, and sales force feedback on customer comments
- Balancing that in-depth view of the customer and the big picture of the business challenges, to create actionability
- Communicating the insights effectively, in a motivating, even inspiring way – taking data from disparate sources and weaving narratives to convey insights and ultimately influence decision outcomes.[8]

Even if you have the right research talent in place, it is critical that the marketers and market researchers work closely together. In too many organizations, insight generation is off-loaded to the market researchers, who generate insights in virtual isolation. It is not surprising, then, that the results often fall short of what is actually needed to drive business decisions. Success requires a true partnership to ensure that the research clearly addresses the key business questions and that the insights are leveraged appropriately by marketers into ongoing activities.

Processes

Leveraging innovative techniques, using the best market research tools and analyses to understand customer behavior in the right context, is key to creating competitive advantage. The pharmaceutical industry remains heavily reliant on traditional research techniques and has been slow to follow the example of other industries in employing innovative techniques to generate deep insights. For example, pharmaceutical companies have lagged far behind CPG companies in adopting needs-based segmentation. Indeed, many pharmaceutical brands are still using behavioral segments (decile-based) to guide all their marketing and sales activities. CPG companies are now relying less on traditional qualitative research methodologies such as focus groups and more on ethnographic-based approaches to understand latent needs in more detail. While there is some evidence that pharmaceutical companies are also finding a role for these newer approaches with patients and physicians, this is by no means systematic or widespread.

Finally, mandating the need for insights in some key decisions creates demand for insights within an organization, and as such is an effective agent of change. In CPG companies, insights are frequently part of the innovation stage gate process and brand planning process. This forcing mechanism has had the net effect that once people have had to reach out for insights they have appreciated the increased clarity they have provided for decision making.

WHAT DOES EXCELLENCE LOOK LIKE?

Novartis' Lamisil, an oral treatment for nail fungus infections, launched in 1997 with a cosmetic focus. Sales stagnated after one year in the market. Novartis, which had invested heavily in building its internal technical research capabilities, engaged in extensive research with patients and physicians to identify their priority customers and the needs of that group. As Novartis has widely disclosed, they identified four insights that helped to explain the stagnation in sales and provided a platform for re-launch:

- Physicians did not feel cosmetic problems justified six months of systemic medication
- Fungal nail infections were not considered a "disease" by physicians or patients
- There was a high degree of under-treatment due to under-diagnosis, in turn linked to patients' poor recognition of symptoms and consequences
- People with fungal nail infections did not make special physician appointments.

Based on these insights, Novartis developed a disease-awareness campaign to create strong patient pull with dramatic new imagery and messaging. The product was re-launched in March 2003 with a medical focus, using the "Digger the Dermophyte" campaign, repositioning the brand as a treatment for people suffering from a serious fungal infection. Messaging emphasized the need for systemic medication by explaining that topical solutions cannot penetrate to the source of infection deep in the nail bed. Novartis maintained strong presence in physician and pharmacist channels to communicate a consistent image from patient's self-diagnosis to actual prescription. Total sales of the product in the U.S. increased by 23 percent in 2004.[9]

CONCLUSION

In today's market, superior customer insights play a crucial role in providing direction for business development. Customer insight teams therefore have a tremendous opportunity to shape the future of their companies. Real success needs to be supported by the right philosophy, clearly defined priorities, and the right people using the best processes.

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[1] "High performers" are defined as having achieved growth above category norms

[2] 2006McKinsey CPG Marketing Survey of CMOs, division GMs/most senior marketer, brand managers, and heads of innovation/R&D

[3] 1,500 telephone interviews evenly distributed in Germany, U.K., and Italy conducted in March 2001; McKinsey analysis

[4] Kravitz, R. L., Epstein R. M., Feldman, N. D., Franz, C. E., Azari, R., Wilkes, M. S., Hinton, L., Franks, P., "Influence of Patients" Requests for Direct-to-Consumer Advertised Antidepressants," *Journal of the American Medical Association*, April 27, 2005

[5] *Medical Marketing and Media*, December 2006

[6] P&G 2001 Annual Report

[7] Report by the President and CEO, Electrolux 2004 Annual Report

[8] The development of these skills is currently being addressed by the ESOMAR Developing Talent Initiative

[9] Figures from Evaluatepharma.com, company reports


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optimizing SPEND

changing the ROI game

HEMANT AHLAWAT
JESSICA HOPFIELD
SANJEEV AGARWAL

INTRODUCTION

Return on investment, or ROI, on brand-related activities is the holy grail for many pharmaceutical company commercial executives. They are not alone. When we asked 300 chief marketing officers across major industries, optimizing brand related spend was their second most important issue (the first being driving brand growth). Increasing cost pressure, payor and regulator demands for reduced sales and marketing spend, and regulatory scrutiny of in-field activities has only intensified the need to increase effectiveness of commercial spend. However, traditional measures of ROI are proving to be insufficient in this evolving environment. They are limited by an inability of the output to aid comparison across various spend options, and even more by the inability to use these measures for non-promotional or educational spend. In addition, these measures don't target newer stakeholders like regulators and payors. As the relative importance of non-promotional spend items and newer stakeholders increases, ROI measures become increasingly insufficient. Finally, the significant effort needed to gather and analyze ROI data bogs down organizations and provides a false sense of rigor and precision, while being unable to aid real trade-offs for optimizing spend.

In this article, we argue that a business-focused and analytically robust approach to optimizing spend need not be an obscure black box. To explain the approach pharmaceutical executives should consider for optimizing their brand spend, we make the following four assertions:

1. ROI in itself is ineffective and often immeasurable for assessing brand spend. Instead, Quality (Q), defined as the ability of an interaction to help meet the brand's objective is a significantly better way to measure the effectiveness of a physician or patient interaction.
2. Combining Q with unique reach and fully loaded costs of each interaction creates a holistic and comparable assessment – Reach-Cost-Quality (RCQ) – across interactions to help executives make more informed decisions on where to invest.
3. Pharmaceutical executives should, in a compliant manner, include all brand-related spend, not just marketing, in assessing their budgets and determining how to meet their commercial and medical goals.
4. Pharmaceutical companies have an opportunity to radically reallocate brand spend beyond the "last year, plus-or-minus" approach that paralyzes many commercial organization.

Quality as a measure of a customer interaction

In our experience, many brand teams have used marketing spend effectiveness tools such as ROI, sales response curves, post-event surveys, and econometric regression analysis to better allocate their spend. These tools all provide good points of information but also suffer from severe constraints. The first is difficulty in measurement. ROI is often hard to measure and even when it is measured, each customer interaction often has a different investment horizon. Other measurements, such as post-event surveys are typically only able to provide a general 'good or bad' qualitative feeling about the effectiveness of the interaction. The second constraint involves inter-comparability. Because each measure is different, it is impossible for executives to make a trade-off across various customer interactions. Finally and most importantly, these tools do not actively take into account brand strategy and objectives. Given that the customer interactions are vehicles for delivering the brand strategy, this separation of strategy and execution often renders many of the analysis, such as ROI or regression analyses, interesting but meaningless for future spend decisions.

We suggest pharmaceutical executives look at effectiveness or impact of an interaction through a different lens: that of quality or Q, defined as the ability of a customer interaction or spend item to meet the set objective. Another way to define Q is through this question: How well does this approach (or customer interaction) support the defined brand objective compared to all other options? For example, will a targeted brand symposium generate greater interest than a local meeting? Will a sales rep detail be more effective than a discussion on the brand with peers?

Quality of each interaction is measured on three specific inter-related dimensions: engagement, attitude, and behavior. Engagement quality is the ability of a customer interaction to interest or engage the customer. For example, if a customer is in a meeting where brand related messages are being communicated, is the customer really listening? Attitudinal Q goes the next step. It is the ability of an interaction to change the customer's attitude or perceptions towards a desired objective. Behavioral quality is the final step, in which exposure to the interaction influences the customer to act differently.

We often find marketers wanting to focus primarily on behavior changes. However, engagement and attitudinal changes are often more predictive and important. For example, if there is low engagement, the likelihood of behavioral change is very low. Also, attitudinal or perception changes related to the brand are often longer lasting and are of higher impact than purely behavioral changes. A combination of these three elements gives a robust platform on the Q of each customer interaction. This can be then used to compare each customer interaction, helping inform trade-offs for brand investment.

Measuring Q cannot be a uni-dimensional and mechanical exercise. We use a mix of robust and tested methodologies including a proprietary survey developed and tested to measure all three aspects of Q, advanced customer insight techniques like enriched focused groups and moment of truth analyses, and mining existing brand team analyses. One of the most rigorous analytical aspects of the measurement is to get beyond physician and patient stated preferences to their derived preferences.

Overall, estimating Q is more of an art than a science. Doing it well requires a strong fact base, solid business judgment and lively debate, and customization of the approach to the specific needs of the brand and the geography.

Assessing all spend related to the brand

Many pharmaceutical executives review brand spend separately for sales, marketing, and medical budgets. This practice is driven by internal organizational silos and often done to ensure regulatory compliance and good business ethics.

However, looking at the brand spend in such a fragmented manner often leads to sub-optimal decisions, especially (but not only) between sales and marketing budgets. In addition, medical budgets are often not reviewed in a fully transparent manner leading to duplication and inefficiency across functional areas.

We suggest executives review the total budgets related to a brand or therapy area, but in a different and regulatory compliant manner. The total brand spend can be broken into three distinct categories: promotional interactions, educational interactions, and scientific programs, each with a distinct objective.

Promotional spend includes all the customer interactions with the specific objective of driving market share through promotion and explanation of the brand and its features and benefits. Educational interactions are for increasing the understanding of disease, treatment pathway and associated therapies among targeted physicians. The scientific program's objective is creating data and information about the product experience from treated patients.

In our experience, this approach enables a much more transparent view of the total budget associated with the brand. In addition, once the above objectives are clear, Q can be used to understand how effective the interactions are at meeting specific business and medical objectives. Of course the specific approach to calculating and reviewing Q varies based on the category of spend and its objective.

Combining Q with Reach and Cost to understand Reach-Cost-Quality

Calculating Q is important, but not sufficient for making brand spend allocation judgments. Two other factors need to be considered: reach and cost.

The reach of an interaction measures the number of contacts performed with targeted stakeholders. Reach analysis combined with cost and Q assesses relative effectiveness of an interaction. At the same time, it is an important stand-alone measure of the execution of interactions.

Pharmaceutical executives typically very rigorously monitor the planned and actual reach of detailing, but not for most other interactions. In addition, the detailing reach is not calculated specific to the segments and adoption-funnel stages relevant to the brand. For most other interactions (e.g., for regional sales and most educational/scientific activities), there is very limited data even on the actual reach.

We have observed that for real measurement of effectiveness, reach analysis must focus not on all contacts using an interaction, but rather on contacts to the "right" stakeholder – i.e. those who are a part of the targeted segments and belong to stages of adoption funnel where the interaction can have impact. In addition, to ensure relative comparison, it is important to adjust each interaction for the level of attention/tune-in it can command. This must be captured using a different tune-in factor for one-to-one (100 percent tune in, e.g., detailing), one-to-many (80 percent tune-in, e.g. local meetings with a speaker) and remote (60 percent tune-in, e.g. mailing) interactions. For educational interactions, where it is not possible and may not be appropriate to target activities to segments or adoption stages, a rigorous calculation of planned vs. actual reach and the related tune-in factors is important.

Calculating unique targeted reach across interactions not only provides executives a relative measure of real contacts across interactions, but also identifies key areas of focus to increase the reach and therefore the overall effectiveness of specific interactions.

The costs of an interaction should include fully loaded costs across different spend categories. This includes all direct and indirect costs relevant to the interaction. While most direct costs can be linked to an interaction, the indirect costs include full-time equivalent (FTE) salaries, bonuses and other overhead allocation, which are allocated to an interaction based on the time spent on the interaction by key individuals or functions. Such fully loaded costs for an interaction are usually not apparent to most brand or medical teams and can be eye-opening.

Allocation decisions based on comparison of Reach-Cost and Quality

A comprehensive understanding of the cost per targeted contact (C/R) and the quality (Q) of an interaction helps pharmaceutical executives make decisions on the allocation of spend. Increasing allocation to interactions with a low C/R and a higher Q helps move to a more effective spend mix.

However, instead of triggering mechanical changes in spend, we suggest executives use the RCQ input as the basis to have more fact-based discussions on the effectiveness of an interaction and the directional change to their spend. Exact allocation decisions are made by defining the minimum and maximum level of investments needed considering various factors: competitive share of voice, coverage and frequency of stakeholders, regulatory constraints, other shared resource constraints, etc.

Potential impact of spend optimization

Our experience in multiple situations suggests that there is a significant opportunity in pharmaceutical companies to improve the mix and quantity of their brand spend. A rigorous RCQ approach can uncover 30 to 45 percent of brand spend across functions for reallocation to higher quality and lower cost customer interactions. It also enables comparisons of brand spend and performance across geographies, even when markets use different marketing and sales tools. We have also seen cost-reduction opportunities of 15 to 24 percent without affecting top-line growth. Very often these savings were reinvested to further drive brand growth or to better meet scientific objectives.

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assessing the health of pharma

MARKETING

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Findings from our global Insight to Actions Marketing Survey identify key areas of opportunities

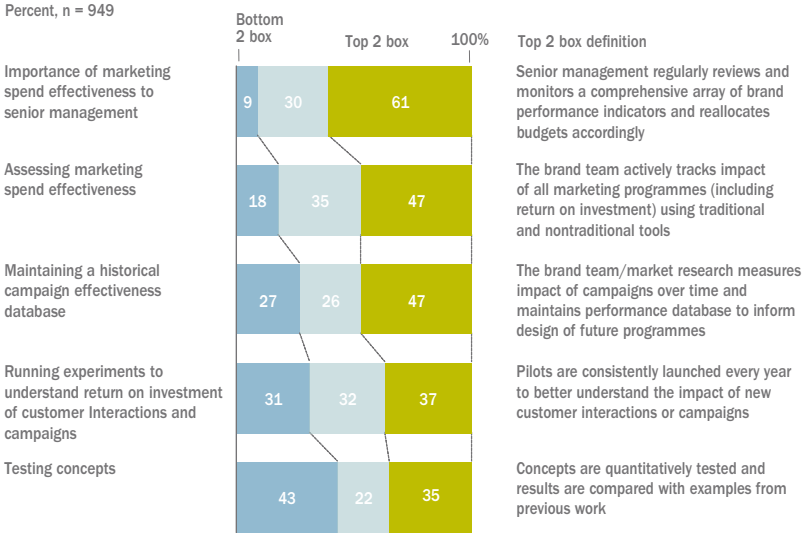
As the articles in this compendium demonstrate, world-class marketing is becoming increasingly important for pharmaceutical companies. But how prepared are their marketing organisations to perform at the required level?

To find the answer to this question, we combined McKinsey's in-depth knowledge of the pharmaceutical industry with the firm's experience working with world-class marketers to create the **Insights to Action Marketing Survey (ITAMS)**. This survey is designed to help companies both to improve their understanding of marketing excellence and to identify their own areas of strength and opportunities for improvement. To date, more than 900 pharmaceutical marketing professionals in seven companies worldwide have completed ITAMS. The sample represents an equal mix of primary care and specialty marketers with good representation from Europe (42%), North America (31%) and Asia Pacific (18%). Preliminary results based on these responses suggest that companies need to improve their performance in three areas:

Shifting the focus from processes to customer/stakeholder insights

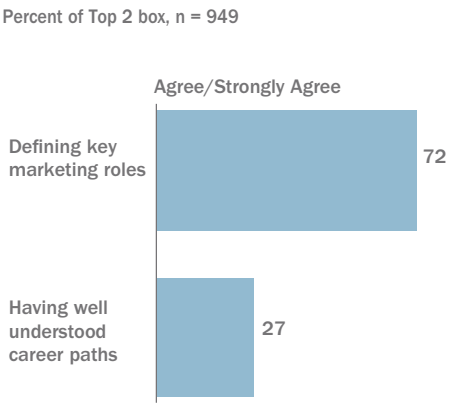
Most pharmaceutical companies believe that they do a good job with their marketing processes (e.g. segmentation, brand positioning, and brand planning). But lack of customer insights leads to sub-optimal marketing results, even when process execution is excellent. To compete more effectively, companies need to move beyond processes and focus more on customer insights.

exhibit 1



Source: McKinsey Insights to Actions Marketing Survey, 2006

exhibit 2



Career planning is mostly vague promises without a longer term view

– Head of Marketing, Europe

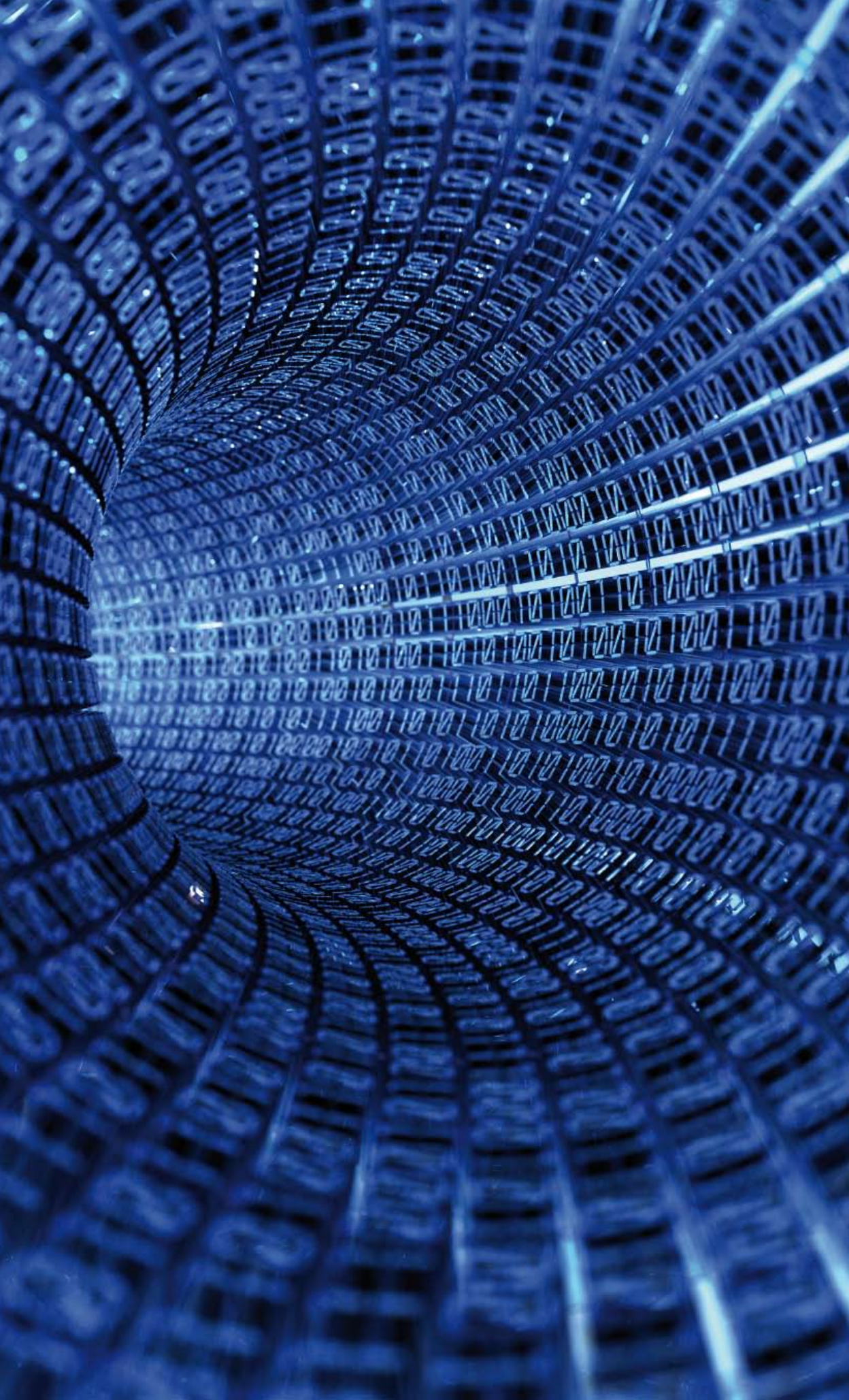
Marketing is an assignment, not a destination within the organisation. Little, if any, outside talent has come and been successful in the organisation

– Marketing Manager, North America

The company does not have a clear set "career path" that allows consistency when hiring into the Marketing department

– Product Manager, North America

Source: McKinsey Insights to Actions Marketing Survey, 2006



Only 35% of the survey respondents thought they were doing a good job at synthesising insights and translating them into actionable recommendations. Most respondents also expressed a lack of confidence in their understanding of the non-physician stakeholders who influence prescribing decisions. Throughout the world, payors and patients are playing an increasingly active role, yet only 20% of the respondents believed that they had good insights into these stakeholders.

Building learning into the system, especially on spend effectiveness

One of the reasons why insights are such a weak spot is that few of these companies have incorporated the feedback mechanisms necessary to track the impact of their marketing programmes and to learn which insights really drive business results.

For example, although most respondents said that marketing spend effectiveness was important to senior management, only a minority had the appropriate analytic tools and processes to permit them to calculate marketing effectiveness *(Exhibit 1, page 68)*. Less than half the respondents maintained a historic brand campaign effectiveness database. In addition, most survey respondents stated that they were not confident in their understanding of physicians' interaction preferences or media habits. Without this information, they cannot identify the most appropriate points of contact or develop optimal interaction techniques.

Furthermore, the culture in many pharmaceutical companies' marketing organisations does not appear to foster experimentation or the learning that would result from it. Almost two thirds of the respondents claimed that their companies do not run pilots before rolling out new customer interactions or marketing campaigns. And only about 40% had experimented with new ways to reach physicians, such as e-detailing and sample-drop forces *(Exhibit 2, page 68)*.

Incorporating pilot programs and experimentation into both the processes and culture of the companies will be critical if they are to continue to improve and meet future growth challenges.

Making marketing a destination career

The survey also highlights a pervasive need for better talent management in pharmaceutical marketing organisations. The majority of respondents believed that marketing roles and responsibilities were clearly defined – but that career paths were not. In particular, marketing was not seen as a route to the executive suite.

Most respondents also acknowledged that they were uncertain about how their performance was evaluated or how rewards were linked to performance. It is not surprising, therefore, that many reported it was difficult to develop a pipeline of talent within, or to recruit new talent into, their marketing organisation.

In short, companies that want to build world class capabilities urgently need to find better ways to attract, develop, and motivate high quality marketing talent.

* * *

The authors' conclusions are based on aggregated data from multiple pharmaceutical companies. However, the challenges and issues faced by each company are, of course, unique. ITAMS is one of the many tools McKinsey uses to help clients understand their most critical performance improvement opportunities. If you would like to learn more about the survey or to participate in it, please email kirsten_westhues@mckinsey.com.

“Most respondents also acknowledged that they were uncertain about how their performance was evaluated or how rewards were linked to performance.”

ten ideas to improve the FRONT LINE

PETER DE BOECK
SVEN DETHLEFS
KRISTIAN VILLUMSEN

An antiquated sales model is like dead weight. Pharmaceutical companies need to shed the load to make sure they are not left standing as the world moves on around them. There is widespread agreement that the current model is untenable. In this article, we summarise the case for change and argue that it may be imposed on the pharmaceutical industry sooner than many people expect, and then lay out ten ideas for companies to consider as they experiment and innovate.

WHAT'S WRONG?

There is no doubt that pharmaceutical sales forces in Europe are under increasing pressure and the reasons have been thoroughly analysed. The authors of **Mastering Complexity with New Commercial Models** describe how physicians are losing their freedom to prescribe, and new stakeholders are controlling budgets and restricting opportunities for customer interactions. At the same time, sales forces have to contend with increasingly crowded therapeutic areas (TAs), non-differentiated brands, growing pressure on costs, and public sensitivity to the influence of the industry on physicians.

It is also clear that physicians themselves are dissatisfied with the industry's sales approach. The overwhelming majority of them dislike "soundbite selling" and are restricting the number and duration of calls they take, making the traditional approach increasingly inefficient. In some countries, such as the UK, our research shows that a sales representative makes four or fewer calls on target physicians on a typical day and that those physicians recall less than 10% of his details. More and more physicians are refusing to see representatives or allowing calls by appointment only, and in some markets, such as Sweden, meetings between physicians and representatives are becoming the exception rather than the rule.

So far, none of this has brought about a radical revision of the industry's approach to selling. The industry has focused on increasing the productivity of today's sales model, making the most of the available tools and techniques – not without success. Optimising operational performance has been the dogma in recent years: flexing and adapting resources to match potential, running training programs, standardising call delivery, cross-selling in meetings spanning several TAs, and working with key opinion leaders.

While these efforts have indeed improved overall performance and reduced its variability in many companies, they have tended to prolong the life of the current sales model by concealing its weaknesses, rather than addressing its fundamental shortcomings. By perpetuating the use of standardised calls, they have also reinforced the frustration with the industry expressed by physicians.

In the end, it may be a completely different development that finally triggers major change – the rise of a fully integrated decision and delivery model.

The tipping point for the pharmaceutical sales model?

Today, the typical physician examines his patient and prescribes a drug according to his training, conviction or preference for a certain brand. The patient takes the prescription to his local pharmacy and collects the prescribed drug. Recent innovations, isolated so far, hold the potential to transform this process in a few years, and herald a world of fully integrated, software supported decision making from diagnosis through to delivery. What might it look like? Imagine this…

Software supported diagnosis will become the norm. An electronic questionnaire will guide the physician through patient examinations, leading her to a quality checked diagnosis that includes the assessment of most risk factors associated with the disease. This approach is already being used to diagnose breast cancer and colon cancer in some German regions, such as Bavaria, where it has led to dramatic quality improvements in the way patients are treated. Another advantage of software supported diagnosis is that it allows regulators to rate the performance of individual physicians against benchmarks on the basis of outcomes and statistical deviations. Physicians who fail to meet targets set by the regulators using these indicators may be prevented from practicing.

In the new world, the electronic diagnosis will be linked to evidence based prescription guidelines issued by medical associations and built into the software. The physician will be free to choose a molecule – but only within a range which the system allows him to prescribe. Only products with unique value propositions are likely to bypass such strict medical guidelines, as physicians will retain relative freedom to prescribe them as long as they can justify the need to do so. The e-prescription system will make it more difficult to introduce new molecules into physicians' offices – unless they are proven to be superior (or at least equal) to current treatment standards.

The system will process the script automatically and send an electronic form to the local pharmacy or the mail order pharmacy that has preferred provider status with the payor. The software system will also select a brand or decide which manufacturer will supply the molecule on the script. Payors will make direct price and discount contracts part of the prescribing system, eliminating the physician's choice of brand within a cluster of similar products. This system, already used for generics in some areas, will be expanded to branded products. In addition, medical drugs may not be delivered in manufacturers' packaging, but in customised blister packs containing all the drugs the patient has to swallow at each meal time.

Too far out? All the systems described here already exist today in many markets, but they are being implemented as stand-alone solutions or are still being tested. As soon as they are integrated within a TA, the life of sales representatives in that area will change dramatically. We believe this integration may happen sooner than most people think. Regulators who discover that improved diagnoses – supported by e-questionnaires – can prevent many subsequent healthcare costs will realise that the logical next step is to link e-diagnosis with e-prescriptions.

In some markets, such as the UK, where various groups including primary care trusts (PCTs) and nurses heavily influence prescriptions, sales representatives are already adapting the way they work. We believe the integration of new software systems to provide support from diagnosis through to delivery could be the final straw for the traditional sales model.

The sales representative as we know him today could become obsolete, replaced, perhaps, by a medical consultant helping the physician to interpret guidelines and choose between therapy options.

Such a scenario has it drawbacks – physicians would fear further marginalisation of their role in therapy selection, and the cost of employing qualified medical consultants would be high – and sales methods will vary between companies, given their different product portfolios and market positions. The important point is that the way the sales model will change in the industry as a whole will be transformational rather than incremental. The new model will need to be flexible enough to adapt to the changes in the environment as they play out – and still deliver the top line. What will it look like? What change is needed and how should it be implemented? We do not pretend to have all the answers but propose ten specific ideas for pharmaceutical companies to consider as thought starters as they wrestle with these questions.

TEN IDEAS FOR GETTING THROUGH TO CUSTOMERS

1. More channels

Sales representatives will remain a highly effective channel to deliver messages from pharmaceutical companies to physicians for the foreseeable future – but also a very expensive channel, particularly now that guidelines are restricting prescriptions and many physicians are resisting spending time with sales people. Given that many physicians hold limited potential, we believe that the least valuable 25% to 35% of the existing customer base of a typical pharmaceutical company in the primary care market should be transferred to a professional call-centre program, which would communicate with physicians using phone calls and various other channels, such as e-detailing, sms, blogging and podcasting. The transfer would release significant resources but strong segmentation would be required to manage the multiple channels and ensure that they meet physicians' needs.

Many pharmaceutical companies have abandoned the least profitable physicians – and found that alternative channels have not been widely accepted. In the cost conscious generics business, however, call-centre based detailing has been successful not only with pharmacies, but also in markets where physicians are the key decision makers. Examples include 1A Pharma's and Aliud Pharma's commercialisation models in Germany, both reliant on telemarketing and both enjoying high growth in this market. Companies which have not succeeded in using telemarketing to open physicians' doors may need to experiment more to find the right keys, and could learn by looking over the fence: telecoms, banking and insurance have spent more than twenty years developing expertise in tailoring the right content, to the right customer, at the right moment, through the right channel.

2. Part-time representatives

In our experience in many industries, part-time representatives can be highly cost effective. It would be difficult to build a sales force entirely made up of part-timers but they are productive supplements. They carry lower fixed costs than full-time employees (with no benefits and relatively smaller bonuses), and anecdotal evidence suggests that they achieve higher performance on a per call basis because they tend to be more experienced, work during the most productive hours of the day and spend less time on work-related distractions, such as meetings and emails. They also provide more flexibility in deployment and resource allocation – especially if "annual work-hour budgets" are used, as they are in the automotive industry.

Pharmaceutical companies tend to find it difficult to adapt training, planning meetings and internal processes to the needs of part-timers but these issues can be solved, particularly if sales managers accept bigger performance spreads.

3. Self-employed representatives

The pharmaceutical industry could emulate sales force models in other industries – particularly the insurance industry – by introducing self-employed representatives. They receive training, sales materials and a target geography, but they are incentivised purely through a performance based bonus system. In insurance, the bonus systems are generally more sophisticated than those currently used in the pharmaceutical industry. Rather than being based on market share and market share evolution, they contain a strong element of revenue related compensation, combined with a portfolio of "bonus-boosters" payable if product portfolio targets, qualitative measures and seasonal campaign goals are met. This model treats sales costs as variable costs, but has the downside of managing strategy implementation purely via incentives.

4. The "pancake" sales organisation

The pharmaceutical sales model traditionally relies on an organisational structure which revolves around regions and districts, with several layers of managers above the interface with the representative and a manager to representative ratio of between 1:10 and 1:14. Other industries seem to have moved away from this model. In the high-tech and software sectors, for example, the ratio is now 1:50 or even 1:100.

Moving towards a flat – "pancake" – sales force organisation, without regional managers, will require a product basket without much innovation or complexity and front-line sales representatives who are more experienced, commercially oriented, and self-driven than in the traditional organisation. We would propose a compensation model with a high performance based component (around 50%). The metrics put in place to measure front-line sales representatives' performance need to be specific, consistent and relevant, and managers need to be able and willing to make very quick performance management decisions. Finally, with less of a career ladder in place, compensation systems need to be adjusted to ensure that high-performing sales representatives have the appropriate incentives to stay with the company.

This model, properly implemented, can produce impressive results. First, eliminating the intermediate layers of management frees up a significant amount of cost. Some of this may be reinvested in enhancing the quality of front-line sales representatives and upgrading systems to boost revenue. There are precedents, such as Hexal's former sales force in Germany, where sales representatives reported to one manager, and the primary care sales force of an Italian pharmaceutical company, where representatives promote a basket of brands and receive up to 50% of their salary as a performance based bonus.

Variations of this model include one where the representative acts as a personal relationship manager and as gate-keeper for specialist representatives. He takes care of a local network of physicians, regulators, nurses and other stakeholders, and his primary role is to co-ordinate the information flows, education programmes and other marketing messages they receive. He also introduces highly specialised experts who interpret therapy guidelines, work on prescription budgets and provide in-depth support in therapy selections – rather like second opinion physicians.

5. Smart use of Share of Voice (SOV)

Conventional wisdom holds that maintaining SOV against the competition (in field force details as well as marketing and media spend) is a pre-requisite for product success. However, we have seen detailing or media spending scaled down dramatically in certain territories with no discernable impact on product sales performance compared with performance in control territories. Only when there is news about a product or its competition (such as new indications, new data, or regulatory news) must SOV be high enough to go on the offensive – or on the defensive – and drive product performance.

The challenge is to use SOV smartly, maintaining a steady base level of detailing and marketing and media SOV significantly below current levels, and heavily pulse commercial spending when there is news about the product or its competition. The idea is to gear up temporarily and then drop back down to the base level. This may mean investing in intensive detailing to the most relevant physician segments as well as in marketing and media spending.

It should be possible for the re-based level of commercial spending plus the pulsed investments to be significantly lower than current commercial investment levels without damaging the top line. It requires the pace of change in spending to be much faster than today, calling for strong competitive intelligence and the ability to deploy flexible field resources quickly. We see some elements of this model already in practice but nobody who has carried it far enough to overtake existing sales cycles.

6. Segments of one

Since the “commercial arms race” (more feet on the street, more standardised messages and push) has clearly frustrated physicians and led them to restrict access, pharmaceutical companies have begun to experiment with more tailored approaches to segments. While “segments of one” may be a dream, we consistently see tailored approaches to sales deliver much more bang-for-the-detail. We believe a healthy objective for most companies is to reduce sales force size by 20% to 30% by adopting a much more tailored approach to call delivery than today.

In this world, representatives are capable of engaging prescribers in scientific dialogues based on their needs and can tailor messages and sales approaches accordingly. They ask more questions, listen more, and work more effectively with their marketing departments to meet physicians’ needs. Such segmentation allows companies to deploy their most experienced (and highly paid) sales resources to the most critical physicians. Examples of this kind of tailoring include Abbott’s launch of Humira with its focus on scientific detailing tailored to the physician’s specific needs, and the highly individualised approaches of NovoNordisk and Baxter in the hemophilia indications. Medical device companies also work with personalised programmes to drive sales and the adoption of innovation.

7. Barrier detailing

Barrier detailing is a simpler approach than the segments-of-one concept: the representative defines the three barriers which are stopping a physician from making a product the first choice in his therapy selection. He then dedicates the next six to eight calls to working with the physician to overcome the barriers. There are two key success factors. First, the representative is trained in a methodology which helps him to surface the barriers in an interview with the physician without asking directly what they are. Second, the representative learns how to sign a "virtual contract" with the physician if the prescription barriers are overcome. In our experience, physicians like this approach and it leads to action-oriented customer segmentation.

8. Regional go-to-market models

As countries send more of their health spending into regions, pharmaceutical companies need to adapt their models to follow. There are often significant differences in potential by region, not only in terms of numbers of patients and procedures but also in terms of access. Regions in many countries manage formularies and guidelines that can affect sales dramatically, and they need to be managed.

Many companies have established key account management functions to handle new stakeholders, such as primary care trusts in the UK, but there is still a long way to go. Takeda provides an example. In May 2004, Takeda UK announced they were experimenting with a new sales model that would make their current sales force redundant. In place of the traditional strategy of making regular calls on primary care doctors, the company put in place a network of Regional Account Directors (RADs) charged with building long-term strategic relationships with local decision makers. The idea was to serve customers and patients better by reallocating resources previously used to limited effect in front-line sales. RADs have their own budgets and, subject to medico-legal approval, make their own decisions on what is required in their local areas to benefit patients and the health service. The early results have been promising, with Takeda's growth in the UK widely attributed to the new model.

9. Strong above-country marketing

In most pharmaceutical companies, country managers hold much of the responsibility for driving sales and market share, and also hold the keys to most of the resources. This model is well suited to an environment where countries differ a great deal from each other in terms of what it takes to succeed. We believe countries' requirements are different but that most of the differences are limited to ways of interacting with customers. Differences in support activities are very minor–related to issues of accounting regulations or employment legislation, for example. Most importantly, the majority of marketing activities do not need to vary between countries.

The opportunity is to move more marketing activities outside countries – usually to a regional level. To make this work, companies need to establish European budgets across core products. These should include responsibility for resource allocation and re-allocation and P&L authority for certain products. This move would generate savings by reducing interface costs between regions and countries and realising economies of scale in areas such as the production of promotional material. It would help to build stronger marketing capabilities and spread consistent ways of marketing throughout the company. It would also free up the countries to operate from a customer-focused perspective.

A relevant example is Novartis's approach to managing its specialty business in a single business unit across Europe.

10. Physical points of sale

We always expect the pharmaceutical company to visit the physician. Why not the other way round? Volkswagen was highly successful in Germany in making customers travel to its factories to pick up their cars, and most automotive companies now build similar delivery centres at their factory sites. BayerSchering has constructed an "excellence pharmacy" to train pharmacists, and most medical device players have huge training centres. It seems reasonable to believe that pharmaceutical companies could follow suit and start training physicians in dedicated TA centres, not only in scientific subjects and treatment options, but also in skills such as interacting with patients and organising process flows in their practices.

MOVING FORWARD

In a world where returns from individual representatives are diminishing and non-physician customers are proliferating, companies will need radical innovation to stay successful. We believe a step by step approach may be the best way to achieve this and manage transition risks, but adopting radical new models straight away is also a possible option. Each company will have to weigh the alternatives, taking into account its starting point in terms of product portfolio, markets, and customer legacy. One thing seems certain, though: as physicians lose their freedom to prescribe what they think right, companies must transform the way they sell.

We believe that the ten ideas laid out above are realistic enough to be piloted. They do not form a full list of options and they are not intended to be tried out all at once. Rather, every pharmaceutical company should be trying out its own portfolio of innovations to change the commercial model. The opportunity to learn and adapt requires experimentation, and we think pharmaceutical companies are doing too little relative to the opportunity. The consumer goods industry has test supermarkets, test towns, even test geographies to learn more about its customers – why not the pharmaceutical industry?

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