

Shaken not stirred

Chaos might be one word to describe the next three years as the NHS restructures. In the first of a series, Katrina Megget looks at what impact these changes will have on pharma

Just when you thought you were getting to grips with the shiny new concepts of market access and key account management, a fresh government steps in and decides to shake things up: not just a little, but a lot. No-one would argue against some of these changes – streamlining the NHS, slashing bureaucracy and putting patients at the heart of healthcare – but what does it all mean for pharma?

With GP commissioning the new norm, could it trigger a return to the old sales model? As primary care trusts and strategic health authorities make a quick departure, whom should pharma be talking to and what will this do to market access? And when value-based pricing replaces the current pharmaceutical price regulation scheme, where does cost-effectiveness fit in and how will value be defined in these uncharted waters?

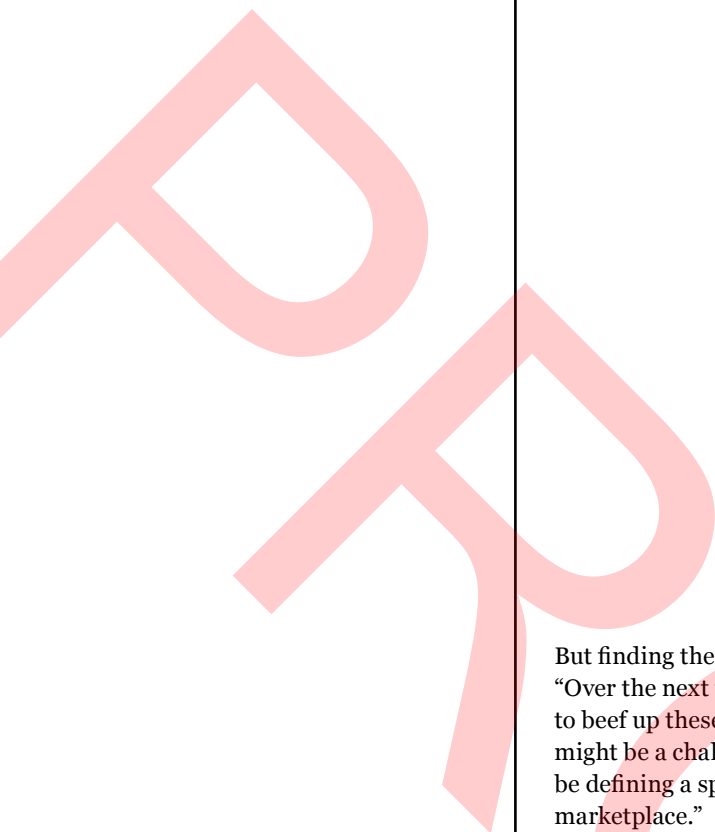
Health Secretary Andrew Lansley's White Paper Equity and Excellence: Liberating the NHS throws up a lot of questions. Answers are still thin on the ground, but according to analysts interviewed by PharmaTimes Magazine, this isn't a rewriting of the industry, more a refocusing and fine-tuning – and the opportunities are plentiful. Of course the White Paper's detail is currently vague – described by BMA council chairman Dr Hamish Meldrum as a large curate's egg: "good in parts, bad in parts, unclear in parts and even internally

inconsistent in parts" – however the most important message to come out of the changes is that while pharma should not assume GP commissioning means a return to the old sales model, neither should it require a whole new restructuring of the already transformed model.

Relocation, relocation, relocation

Value will be at the heart of the new model with key account management taking precedence over traditional sales techniques. Jean-Francois Delas, a vice president at Kinapse, says the model will need some tweaking to adjust to the changes and this will probably be

“X”



But finding these people will be difficult. “Over the next few years pharma is likely to beef up these kind of people, which might be a challenge because they will be defining a specific skill set in the marketplace.”

Adam Knights, managing director of 15 Healthcare, agrees saying it’s time to stop playing around with KAM – pharma needs to knuckle down and do it properly. “The next level of key account managers will be clinically smart, business savvy and will know how to align their company strategy with the NHS at a regional level.” As a result, he anticipates a “natural cull” of sales representatives over the next three to five years as pharma realises the need to invest in a core team that can deliver many objectives. However, there may be a rise in new roles as well, says industry veteran Professor Trevor Jones, particularly in sales economics, where roles are likely to involve negotiating ad hoc ‘discount on volume’ prices at regional and local level.

Unfortunately, realigning the workforce isn’t the only fallout from the changes that will take place. While GP fund-holding might have some takers in the deficit-busting Conservative camp, the logic of introducing GP consortia has been questioned by many, with recent surveys of doctors indicating the profession has serious concerns about the move. A Doctors.net.uk poll found 83% of doctors felt they were

not adequately equipped to make the outlined changes to commissioning, with 67% saying they didn’t welcome the changes. A Synovate survey in contrast found 75% of GPs in favour of the White Paper’s concepts but concerns were voiced about the likelihood of increased administration. Some have said, if PCTs can’t handle the budget, what makes the government think GPs can do a better job? Others hark back to the fallibility of the former practice-based commissioning.

Delas expects GPs and the related consortia will become increasingly financially driven despite their role as prescriber. And even though many people responsible for commissioning in PCTs will jump ship and move to take on these roles within consortia, it doesn’t mean this will solve the anticipated capability problems. “We are talking about an even bigger challenge for GPs and many will struggle,” says Delas. “Private companies will pitch to help run the business and the budget, and if the private sector is involved then the decision will be much more financially managed and it will become increasingly difficult for pharma to make its case.”

What about expensive medicines?

Indeed, as Jonathan Anscombe, partner – European lead, pharmaceuticals and healthcare practice at A.T. Kearney, says, GP commissioners will focus on the things they are able to control – most notably the drugs budget. Generic alternatives and cheaper therapies are likely to be popular, as was found in a Cegedim Strategic Data survey. The results found only 4% of GPs said patients will be more likely to be able to use new drug therapies and half of the GPs believed their consortia would be more likely to use generics.

So does this mean expensive drugs will stop being prescribed? Anscombe doesn’t think so. “If it’s an expensive drug that doesn’t have a huge number of users and therefore won’t have too great an impact on the budget then they will fund it.” But with details lacking on how the new system will really work,

challenging for pharma. “The transition to GP consortia means pharma will have to align itself and its resources to this new mix of stakeholders. We’re not talking so much about changes in skills or capabilities but a relocation of resources, specifically for those who interact with regional bodies. The biggest change will be health managers now having to interact at a local level.”

And with 152 primary care trusts giving way to about 500 GP consortia the fragmentation is huge, which means pharma will need more people on the ground interfacing with the consortia, Delas says. These won’t be representatives, he adds, they will be account managers with different skills.

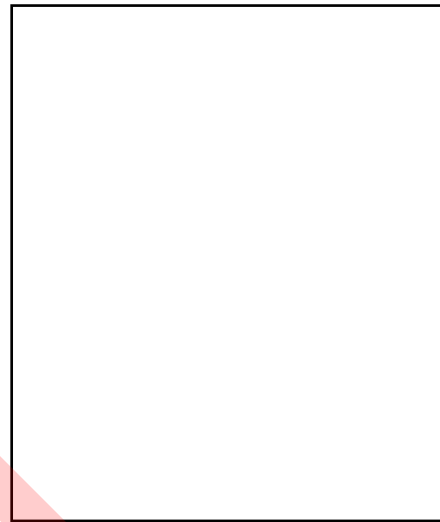
Paul Catchpole, director of value and access at the Association of the British Pharmaceutical Industry, says it's too early to say whether the proposed changes will have a positive or negative impact on the uptake of medicines. However, he adds, companies will need to evaluate the impact of the reforms in terms of the shape and mix of future drug pipelines, looking at primary care versus specialist care medicines and targeted versus non-targeted therapies.

Knights, on the other hand, believes there will be a special place in the NHS for innovative products even if they are expensive. "It's not just market access but access to market that is now the challenge," he explains. "With no more PCT Mandarins blocking drug delay the consortia can start to use more effective branded products earlier as they will have to keep the referrals to the acute trust down to save money." And this is really the take home message: what is more cost-effective: constant referral to hospital or early intervention via primary care? "The name of the game," says Knights, "is to keep patients out of hospital, and that means newer, more expensive, innovative products".

Demonstrating real world value

Anscombe agrees, saying pharma needs to think about positioning the value proposition in regards to this: "Can a drug reduce the hospital stay; provide compliance schemes and thereby reduce side effects and acute care incidents; and can it demonstrate real world value? Being innovative is not developing another diabetes drug but rather a diabetes drug that people take consistently. If you want to be innovative then reduce healthcare costs and really improve the lives of citizens – not in randomised control trials but in the real world; in Birmingham or Stockport."

Catchpole also emphasises this point: "We all need to help ensure the new era of commissioning delivers effective prevention, early diagnosis and timely treatment necessary to halt the burden of chronic disease that might threaten the financial future of the NHS." As a result, disease management (particularly of chronic diseases) looks set to be making a comeback, especially as the realisation dawns that the NHS spends more on unplanned hospital admissions for chronic disease sufferers than it does



on medicines to prevent them.

So what opportunities does this provide for pharma? The big one is undoubtedly joint working. Disease management, public health promotion, packages of care that involve drugs – these will all be intertwined with joint working in the future. Any project that can streamline services and reduce hospital admissions will be a front-runner. However, success won't be guaranteed without pharma having an intimate knowledge of local health priorities, and the 150 Quality Standards to be produced by NICE will be instrumental in this. Not only will these dictate the behaviours of GPs and the consortia, but they should also dictate the behaviour of pharma – particularly as to what drugs might be deemed more valuable and therefore more likely to be reimbursed, Delas says.

No time to waste

While it is still three years until the full NHS changes are implemented, there is no time for pharma to rest on its laurels. Indeed, some shifts will be seen as early as next year (see side box). 2013 should not be the deadline, says Delas. Pharma needs to work with the timeline the government has laid out. "It's time now for pharma to understand in detail what these changes mean and what the implications are and how to adapt. What

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Read the White Paper, get the background and have your say in the consultation: <http://bit.ly/cCOMnL>

they need to do is not only understand the new model but translate that into a new way of operating and defining new processes and roles. That takes time. It's a big change for pharma."

Meanwhile, Clive Johnstone, managing director of Medical Management Services, says changes to GP consortia have already started, with many keen to hold the commissioning budgets as soon as possible. "Pharma has no time to waste. It really needs to take these changes on board now and keep eyes open and ears close to the ground to learn of the changes happening locally." Specifically, he says pharma needs to identify which PBC clusters will be GP consortia and which PCT managers are moving over to consortia to provide commissioning expertise, and then to understand the details of the changes as they come to light.

The changes to the NHS hold a promise of benefits not only to the service and its patients but also to pharma. A work in progress it may be, but as many commentators are quick to point out, the earlier pharma starts the process of understanding and adapting to the new model, the better the place it will find itself.

Next month, PharmaTimes Magazine looks at the impact of the changes on market access and what value means in the new NHS. A second article will explore the new opportunities for joint working.

Implementation timelines

- 2011 – creation of the Cancer Fund
- 2012 – NHS Commissioning Board fully established, GP Consortia will be established
- 2013 – SHAs and PCTs abolished, GP consortia begin to commission services
- 2014 – introduction of value-based pricing; Monitor will serve as the economic regulator for the NHS; efficiency savings of up to £20 million envisaged.