



Communicating product value to local payers is a new challenge

In Europe, pharmaceutical budget responsibility is being transferred from national to regional healthcare organisations, resulting in cost-containment measures being decided at a local level. Such measures include prescribing restrictions, guidelines and incentives. Local payers and their advisers have to analyse a wide range of information and data in order to evaluate a product's clinical benefits and economic effectiveness before making a decision about guidelines and/or funding of medicines. Payers at the local level are therefore key stakeholders with increasing influence. Despite recognising them as key decision-makers for market entry and access, pharma tends to view them as obstacles to overcome rather than important customers to understand and to communicate with effectively.

Local communication

Traditionally, communications at a local level have focused on clinical stakeholders. Targeting product value communications to local payers is a new challenge for the industry, and an area which is evolving rapidly. As part of a wider European project, Pope Woodhead conducted 27 in-depth interviews with payers throughout England, Scotland, Wales and Spain, to determine the current interactions taking place between pharma and local

decision makers. The objective was to survey the types and usefulness of value communications received by local payers; the channels used by pharma companies to communicate with payers; and payers' perceptions of the industry.

Complex environment

One of the difficulties in communicating product value to local payers stems from the complexity in defining who these payers are within the structure of national or local healthcare providers. In the UK and Spain, the healthcare systems are complex and organised in different ways.

In the UK, healthcare is provided by the National Health Service (NHS) which differs in structure depending on the country and includes many local health providers with varying pharmaceutical budget responsibilities. In England, these are primary care trusts, care trusts, foundation trusts and NHS trusts; in Scotland, health boards and specialist health boards; and in Wales, local health boards and NHS trusts. In Northern Ireland, the NHS is called Health and Personal Social Services (HPSS) and has its own organisational structure, but this country was not included in the project. England, Scotland and Wales have their own national health technology assessment (HTA) bodies responsible for assessing the value of medicines and health technologies: the National Institute for Health and Clinical Excellence (NICE), the Scottish Medicines Consortium (SMC) and the All Wales Medicines Strategy Group (AWMSG), respectively. Local networks, such as London New Drug Group (LNDG) and Greater Manchester Medicines Management Group (GMMMG), also provide evidence-based information.

In Spain, each of the 19 regions - 17 autonomous communities and two autonomous cities - organises and funds its own healthcare system. Although every region has responsibility for choosing the best treatment for its patients, the procedure to assess treatments and generate guidelines differs depending on the area - ranging from a formalised process driven by the region's own HTA body, as in Andalucía and Valencia, to a simple collation of other regions' recommendations in localities on a lower budget, as in Rioja.

Local authorities in Spain and the UK base decisions on their own clinical and economic assessments. Where possible, these are the assessments of validated and independent national or international bodies, such as NICE, and assessments from other regional organisations, like LNDG and GMMMG in the UK, or the Comité Mixto de Evaluación de Nuevos Medicamentos (Joint Committee for the Evaluation of New Medicines) in Spain.

The payers interviewed had a mix of different job titles, roles and responsibilities. However, even those with similar job titles were found to have different roles and responsibilities affecting their information needs.

The interviews in both Spain and the UK

revealed that the pharmaceutical industry provided local payers with a large selection of communications, ranging from simple product leaflets to interactive economic tools. However, perception of the quality and usefulness of these tended to vary from company to company.

Furthermore, rather than value-specific communications, payers reported receiving mainly product materials, which they perceived as overly promotional and biased towards the company's product. As one interviewee put it, "Most of the time, the only things they provide are their glossy leaflets".

The interviewees felt that the overwhelming amount of information received from pharma did not include local data or data considered relevant or useful to them. Unsurprisingly, the more evidence-based the content, the more useful the payers found it. However, when making decisions, they reported that they were not overly influenced by pharma communications.

The payers agreed that pharma companies had a unique insight into their own products and were a useful source of information. They used these materials mainly to monitor what general practitioners (GPs) were receiving, to find out the latest clinical trial data and cross-check published articles. But the main interest was in gathering information about new products and indications in the pharma pipeline to help them plan and allocate resources for their regions in the following year. One common complaint regarding new developments was that information was not always communicated early enough.

Local payers and pharma

Around half of the payers interviewed valued direct interaction with pharma companies through regular face-to-face meetings; the others limited their interactions to post and email, or even avoided all contact with the industry. Unsolicited interactions or emails were not welcomed. The main reason given for avoiding or limiting interaction with industry and not valuing face-to-face meetings was that local payers considered the information provided biased and not tailored to their needs. To balance the messages provided by industry, local payers in some regions of Spain and the UK invited several companies to the same meeting to discuss one indication or therapeutic area. All payers mentioned that it was important for the industry to build relationships and trust at a local level.

In general, they welcomed interaction with people who were able to understand their needs and were well trained. However, the perception was that some pharma personnel did not seem to fully understand the therapeutic area and/or the economic data, and were not adequately prepared to discuss the evidence. One interviewee commented, "It's all about the training; the industry is not trained well enough". Therefore it is crucial for the industry to ensure that the payer perceives benefit in each interaction and through

"One difficulty is defining who these payers are within the structure of healthcare providers"

➔ each of the pharma communications materials. Payers said they had never been asked by pharma what information they required, how they would like it communicated and at which point in the market access process this information would be most useful.

Improving communications

In terms of product value communications, the research showed that payers were not fully satisfied with pharma's interactions. Considering the sphere of influence of the local payer, the complexity of the payer environment and the constantly changing healthcare systems in Europe, it should be a priority for pharma to understand, and determine the needs of, all groups of payers on a regular basis.

Most importantly, communications strategies and tactics must include this new range of payer stakeholders. The variety in payer roles and responsibilities means that product value communications need to be tailored accordingly on a case-by-case basis, to ensure that they not only address the payer's range of content needs but are delivered via appropriate channels.

Payers said they preferred concise evidence-based communications materials, adapted to their area of responsibility and geographical location. They might also welcome other types of interactions, such as face-to-face meetings, but only when pharma personnel were trained in the clinical and cost-effective aspects of the disease area and were adequately prepared.

As for any other customer segment, the industry needs to address the negative image and dissatisfaction that payers have regarding their current interactions with pharma. Through our interviews in Spain and the UK, as well as preliminary research from other European

countries, including Sweden, Italy and Germany, it is clear that payers perceive educational and training support around a therapeutic area to be a valuable service from the industry. However, pharma could also offer services beyond product value communications by further exploring initiatives that provide additional benefit to payers and payer advisers, such as patient registries and risk-sharing schemes for new products.

“Although payers and pharma have different viewpoints, their common goal is to help patients”

Only by acknowledging payers as customers, understanding what information they need and knowing when and how to communicate it, will the payer paradox be resolved. This fundamental approach, coupled with the introduction of new evidence-based initiatives, may allow pharma to gain greater credibility with payers and build a basis for future interactions. Although payers and pharma have different viewpoints, they have a common goal in aiming to achieve the best possible outcomes for patients. It is therefore vital to find the best way to interact with, and learn from, each other.

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Payer segmentation: needs and responsibilities at local level

Job Title	Key responsibilities					Information needs	
	Clinical evaluation	Economic evaluation	Drug budget allocation	Data presentation to practices	Ensuring cost-effective prescribing	Clinical data ¹	Cost effectiveness data ²
Clinicians, GPs	X						
Pharmacists	X	X	X				
Economists		X	X				
Managers ³			X	X	X		

¹clinical trials; ²cost models, health economic data; ³regional policy makers, head of medicines management