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NHS reforms

What next for the pharmaceutical industry? Mike Sobanja, Chief Executive, NHS Alliance shares his views with Capgemini's Mark Holliday.

People matter, results count.

With the consultation at an end, it is evident that this train isn't stopping.

In July 2010 Andrew Lansley announced the government's ambitious plans to reform the NHS in England in the white paper Equity and excellence: Liberating the NHS. Since then there has been vigorous debate, with numerous groups and interested bodies having their say through the consultation process. With the consultation at an end, it is evident that this train isn't stopping: with the Bill's introduction into parliament on 19th January 2011 the government's plans are well on their way to being fully implemented.

In this article we examine some of the more significant aspects of the reforms, and the potential impact on the pharma industry.

Individual or guideline-driven prescribing?

Shall we see a return to the "good old days", with individual prescribers making the decisions, or will it still be a case of group decision-making in the form of guidelines, protocols and formularies?

Alas for GPs and the pharma industry, the "good old days" are just that. It is likely that prescribing will be more guideline- and formulary-driven, with a greater emphasis on decision-making at a national level and through the GP Commissioning Consortia (GPCC) at a local level. In fact, the freedom of the individual to prescribe will decrease overall, though this will vary by therapy area, with primary care diseases, such as hypertension, being more tightly controlled compared to more specialist disease areas.

Impact on the pharmaceutical industry

It's fair to say that not all 143 clauses within the white paper will have an impact on the industry. However, where there is an impact it will be significant and will be felt across the whole industry. Here we look at three areas of impact: the shift of accountability for public health, the emergence of GPCC, and the increasing influence of the patient.

The shift of accountability for public health from the NHS to local government will see the introduction of a whole new set of customers and stakeholders. If we didn't think the stakeholder landscape was changing enough through traditional clinical developments, the white paper introduces a whole new set of customers in local government. Thus politicians, locally-elected councillors, chief executives and directors of social services amongst others will become pharma industry customers Therefore, the

Key elements of the reforms

The broad initiatives are designed to meet the financial challenges faced by the NHS, and specifically to save the required £20bn. They can be divided into three main groups:

- More focus on patient-centred care, and moving commissioning and (especially) clinical decision-making closer to the patient. As the white paper puts it, "no decision about me without me". For example, patients needing hospital treatment will no longer have to go to their local NHS facility: they are free to choose a different one in consultation with their GP.
- Big focus on outcomes and quality standards, not process. The government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all. The Labour government had reducing waiting times as a key target, whereas the coalition government is focusing on the outcome, irrespective of how long you have to wait. As a result, we have already seen a small increase in waiting times from 18 to 21 weeks.
- Better services to patients in both outcomes and the overall patient experience.

Efficiency must also be increased, as the NHS has to cope with greater demand with little extra money. Opening the health service to market competition is a key strategy to help achieve this efficiency improvement.

industry will need to identify, understand and map this new local government customer base, in the same way it does with other key stakeholder groups.

This area of public health is increasingly important, as several studies and reports on health improvement illustrate. It has been widely reported that over the last 60 years around 50% of health improvement gain is attributable to health care and 50% to the wider determinants of health, including environment, education, housing and personal lifestyle choices.

Asthma/ COPD (Chronic Obstructive Pulmonary Disease) is just one therapy area which illustrates this point. An example of numerous public health initiatives in this area is CHARISMA (Children's Health in Asthma from the Wrexham Public Health Team), which conducted research with the aim of improving health status through modifying accommodation (i.e. housing). On this project the Betsi Cadwaladr NHS Trust collaborated with Wrexham Public Health Team, Wrexham County Borough Council and colleagues from academia. This illustrates the range of stakeholders with whom pharma companies will increasingly need to engage.

The development of GP commissioning consortia will undoubtedly have a significant impact on the industry. As with new local government customers, there is a need to understand a whole new customer group and landscape. With an estimated 200-500 GPCC replacing 151 PCTs, there will not only be more individuals with different roles, but also more organisations and therefore more accounts to manage. Furthermore, these organisations and individuals will have more freedom than PCTs ever had.

The NHS in England is being opened up to market competition with the likely result that there will be more players from the private sector, voluntary organisations and social enterprise. This will mean a growth in private providers running both hospitals and primary care – do we understand these players, their drivers and methods?

In addition to the GPCC, it is important to understand the new system and superstructure. There are new bodies such as the National Commissioning Board (NCB), as well as existing bodies whose remit is changing. For example, NICE's role in recommending and assessing drugs/ treatments will be downgraded and will move towards offering advice on treatment effectiveness, where it will have responsibility for constructing 150 quality standards by July 2015; these standards will be used by the NCB to performance-manage GPCC. The overall theme is a move from a health service to a health system, and one that will operate less as a state-run monopoly than in the past.

The patient-centric nature of the reforms will strengthen an existing trend: **the rise of "patient power"**, both on an individual level and through patient groups, charities and so on. Engaging with these groups has always been difficult, especially with direct-to-consumer regulation. However, it is becoming more important for pharma companies to understand these groups of stakeholders and find ways to collaborate effectively with them.

Is pharma's current commercial model fit for purpose?

In response to the impact of the NHS reforms and the evolving healthcare landscape, the pharma industry yet again needs to review and restructure its commercial and business model fundamentally. In particular, they should consider how they should behave towards the "new" NHS system: it is arguable that they should adopt a business-to-business model rather than a supplier-to-customer one. As discussed above, this is as a direct result of the ever-increasing numbers of stakeholders (now operating at a variety of levels) and the changing organisational environment.

In light of the reforms many companies have already undertaken significant transformation projects and many more are in the process of reviewing what to do next. The concept of Key Account Management (KAM) is of central importance here.

With the lack of new blockbusters, the well-documented patent cliff and pressure from generics, we have already seen a dramatic shift away from primary care to KAM over the last few years. With the healthcare environment changing to reward products that generate superior outcomes, companies will need to transform their business models to a collaborative model that supports healthcare delivery and health management from diagnosis to long-term care. It could also be argued if clinicians have less individual discretion, then less resource is required and therefore fewer salespeople.

KAM remains the best approach to overcoming the challenges and maximising the opportunities of the NHS reforms. Pharma companies should increase their emphasis on KAM and improve the way they do it, in terms of both structural organisation and the skills sets available.

The new key account manager needs to be a resource investigator, able to gather intelligence on a local level which is then turned into corporate knowledge. An integral part of this intelligence gathering is to have an excellent understanding of key drivers at a local level. Thereafter, this information must be transformed into insight and a key account team deployed to work with, and ultimately influence, the key stakeholders, including commissioning consortia, providers, regulators (such as the Care Quality Commission (CQC) and Monitor) and NCB.

With an increased focus on local needs, it is evident the skills and capabilities of the key account manager and team will differ across different parts of the country to suit the different demographics and healthcare requirements of different areas.

Talent management

Over the years, we have seen a natural progression of the sales rep from primary care rep to hospital specialist to healthcare development executive to market access and key account manager. In general the skills and capabilities of these people haven't significantly changed; it wasn't uncommon for the same rep to progress through each of these roles.

There is no doubt that the skills and capabilities of sales representatives (irrespective of what title they are given) need to undergo a full review in the light of the current reforms.

The skills required as part of a key account team today vary dramatically. There is a need for a multi-skilled "super rep" with in-depth local knowledge and a good network. In addition the key account team must be able to draw upon specialist skills, for example commercial, Key Opinion Leader management, clinical, economic, medical and so on.
This will represent a significant challenge for many pharmaceutical companies as the skills required are in limited supply, not only within their own organisation but across the whole industry.

Conclusion

The reforms will not be fully implemented for a couple of years, but pharma companies cannot afford to wait until then to prepare. They need to overhaul their commercial model and talent management now, using what they already know about the basic structures of the reformed system and the output from the pilots that are now underway.

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