FOCUS ON
SPAIN

Overstretched primary care services, drug price pressure resulting from the
global financial crisis and regionally managed healthcare budgets together
create a challenging environment for the pharmaceutical industry

SPAIN AT A GLANCE

Area: 505,998km²
Population: 46,030,109*
GDP: €1,051,151m
GDP growth: -3.6% in value in 2009
GDP per capita: €22,886
Healthcare expenditure as % of GDP: 5.9
Total pharmacy sales 2009 (reg. & and non-reg. products):
€20,821m (price to consumer)**
Sales of subsidised medicines as % of total market: 76
Number of pharmacies: 21,166
Population/pharmacy ratio: 2,175

Figures from LUBA Consult. Sources: "INE,""IMS
INTRODUCTION
Spain is one of the top five countries in Europe, in terms of population, spend capacity, healthcare needs and pharmaceutical market size. This makes it attractive to the prescription, OTC, cosmetics, food supplement and other similar markets.

In fact, most international companies have a presence in Spain and smaller companies with a regional presence in Northern or Western Europe are showing an interest, particularly in the non-prescription areas of cosmetics, food supplements and medical devices.

The Spanish healthcare model is based on the assumption that all Spanish citizens have the right to health protection and health assistance. It is highly regulated for patients, pharmacists, doctors and industry to ensure spending is controlled.

Health care has been decentralised, so each of the 17 regions is responsible for managing its own healthcare. This results in a complex system, with each area having its own systems and legislation with which pharma must comply.

Patients are assigned to a primary care centre depending on their home address and have a General Practitioner (GP) who can refer them on if a specialist consultation is needed. There is no free choice of doctor, nor free access to a specialist.

A doctor’s consultation is free and prescriptions provided are subsidised at 65 per cent (100 per cent for pensioners), so when a patient collects the prescribed medicine at the pharmacy, the bill is 35 per cent of the price, the rest being paid directly to the pharmacist through Social Security.

The system is overstretched, with too few doctors and specialists. There has been a huge increase in healthcare demand owing to massive immigration in the early 2000s and further burdens from a growing elderly population.

In order to circumvent these problems, patients in some areas (particularly big cities) take out private insurance (e.g. BUPA) where they can choose their doctors and avoid delays. The insurance covers most expenses, apart from a small fee (a few euros) for each doctor consulted and the cost of the medicines prescribed, which are paid for by the patients.

Most doctors work for the public healthcare system, in hospitals or primary care centres. They can work exclusively for this service or share public and private practice, which is the case for most.

In public practice, doctors are governed by the social security system, where expenditure is an increasing issue. Control of volume of prescriptions and budget, plus a preference for generic prescriptions, are increasing.

In private practice, doctors may work on their own, but most join doctors’ pools in the different insurance companies.

HISTORICAL PERSPECTIVE
The Spanish health protection system began with the Social Security Law of 1956, established under the Francoist regime. It was one of the laws approved between 1955 and 1959 which helped the country modernise. The law was necessary to manage the health of salaried workers as well as their pensions. Both systems were financed through contributions from workers and companies. The Social Security Law made an allowance for the public health protection system for almost 40 per cent of the population that did not depend on salaried workers such as the self-employed. This initiated the emergence of a powerful private health sector.

Next came the General Health Law, approved in 1984 by the first socialist government to rule in democracy, under which healthcare provision became nationwide and health financing was separated from that of pensions. Health care was financed through taxes, while social security financed just the pension system through employee and company contributions. This law gave Spain a level of health cover suitable for a developed country.

Finally, decentralisation took place between 1996 and 1998, when the management of health care was handed to the 17 Regional Authorities (RAs). Its financing continues to depend on general taxes, however the RAs can manage it in different forms and add additional financing as well as appropriate benefits.

The current health system has good and bad points. In the organ transplant field, for example, it is renowned worldwide. Spain is the leading country in the world in transplants per head and they are free for patients. For serious diseases or important surgery, citizens undoubtedly prefer the public system as there has been enormous investment in excellent hospitals since the 1980s. However, the opposite is true in primary health care, where the treatment of basic or chronic illnesses faces an overstretched service, particularly in paediatric care, overburdened further by the increased population resulting from immigration.

A notable feature of the Spanish system is the generosity of its open benefits, including those for immigrants without formalised status. Various authorities are, somewhat surprisingly, offering operations that are not available in other European public health systems, such as sex changes. The result is a chronic and increasing deficit.

Different studies show that Spaniards’ satisfaction is high with regard to the great facilities and care offered for major operations or diseases, but that it is quite low regarding care of minor illnesses. However, various private medical insurance companies cover this area well.

Questions are being asked about whether the healthcare system will be sustainable and how long pharmacies can survive.

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HEALTHCARE EXPENDITURE

The Spanish Government has spent ten years applying various measures to curb public expenditure on medication. The last Law of Guarantees in 2006 outlined some policies based on:

- Reference prices (RP)
  - The active ingredients with patents that have expired and given way to commercialisation of generics are included in uniform groups (e.g. ibuprofen)
  - All of the pharmaceutical specialties included in the same group are subject to the price marked as a reference which may be financed by Social Security. Those which exceed the reference price must be substituted with a generic, unless the patient pays the difference.
- Prescription for active ingredient (PAI)
  - The prescriber is encouraged to prescribe just one active ingredient on the prescription. In this case, the pharmacist dispenses the medication that costs the least. In the event that the price is the same, the generic will also be sold if it is available.
- Deductions
  - The pharmacy must make contributions to the Regional Authority (RA) based on the value of subsidised medication it has sold.

Not all RAs apply RP and PAI uniformly. Thus, while the RA of Andalucía prioritises prescription for the active ingredient, those of Madrid or Catalonia favour reference prices.

Each measure holds a different significance for the industry:
- Brands without generics
  The PAI is interesting for brands without generics. Although prescribers are encouraged to prescribe an ingredient in the prescription, they can also prescribe actives with a valid patent, thus impeding the availability of generics.
- Generics
  These suffer under the PAI as a result of pressure on the dispensing pharmacist who must apply the lowest price. The latter puts them aside to have the cheapest price affecting their profitability as well as viability. On the other hand, the constant reduction of reference prices is an obstacle to the generics sector. According to the Spanish Generics Association, the AESEG, the share of generics in the drug market is 6.6 per cent, which is the same as in 2007. This figure has only risen by two percentage points in five years. At the current rate, it will take 15 years to achieve the average rate in Europe of around 12 per cent.
- Original medicines
  These are also harmed by the reference prices. Their only chance of survival is to offer the cheapest price so as not to lose the prescription nor be substituted.

The generic development policies observed in RAs like Valencia, Catalonia or Madrid are a further obstacle to the growth in sales of original medication.

FOCUS ON SPAIN

DRUG PRICING AND REIMBURSEMENT

The Spanish drug market is one of the most regulated markets in the EU, yet its National Health System (Sistema Nacional de Salud, SNS) is one of the most generous for financing pharmaceuticals. SNS pays for 80 per cent of all pharmaceuticals marketed.

Determination of price and reimbursement is centralised at national government level. The Regional Authorities (RAs) are responsible for implementing national policy, carrying out inspections and quality controls and imposing sanctions within their respective territories.

Once a drug is approved, the process of establishing its price and reimbursement begins the moment the Spanish Agency for Drugs and Health Products (Agencia Española de Medicamentos y Productos Sanitarios, AEMPS) informs the Directorate General for Pharmaceutical and Health Products (Dirección General de Farmacia y Productos Sanitarios, DGFPS) that a new drug has been assigned a national code. The Director General of DGFPS then officially initiates the procedure to determine the price of, and funding for, the drug in question. Based on the DGFPS determination, products receiving European Medicines Agency (EMA) and AEMPS approval are made available in Spain at one of four reimbursement levels, ranging from 0 to 100 per cent.

The reimbursement decision considers: severity, duration and associated after effects of the diseases for which the drug is indicated; specific needs of selected patient groups; therapeutic and social utility of the drug; rationalisation of public drug expenditure; alternatives for the indications targeted and its innovation.

The use of cost-effectiveness analyses in determining reimbursement status at national level has increased over the past few years. However, it is not mandatory and, so far, has played a small part in national pricing and reimbursement decisions. When they are undertaken, they are generally used to determine reimbursement levels for innovative new drugs that lack obvious comparators. European average prices and volume/unit price trade-offs are also important factors in these analyses.

As national pharmaceutical expenses continue to rise, greater emphasis on economic evaluation in reimbursement decision-making can be expected. Manufacturers should anticipate greater scrutiny of the costs of drugs that provide no significant survival or quality-of-life benefit relative to existing therapies.

Spain implements direct price controls for branded drugs and reference pricing for off-patent drugs, thus prices are established using international price comparisons. Ultimately, increased therapeutic value and international reference pricing are the driving criteria for setting prices. Spain’s reference pricing system applies to all off-patent products marketed in the country for 10 years or more that have generic bioequivalents (i.e. generics with the same active ingredient). If a second indication has been approved for a given product, it can stay outside the reference pricing system until it has been on the market for 11, rather than 10, years. To get a product approved, a generic manufacturer must price its product at least 30 per cent lower than the original brand.

The Ministry of Health and Social Policy (Ministerio de Sanidad y Política Social, MSPS) relies heavily on price cuts, having implemented a 4.2 per cent cut in 2005 followed by 2 per cent in 2006. Furthermore, in 2006 retail and hospital drugs on the market for 10 years (11 years if a new indication was authorised since the first approval was granted), had to take a compulsory 20 per cent price cut.

At national level, heavy reliance on the reference pricing system and selective price cuts will continue to control drug expenditure. At RA level, alternatives such as selective financing may be explored, as long as they do not cause legal conflicts with national regulations.

The Author

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HEALTHCARE EXPENDITURE CONTINUED

Different studies published in 2009 illustrate how these policies are slowing in their ability to curb the rise in medicine expenditure. Even though they are having some effect, it is insufficient and the Ministry of Health continues to introduce more control measures.

The pharmaceutical industry in general faces a challenging future. Increasing expenditure on medication is affecting the majority of European countries as well as Spain (see figure below). The current crisis merely highlights the need for greater control of expenditure.

It is to be hoped that measures will be taken soon which focus on rationalising drug use and solving inefficiencies that are inherent in a vast organisation, including monitoring of chronic patients, identification of duplicate prescriptions and unnecessary treatments. These measures, if implemented, will result in fewer sales for pharma and consequently should not be a cause for optimism.

Finally, the cost of public health, particularly medication, cannot be permanently reduced. The Government does not have much option but to choose between:
1. Bearing the increasing drug cost in its budgets (for the growing population, the ageing population, the development of new drugs that are more effective but also more expensive) or,
2. Transferring part of the cost to the patient, which has not been suggested by the Government so far owing to the unpopularity of the measure.

In the welfare state as it stands, health care will continue to find support, but in an increasingly competitive and challenging environment.

The industry urgently needs to make a plan to sustain the industrial and employment framework, although it has to accept that innovative laboratories are not the only companies in the industry. In times of crisis, production and employment must be examined. The industry’s unstated aim is to avoid lowering linear prices at all costs, which is what occurred in 2004. However, the cards laid out on the table: innovation, globalisation and maintaining employment, may not be sufficient because innovation is intangible, globalisation would only affect a few national companies and maintaining employment levels may not be feasible when it comes down to selling or going out of business.

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MARKET ACCESS STRATEGIES

With one of the lowest drug price environments in Europe, Spain poses a serious challenge to pharmaceutical companies. Plus, the industry must take into account that though price is set centrally by the Ministry of Health, which makes the national decisions, from technical approval of a new drug to pricing and reimbursement, the 17 RAs can evaluate and categorise pharmaceutical products.

Some of these regional organisations are leading the way in drug evaluation, setting up innovative processes and procedures, creating assessment committees and looking for feedback from scientific societies. Some also act as advisers to the Ministry of Health and some are part of ‘Grupo Mixto’ aiming to reach a consensus about the evaluation of new pharmaceutical products.

It is therefore imperative that pharmaceutical companies focus their efforts on these leading Health Technology Assessment (HTA) agencies to maximise the chances of getting new drugs to the regional formulary.

In this multi-tiered market, stakeholders now have several roles and can be accessed through different channels. The same person could be a top influencer, a prescriber and also a key decision maker in the pricing and formulary committees.

The style of communication with different stakeholders varies. Contact with the Ministry of Health – and advisers – typically includes detailed clinical information. While this is handled primarily by clinicians in the medical department, discussions on technical approval, pricing and reimbursement also demand an understanding of regulatory procedures.

Communicating effectively with the regional HTAs, meanwhile, requires an in-depth understanding of the different rules of usage applied in each, as well as insight into the varied regional processes.

Not only must pharmaceutical company representatives, whether in the medical department or regional market access, understand the role of each individual in affecting drug evaluation decisions, but they must also understand how these key individuals interact and share information to create a vital network of influence. Determining these networks and recognising the spheres of influence will be key to developing effective market access strategies.

If these key stakeholders are to receive consistent messaging, data must flow between the teams to create a complete customer view and ensure a holistic approach to communicating with each one.

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POLICY OVERVIEW

Spanish healthcare is currently facing multiple challenges, including: financial sustainability of the national health system (Sistema Nacional de Salud, SNS), the shortage of healthcare staff, unjustified inequities in access to healthcare services (e.g., waiting lists, clinical variations) and poor leadership from the centre.

Arguably, the lack of leadership from the Ministry of Health and Social Policy (Ministerio de Sanidad y Política Social, MSPS) has been an issue since health power was devolved to the Regional Authorities (RAs). In the pharmaceutical sphere, for example, the MSPS has been struggling to issue much-awaited regulation, including development of key articles of the 2006 Law of Guarantees and Rational Use of Drugs (Ley de Garantías y Uso Racional de Medicamentos). It has also failed to pass a new public health law that was expected in 2008 and is now anticipated in 2010, and to coordinate promised health policies across Spain, such as establishing a common vaccination calendar for all RAs and forging a national health pact (Pacto de Estado por la Sanidad) around the principles of equity, cohesion, quality, innovation, patient safety and sustainability.

A reason for these legislative failures related to health care is the new political emphasis given to social policy (and, arguably, the low priority given to healthcare), much in line with the personal decision of President Zapatero to give a ‘social overtone’ to the present legislative period.

In April 2009, the former Ministry of Health and Consumer Affairs (Ministerio de Sanidad y de Consumo, MSC) changed its title to the MSPS to reflect its new emphasis on social affairs. To lead this agenda, a new Minister of Health and Social Policy, Trinidad Jiménez, was appointed, who has a more political profile than former Minister Bernat Soria, but little experience in the health sector.

In the first half of 2009, most of the MSPS’s attention was focused on managing the influenza virus pandemic, implementing the 2006 Disability Law (again marking the growing importance of social policy matters on the MSPS’s agenda over healthcare issues) and authorising the morning-after pill to be dispensed at retail pharmacies without prescription to women and girls, without age limits. Many government critics believe these measures have been designed to help the Government distract public opinion from other key socioeconomic and political problems, namely the economic crisis and even some undermining of the state institutions established by the 1978 Spanish Constitution.

Despite these challenges, the Government seems committed to continue the current levels of public healthcare expenditure (including drug expenditure, with an annual growth of around 5-6 per cent). Furthermore, the national government has made a number of overtures to industry to maintain positive government-pharmaceutical relations within the healthcare system. The newly appointed Minister of Health and Social Policy has rushed to confirm the good relationship with the pharmaceutical industry held by the previous health minister. The MSPS explicitly sought the industry’s commitment to continue investing in research and development and securing jobs, and announced health policies that provide quite stable ground upon which the pharmaceutical industry can operate. As part of the government-pharmaceutical agreement, industry will provide €180m to help improve healthcare coordination between the RAs. The money will be allocated to projects in the five areas of: controlling pharmaceutical costs; clinical trials; clinical research in primary care; biological banks and hospitals willing to become accredited healthcare research institutes.

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POLICY IMPLICATIONS

Spending on healthcare grew significantly between 1998 and 2006 at between seven and 11 per cent. Attempts to curb this expenditure resulted in radical measures to control spending, including a direct tax on pharmacy sales, ranging from eight to 15 per cent, depending on the size of the pharmacy; the bigger the pharmacy, the larger the tax. However, these were not enough, particularly in 2008, when GDP began to slow.

In 2009, GDP crashed to -3.6 per cent and pressure from Europe to reduce costs and correct the deficit has led the Government to make more aggressive cuts. In June 2010, it implemented a new set of measures that for the first time affect the price of innovative medicines and not only generics.

Under the new terms, branded medicines face a 7.5 per cent discount, taken directly by the social security system, while generics have price reductions of 25 per cent on average. IMS has estimated that the impact of the measures will drive the market down by 14.2 per cent. Generic companies are expected to lose between 25 and 35 per cent of their sales. Pfizer is expected to see sales decrease by 23 per cent, while sanofi-aventis and Almirall could lose €138m and €110m, respectively.

Through the president of the pharmaceutical industry association, Farmaindustria, the industry has warned that the measure will have a severe impact on profit, with implications for R&D investment and companies’ viability.

The outlook is bleak and if further savings are made through cutting the profitability of healthcare stakeholders, pharma companies and pharmacies could close. The Government needs to turn its attention to inefficiencies in the system. This will still be a challenge for the pharma industry as making the system more efficient will result in less demand for medicines.

There will be a smaller subsidised prescription market, in terms of quantity or price, or both, so pharma companies must prepare for this.

Patients, too, will have to prepare for the possibility of higher priced medicines.

In light of the pressures on prescription medicines, perhaps the OTC market will become a serious alternative profit source.

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BIOTECH INDUSTRY

Biotechnology has become an essential driving force in a wide range of innovations in agriculture and industry, as well as medicine, in Spain. Its highly innovative nature and presence in ever more sectors suggests it may be a strong field to support the economy. The macroeconomic impact of biotechnology in Spain has now risen to 1.2 per cent of national GDP and for an economy eroded by construction and short-term investments, it is undoubtedly a foundation on which to build.

Spain will only realise its optimum economic development by applying biotechnology to the economy, in other words, through bioeconomy.

In 2008, the Spanish association of biotecon (ASEBIO) assessed almost 1,000 companies working in the biotech field in Spain, which represents an increase of 23 per cent over the figure for the previous
BIOTECH INDUSTRY CONTINUED

year, collated by the INE (National Statistics Institute of Spain) in the 2009 ASEBIO Report. This demonstrates the growing importance of biotechnology and its influence on the economy.

Furthermore, the turnover of the biotech industry now exceeds €30,000m, an increase of almost 19 per cent in 2008, alongside private expenditure on R+D of €640m.

This is encouraging news for this sector in a difficult year for the economy, but it needs more support from private investors and government. The financial crisis is hindering investment in a market with high costs in innovation and high profitability, albeit in the longer term.

Currently, this sector is being heavily affected by a lack of liquidity and capitalisation. ASEBIO believes that biotechnology, which has seen little more than a decade of development in Spain, will only prosper if it has a regulatory framework that protects and recognises innovation and its products. It is fundamental to have management and financing for academic and business projects, identify R&D priority areas, increase coordination of regional policies, promote the transfer of technology, strengthen international links and offer tax incentives to companies and investors.

Biotech companies have been behind a multitude of alliances, scientific advances and international agreements in the last year. For example, the European Commission approval of PharmaMar’s Yondelis, for ovarian cancer, the new treatments for cancer by the Centre for Applied Medical Research (CIMA) at the University of Navarra, the establishment of CITRE (Celgene Institute of Translational Research) in Seville by Celgene, the ranking of Spain as 14th best producer in the world of genetically modified organisms and the construction in Cáceres of the largest biomass factory in Europe by a Spanish company.

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PERCEPTIONS OF SALESFORCE

Research investigating the preferences of primary care physicians (PCPs) in Spain regarding pharma salesforces shows PCPs ranked Novartis first in its ability to drive customer retention for the third consecutive year. Spanish oncologists, meanwhile, ranked Roche/Genentech first in customer retention.

PCPs in Spain rated the industry as a whole higher than PCPs in the other European markets surveyed, namely the UK, France, Germany and Italy. Novartis ranked first with a rating of 91, the highest PCP score of any company in any country. Pfizer/Wyeth followed close behind with a score of 88. While 2010 is the third consecutive year Novartis and Pfizer/Wyeth have held the top spots in this survey, both companies’ scores fell compared to those of 2009.

Six companies improved their scores by a significant amount in 2010: AstraZeneca (AZ), GlaxoSmithKline (GSK), Janssen-Cilag, Roche, Schering-Plough and Takeda. In fact, AZ and GSK’s scores increased enough to position them directly behind market leaders Novartis and Pfizer/Wyeth.

Oncologists ranked the industry as a whole in Spain the fourth lowest of the five European markets. Roche/Genentech ranked first in salesforce performance, as it did in three of the four other European markets. Its score of 93 far outpaced its nearest competitors, Amgen with a score of 79 and sanofi-aventis and Novartis with scores of 77.

Customer sentiment, interpreted as either positive or negative word of mouth, was reasonably good for the second straight year among Spanish PCPs. They also had the most positive sentiment towards the pharma industry among surveyed EU physicians, with Novartis, Pfizer/Wyeth, GSK and AZ having the best scores.

Rankings were based on Kantar Health’s TRI*M index, derived from physicians’ evaluations of the skills of a company’s sales reps and how these influence a physician’s intention to prescribe a brand.

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OTC OVERVIEW

Spain has one of the smallest over the counter (OTC) markets in Europe, with a retail value of €690m, according to IMS figures in 2009. It is worth 3.3 per cent of total sales in pharmacies, including ethical brands and unregistered parapharmacy brands.

However, a small OTC market does not mean an aversion to self-medication among consumers. In fact, Spanish consumers are comfortable with buying medicines.

Several factors empower the patient in buying medicines:
- Following a prescription from a doctor, patients learn about the medicines available for certain symptoms
- Patients may decide that it is easier to go to the pharmacy direct and pay for the medicine rather than wait in endless queues to get a subsidised prescription from the doctor
- Often the medicine is prescription-only, but the law is not followed too strictly and pharmacists know that if they do not supply the medicine, another pharmacist will
- If the consumer/patient is offered an OTC product instead, the price of the OTC version may be higher and the decision to get the prescription product will be proved right.

The result is a substantial volume of sales sold without prescriptions as if they were OTC products.

Also, consumers have discovered generics are a cheap alternative to well-known brands. What is the point of paying €3 for a branded ibuprofen if a similar product is available under a generic brand and at less than half the price?

So, OTCs suffer from the disloyal competition of prescription brands. This competition is not really promoted by the industry, but by a permissive system where similar drugs are available both as prescription and OTC, such as analgesics, cough remedies and antihistamines.

However, perhaps the time has come for OTCs, as the ethical prescription business and generics lose profitability in the financial crisis. While profit from the ethical prescription business erodes, the OTC brands remain immune to government measures. So OTC divisions, traditionally the poor relations, now have the opportunity to provide returns. A shift in priorities from ethical to self-medication is likely.

In addition, generics manufacturers have to look for ways to compensate for the dramatic loss of profit following radical reductions in prices. Many of them are working at developing their own OTC brands covering different ranges of products in different categories.

Profitability of pharmacies is also a factor. Profit from the sales of OTCs and parapharmacy products is becoming a higher proportion of total sales from pharmacies. A pharmacy with 20 per cent OTC sales will obtain 33 per cent of the gross margin. A clever pharmacist will
OTC OVERVIEW CONTINUED

Therefore invest effort in developing non-prescription brands, which will give significantly higher profitability, without disruption from cost-containment measures.

The association of self-medication laboratories (ANEFP) estimates that Social Security could save €1bn by withdrawing all medicines for minor symptoms from reimbursement. So far, the Ministry of Health has not considered this because of its potential unpopularity, but budget pressures could mean it becomes an option. Such alternative measures are increasingly likely to be considered.

All this suggests that this could be a new era for OTCs and self-medication solutions in Spain.

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OTC TIPS

When companies are deciding whether to enter the OTC market in Spain, they may set up their own company or look for partners. In both cases, there are various factors to consider.

- **Target pharmacies with a pro-OTC profile**
  - New brands should target 3,000 direct pharmacies
  - Consolidated brands should target a minimum of 5,000 direct pharmacies
  - Established brands should target 8,000 direct pharmacies
  - Remaining pharmacies can be accessed via telesales and wholesalers.

- **A minimum salesforce of 8-12 reps to ensure initial target coverage**
  - The team can grow as brands consolidate and coverage increases
  - A team of 20-25 reps provides maximum effective coverage.

- **A sales strategy that focuses on frequency and quality of visit**
  - Frequency: depending on pharmacy potential, between one and three visits per quarter
  - Quality: ensure each rep has the time to focus on each of the brands available, deal with competitive commercial terms, manage point-of-sale material and provide information on brand and training if necessary.

The next step is that pharmacies may make orders and accept stock. However, remember that they can send the order back if stock turnover is high enough.

Alongside this, consider:

- **Visibility of Point-of-Sale (POS)**
  - To keep POS material visible in the store requires a strong relationship with the pharmacist. Often, displays have a few days on the counter and then disappear into the bin
  - Another option is to use external companies who have agreements with pharmacists and rent their space on behalf of pharmaceutical companies for a set period, which is normally three weeks.

- **Recommendations of pharmacy staff**
  - This is not always possible and will depend on the product category and added value of the brand
  - The strategy requires solid commercial terms, dedication to motivate the staff and permanent product training in the store
  - Consolidated brands will also use stock pressure to push pharmacists to recommend the product so that they get their money back.

- **Communication to consumer via different media**
  - Although TV is the star, few OTC brands have the size and the resources to invest in it
  - Brands have to consider alternative media that are compatible with their size, such as radio, magazine and internet advertising.

- **Recommendation from doctors could be an option for companies with a strong ethical bias and products with a sophisticated argument**
  - Doctors are beginning to take an interest in non-prescription treatments that complement the efficacy of ethical medicines by helping to reduce the side effects while maintaining the efficacy
  - Many food supplements or medical devices have proven efficacy and lack of side effects
  - The fact that the product is not reimbursed/subsidised by the health system is no longer an issue so doctors feel comfortable recommending it.

When choosing a local partner, companies want:

- A fast introduction of their brand: direct and weighted distribution achieved in X months plus a commitment to annual volumes of Y units
- Minimum risk and investment, with advertising and promotion financed mostly by the local partner
- Income from the outset: the company sells stock to the local partner to develop sales in the market.

While these three factors need to be considered separately, they may not be compatible when put together.

A product introduced rapidly with consistent advertising and promotion support and stock purchased from the start can be achieved if the partner has substantial resources and strong market entry capabilities. However, partners with such a strong profile accept external projects only if the brand represents an extraordinary opportunity, which is the case for very few, and only if the partnership is protected by a strong penalty in case the brand owner wants to exit the deal.

Therefore, when looking at entering the market, companies must set priorities:

- **Where the priority is low risk and fast cash = LOW PRICE**
  - Low profile partners
  - Sales are needed to build critical mass
  - They do not have the negotiation power to obtain better distribution terms
  - Limited capacity to build brand
  - No substantial brand development in the long term.

- **Where the priority is to build brands even if cash is slow = HIGHER PRICE**
  - Higher profile partner
  - More demanding
  - Costs at the start are shared between the partners
  - Higher capacity to perform and deliver
  - More options to exploit actual brand potential.

Building a brand without establishing a local structure is definitely more affordable than putting a full company in place. However, the value built will also be lower. In the end, you get what you pay for.

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SPANISH MARKET - SALES PER PRODUCT CATEGORY

- RX POM: Reimbursed and available only on prescription.
- OTX: Reimbursed but available without prescription.

Source: Nielsen. MAT data at price to consumers: '000€.

SPANISH MARKET - SALES '000€ AT WHOLESALER PRICE

Top 10 Pharma companies

Source: IMS. MAT data: '000€.