FOCUS ON UK

With a new coalition Government and the global financial crisis to face, the UK is entering an uncertain future. After many years of support, the NHS will have to contend with less funds and the demands of an ageing population.

UK AT A GLANCE

Total Population: 60,512,000
GNP per capita (PPP international $): 33,650
Average life expectancy at birth (years): 79.1
Probability of dying under five (per 1,000 live births): 6
Total expenditure on health per capita ($ 2008): 3361
Total expenditure on health as % of GDP (2008): 8.7
Total expenditure on medicines as % of GDP (2008): 0.85

Sources: WHO World Health Statistics, 2008; OECD Health Data 2009; ABPI.
INTRODUCTION
The United Kingdom (UK), like most economies, is facing challenging times. The National Health Service (NHS) faces continuing criticism on its operation and recent reports suggest that the government-run body may face bankruptcy from a soaring drugs bill, which is outstripping Britain’s GDP growth. The predominant health concerns of the past few years include the MRSA outbreak and the influenza pandemic that threatened not only the health of the nation but would have had severe implications for a weakened economy. Now, with the embryonic coalition Government at the helm, the UK is faced with more changes that could have profound impacts on its health systems and the pharmaceutical industry. The NHS has already received its budgetary allocation for this financial year with a rise in excess of five per cent bringing the budget to over £100bn (£116bn). The fact remains that the health service is responsible for nearly a fifth of government spending and with ambitious aims to make £6bn (almost £7bn) in savings across all sectors, cuts in the NHS must be expected. Coupled with a fragile operating environment for industry and a communications revolution that is being negotiated blindly, this uncertainty must be managed carefully to ensure survival.

OVERVIEW
Total health spending reached £125.4bn (£145.5bn) in the UK in 2008, representing 8.7 per cent of GDP, compared with an average of 8.9 per cent across Organisation for Co-operation and Development (OECD) countries. To put this in context, the US, which spends the most by far on health as a share of its economy, allocated 16.2 per cent of its GDP to health in 2008, exceeding $2.3tn. OECD figures from 2007 suggest that several EU countries routinely spend more than 10 per cent of their GDP on health, including France (11 per cent) and Switzerland (10.8 per cent). Expenditure on medicines is 0.85 per cent share of GDP, roughly £106bn (£123m).

In terms of per capita spending on health, the UK spent £3,361 in 2007. This remains much lower than the figure for the US (which spent £7,290 per capita for the same year), and significantly lower than other big spenders, such as Norway and Switzerland (with spending of over £4,400 per person).

In 2008, life expectancy at birth in the UK was 79.1 years, just above the OECD average of 78.9 years. In terms of infant mortality rates, the UK is below the OECD average of 4.9 per 1,000 live births, at 4.8 per 1,000 live births. However, this is still higher than most European countries, including the Netherlands, France and Spain. The UK has achieved some progress in reducing tobacco consumption, with current rates of daily smokers among adults standing at 21 per cent in 2007, below the OECD average of 23 per cent.

ONE of the most worrying health indicators is the obesity rate among adults, which in the UK stands at 24 per cent (2007), representing one of the highest rates in the OECD countries. Childhood obesity, although levelling off, rose from 10.1 per cent in 1995 to 13.8 per cent in 2008. Overall, this represents a tripling incidence over the past 20 years and it is estimated to cost the NHS up to £4.2bn (£4.87bn) each year. As there is a time lag of several years between the onset of obesity and related health problems (such as diabetes and asthma), the rise in obesity will have definite implications for health systems in the future and costs associated with treating the co-morbidities is expected to double in the decades ahead.

HEALTHCARE SYSTEM
The National Health Service (NHS) is the largest organisation in the UK (and one of the largest in the world), employing over 1.7 million people, roughly half of them holding clinical qualifications. The NHS is publicly funded, and free at the point of use for all UK residents. Of its annual budget of roughly £120bn (£139bn), about 60 per cent goes on staffing costs, 20 per cent is spent on drugs and the remaining 20 per cent covers an assortment of costs including buildings and infrastructure, training and medical equipment.

However, the current fiscal climate in the UK means that significant cost pressures have been forecast for the NHS in the next five years. Under the 2010-2011 budget, 2010 is predicted to be the last year until 2015 that the NHS budget grows, with 2011 to 2015 being an era of austerity for the health system, with funding becoming increasingly tight.

The previous Labour Government tasked the NHS with finding £20bn (£23.8bn) of “efficiency savings”; a figure which the under the Conservative-Liberal Democrat coalition is likely to increase. In this climate, finding continued efficiency for the NHS will be paramount, and the service is being asked to provide better care for less money.

NHS QUALITY MANAGEMENT
In order to deliver quality services at an affordable level, effective management is a key priority for the NHS. Several structures are in place to ensure the efficiency and quality of its services.

In England, separation between purchasers and providers of care is intended to create efficiencies through an ‘internal market’ system - commissioning Trusts receive a budget from the Department of Health, which they use to purchase services from the providers in their region. Most care is delivered by NHS providers, but the NHS is able to use private providers as well and private care is increasingly purchased by the NHS. To standardise costs of care, NHS providers are paid by fixed tariffs for each procedure, based on the average cost to the NHS as a whole. This system, known as ‘payment by results’, rewards efficient providers (who retain the payment surplus) and offers a strong incentive to keep costs down. To ensure this does not result in poor standards of care, systems are in place, including hospital ratings, to ensure quality and overrides for the most ill patients whose care costs are above the average.

Another quality management system, for primary care, is the Quality and Outcomes Framework (QOF). Introduced in 2004, the QOF is a financial incentive system for primary care providers (GP practices). The system includes a number of financial targets based around clinical care, organisation and patient experience. GP practices receive an additional bonus payment based on the number of targets they meet. While the QOF has been a controversial topic in the past, with critics claiming that it rewards physicians for tasks that should be carried out as a matter of course, the system continues to be refined. Notably, in 2009, the National Institute for Health and Clinical Excellence (NICE) was asked to develop recommendations for reforming QOF targets based on cost effectiveness criteria.

During the past year, the NHS has taken further steps towards...
FOCUS ON UK

NHS QUALITY MANAGEMENT CONTINUED

becoming a more quality-focused organisation. The Quality, Innovation, Productivity and Prevention initiative (QIPP), introduced in 2009, is a policy designed to help the NHS improve quality while at the same time benefiting productivity. Since its introduction, the QIPP has been renamed the Quality and Productivity Challenge (QPC), a move which implies that in the continued climate of financial pressure, innovation and prevention are difficult goals to meet. The QPC aims to move the NHS away from measuring quality in terms of ‘process indicators’ like the QOF targets towards more meaningful patient-based quality outcomes. An additional feature of the QPC is the anticipated revising of NHS purchasing tariffs away from prices based on national averages and towards ‘best practice’ tariffs – the cost for providing high quality, efficient care. The main idea behind the QPC is the view that better quality care will cost the NHS less, while improving people’s health.

MARKET ACCESS AND REGULATION

Once a drug has been granted marketing authorisation, pharmaceutical companies are generally free to set their own price in the UK, within an allowable rate of return. The UK’s pricing system (the Pharmaceutical Price Regulation Scheme – PPRS) allows the Government to set prices for generics based on an allowable profit for distributors, and for occasional price cuts to be negotiated with the industry. The most recent round of negotiations resulted in a price cut of almost six per cent over three years. However, marketing authorisation and the setting of the initial price is only the first step as new medicines are also subject to the ‘fourth hurdle’ of health technology assessment (HTA).

As one of the leading HTA countries in the world, the UK requires the manufacturer to demonstrate cost effectiveness to achieve wide reimbursement. NICE is the UK’s main HTA body. An independent agency funded by the Department of Health, it appraises most new medicines in the UK within a year of their launch (Scotland and Wales also have their own HTA bodies which generally perform simpler assessments). NICE requires manufacturers to show clinical-and cost-effectiveness against the current standard of care in the UK. Appraisals are in-depth and last about one year, but have been known to take up to 21 months. However, NICE is currently working to decrease timelines to six months.

Without a positive NICE decision, manufacturers often face negotiations at regional level for access to new drugs, with certain NHS Trusts agreeing to pay for them, while others do not, a situation often referred to as the ‘postcode lottery’.

For a drug to obtain NICE approval, not only must it be as effective as the current treatments on the market, it also has to be more cost effective. This means that paying premium prices for a drug with no efficacy benefit in the UK is largely a thing of the past. NICE’s willingness-to-pay value establishes whether or not a drug is cost effective and stands at about £30K (almost €35K) per Quality Adjusted Life Year (QALY).

A drug which can demonstrate a cost effectiveness ratio under this level is considered good value for money, and can be expected to be endorsed by NICE, which legally obliges the NHS to reimburse it. It is a harder process for more expensive drugs and reimbursement is unlikely unless the manufacturers agree to a price cut, commonly known as a patient access scheme (PAS). While many drugs come below the NICE threshold, innovative medicines often do not. This is the case for cancer treatments especially. The resulting situation for cancer medicines in the UK, with postcode lotteries, patients having to pay for treatments themselves and lower survival rates than most of Europe, led to a new policy in 2009 allowing NICE to approve medicines for patients with terminal illnesses at almost twice the usual cost. This ‘end-of-life guidance’ has resulted in access to more cancer medicines. However, many are still rejected based on cost. At the time of writing, it seems likely that NICE will reject Everolimus for kidney cancer and Sorafenib for liver cancer, two medicines which are currently funded on the European continent, unless a PAS is put in place.

The UK is seen by many as having one of the most transparent and rational systems in the world because of the NICE process. NICE guidance is respected by pharmaceutical decision makers in other countries. Also, the UK regularly pays lower prices for medicines than most of Europe. In fact, inflation-adjusted drug prices are actually lower than they were 10 years ago. However, critics of NICE point to the large numbers of medicines which are rejected or given partial authorisation in a smaller group of patients. In particular, the Conservatives have criticised NICE’s record on approving new cancer drugs, noting that for 19 of the 21 cancer drugs assessed by NICE in the last year, patients in the UK are less likely to receive them than those in countries in mainland Europe.

VALUE BASED PRICING

To help remedy what they see as unacceptably low access to cancer treatments, the Government has pledged to introduce a £200m (£232m) fund to provide access to cancer drugs not currently approved by NICE. It has also announced broader plans for areshaping of the pricing and market access system in the UK towards a new one founded on value based pricing (VBP). VBP, which the Conservatives aim to introduce by 2014, will probably result in the scrapping of the current rate-of-return pricing scheme where HTA assessments are carried out after marketing authorisation, and will move towards price setting based on cost effectiveness criteria. The system is likely to look beyond the current cost effectiveness criteria, taking into account other benefits like the value of innovation and value to society.

A spokesperson for the Association of the British Pharmaceutical Industry (ABPI) commented: “The ABPI strongly supports the principle that NHS patients should receive faster access to innovative new medicines. Industry needs to be accountable for demonstrating the full value of its medicines, while NICE and the NHS must put in place systems commensurate with evaluating this full value. Value based pricing is clearly a priority for the new coalition Government, but it faces some significant design issues, and we look forward to a dialogue with government on these issues. No country has yet implemented a full VBP system and its design will be critical in order to avoid unintended consequences for patients, government, the NHS and industry alike. The current PPRS scheme runs until 2014 and, under this scheme, the UK enjoys the lowest prices in Europe.”

The UK is a world leader in evidence-based assessment, which has allowed it, arguably, to gain better value for money than most countries. However, the coming years will be an exciting time for HTA. Reforms are still in the early stages, but it is likely to be transformed.

The Author

These four sections are by Adam Johns, a UK-based health economist and writer.
One of Britain’s leading manufacturing sectors, the pharmaceutical industry’s value to the economy cannot be understated. In the UK, it is a core industry for the future. It is critical to the economy as the single biggest contributor to the balance of trade and, in 2008, was responsible for a trade surplus of over £6bn (almost €7bn). In the same year, the industry invested more than £4.5bn (£5.2bn) in UK research and development - equivalent to more than £10bn (£11.6bn) every day - and the value of exports reached £17bn (£19.7bn).

The two largest pharmaceutical companies in the UK, GlaxoSmithKline (GSK) and AstraZeneca (AZ), are among the most successful in the world and an analysis of the world’s top 100 medicines reveals that, after the US, Britain’s pharmaceutical companies’ market share is more than that of all its European competitors combined.

On an international scale, global pharmaceutical companies carry out more than 25 per cent of all industrial research and development in the UK, and it is estimated that about 20 per cent of the world’s top medicines were discovered and developed in Britain. A breakdown of the statistics by therapeutic group shows that a large part of the industry’s investment in medicines goes into drugs for cancer, heart disease, stroke and disorders of the central nervous system. The industry is also a major employer, with around 100,000 people employed directly, and three times as many supported indirectly. However, the looming end of blockbuster drugs, imminent patent expiries on top-selling medicines and increasing pressure from demands for better value for money threaten the industry.

Many of the big-selling medicines launched in the 1990s are about to come off patent, allowing generic drugmakers to make cheaper versions, including respiratory drug, Seretide, which loses its patent this year, threatening GSK’s £9bn in annual sales. Overall, only four of the 10 major pharma companies have enough products in their pipeline to plug the looming revenue shortfall (ie. Roche, with Avastin, Rituxan and Herceptin; Abbott with Humira; Pfizer/ Wyeth and Amgen with Embrel and sanofi-aventis with Lantus).

One of the main criticisms faced by the industry is the lack of innovation and the claim that the number of new drugs to treat unmet needs has been declining. According to one report, fewer than half of the drugs licensed between 1993 and 2003 offered a potential improvement on those already in use. Some commentators warn that the industry is in trouble because of this short-fall and as a result, that it could potentially be the next big industry to fall foul of the economic crisis.

The reduced number of unmet clinical needs, coupled with pricing pressures, safety concerns and competition from countries such as India, mean that companies are chasing fewer new compounds, which has resulted in the fall off in innovation over the past five years, making any investment in R&D more risky and expensive. Alan Sheppard at IMS Health estimates the chances of discovering a blockbuster have halved from 10-1 to 20-1; stating: “The increased rigour in being able to get a product to market means that far more molecules have to be screened before a likely candidate can be positively identified.”

Furthermore, there is mounting pressure on the Government to regulate the industry more tightly in an attempt to curb prices and reduce expenditure. Professor Sir Michael Rawlins, chairman of NICE, recently accused the industry of overpricing vital new medicines. Despite protests from the ABPI that UK drug prices have fallen by 21 percent in real terms over the past decade as a result of innovative pricing initiatives, the new Government looks set to change this landscape and an imminent system of value-based pricing could prove disastrous.

However, the industry has reacted confidently to the challenges, with a slow but certain change in the focus of R&D and the corresponding product of investment, with several different routes being exploited. Companies are increasing investment in high-tech niche drugs for cancers and neurological diseases, which are expensive treatments for relatively small numbers of patients. Plus, there has been a renewed focus on vaccines, which are harder to copy. Recently, Andrew Witty of GSK announced the switch in focus to ‘middle-earners’ with annual revenues of £200-300m (£232-348m). Speaking last July, Witty declared: “GSK must change if it is to be successful in the future.” Many pharma companies are really recognising the value of their consumer brand divisions and renewing interest in the low-value, high-volume cost base.

Several mergers and acquisitions in the past few years have reflected the trend towards biotech medicines in particular. Large molecule drugs, generally injected, can often be used to treat several conditions and are harder to replicate than conventional chemical drugs.

Since its acquisition of MedImmune in 2007, 25 per cent of AZ’s product pipeline is now attributable to biologics, while GSK set up a new biopharmaceuticals R&D division in 2009, with the aim of growing biological products from 6 per cent to 20 per cent of the pipeline by 2015. A recent report estimates that biotech drugs will account for half of the top 100 drugs in 2014.

To boost revenues further, the industry is also tentatively venturing into the generics market. Although in boom times this would have been a sacrosanct move, given that R&D is a central pillar of the research-based pharmaceutical industry, with the global generic medicines market now valued at £71bn – a tenth of the entire world drug market – the pharma industry has had to make tough decisions. For example, AZ, which is due to lose patents on several blockbuster medicines, including its three biggest sellers – Nexium, Seroquel and Cretor – recently unveiled its first partnership with generics drug maker, Torrent. Far from being a knee-jerk reaction, such partnerships are highly strategic and will also serve as an entry point into developing markets that are notoriously hard to access. Initially, AZ will be supplied with 18 generic medicines by the generic manufacturer and will add its own brand to them in an effort to secure brand loyalty among consumers and doctors in developing markets. AZ is seeking to boost sales in emerging markets to 25 per cent of annual revenue by 2014, from 13 per cent last year, in part to minimise the impact of patent losses.

This focus on producing costly treatments for rare diseases or benefiting certain patient groups will, in turn, affect the NHS which will face new spending dilemmas. Without government assistance or insurance, treatment may not be affordable for many and, rather than an era where high-tech medicines become affordable for all, it is likely that the ‘postcode lottery’ in the NHS will be perpetuated.

Undoubtedly, the hottest topic in pharmaceutical marketing circles at the moment is social media and the digital marketing landscape in general. Social media is a relatively new, unknown animal, and one that has been approached with caution and suspicion initially. Although some players are engaging with new media forms, other UK companies are still reticent and have been unwilling to enter this arena.
DIGITAL MARKETING CONTINUED
for fear of breaching the ABPI’s Code of Practice.

The main issue here is that as a relatively new phenomenon, and one that is so rapidly evolving and changing, it is not adequately covered by guidance in the Code. Globally, the popularity of sites such as Facebook and Twitter, with corporate entities as well as individuals, has introduced new challenges. In this environment, companies are struggling to understand what ‘appropriate’ behaviour is and how they can be part of an enabling culture without breaking the rules. Digital media – including social networking, blogging, webcasts/Youtube and newsfeeds – are still viewed for the most part as a liability. Furthermore, this communications revolution has made every consumer a journalist and, as well as the Code, the pharma industry now has to contend with bloggers. Without guidelines, the industry’s hands are tied when it comes to developing policies and technologies to respond to digital commentary.

The industry needs to embrace social media and see the opportunities rather than the threats presented by digital communication.

However, there is evidence building of a two-way conversation developing between the industry and its consumers, as well as a sense of community, enhancing reputation and trust in a sector that has carried some negative baggage, historically. There are examples of innovative marketing via YouTube and Twitter that attempt to embrace social media and connect with customers in the space where they are. For example, companies are increasingly using Twitter to recommend web-based information about disease areas, articles of interest to their followers, and even, occasionally, to engage in chat with the wider Twitter community, rather than simply using it to publicise links to press releases.

Alex Butler, communications manager at Janssen-Cilag and a member of the PM Society’s working group on social media (see below), feels that this real-time, global sharing of information, where executed correctly, has fundamentally altered the doctor-patient dynamic, stating: “The revolution of social media is the most important change to healthcare since the inception of the NHS. This time the patient really is in control.”

On the other hand, there are examples, notably in the US, where companies have found that, having made the step into social media, its free style of expressing information and personal opinions is just too different from their strict corporate and regulation-controlled approach. Caught between an innovative strategy and cautious outlook, the result is a staid, dull, corporate message board, far from the colloquial, chatty and often controversial discourse of a real blog.

So, while some are getting their heads around the potential of this new resource in theory, the reality is that most online activity remains viewed for the most part as a liability. Furthermore, this communications revolution has made every consumer a journalist and, as well as the Code, the pharma industry now has to contend with bloggers. Without guidelines, the industry’s hands are tied when it comes to developing policies and technologies to respond to digital commentary.

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For social media to be not only useful, but valuable and a worthwhile investment of resources, industry must be equipped with the tools, the knowledge and the rule book that goes with it.

A UK industry working group has been set up to address these needs. The PM Society’s digital media initiative aims to bring some much-needed clarity to digital pharma marketing in the UK. Headed by Steve Gray, formerly of A2 and now managing director of Compliance Hub, this group grew from the PM Society’s workshops on the ABPI Code and discussions with the Prescription Medicines Code of Practice Authority (PMCPA), the body that oversees it. Its purpose is to help members understand the application of the Code as it stands and make recommendations on possible changes or inclusions for consideration in the new 2010 Code.

Gray recognises that regulation, however up to date, can never match the pace of change in the digital arena. “What the industry will want to do will always be ahead of what the Code can deliver. The digital environment is progressing at a rapid rate of knots,” he states.

Speaking at the PM Society’s Digital Update meeting in May, Heather Simmonds, director of the PMCPA, said that the body will produce guidance for the industry on digital marketing, but it is unlikely that formal changes to the Code will be made. “There is a lot under the Code that you can do,” she said, making reference to the fact that, for the most part, the pharma industry is not yet utilising the more basic aspects of Web 1.0, let alone Web 2.0.

In the US, the Food and Drug Administration (FDA) is preparing draft guidance on social media, submissions to which closed in February. Although ultimately it may have no bearing on the industry in the UK or Europe because of the remarkably different operating environments, all eyes will doubtless be trained on Washington as this will be the first guidance on social media to exist.

Developments in social media are occurring at such a fast rate, with exponential uptake, that developing guidance for any jurisdiction will be a challenge. It must be broad enough to cover change and reflect the social media world as it is, but also as it will become, while at the same time being specific enough to be effective and useful. Regardless of how daunting the task, it is not insurmountable and it is needed urgently. In the UK, whether it takes the form of a revision or an addendum to the existing ABPI Code, or simply an interpretation of how the Code can be applied to new media, companies must be steered if they are to unlock the potential of these new channels of communication.

Digital communication is part of the here and now, and is most certainly the future. Social media is a space that the industry’s customers are increasingly active in, both socially and professionally, and although it may be a more difficult landscape to negotiate, consumers (who may not be fully versed in the restrictions applying to the pharma industry) also as it will become, while at the same time being specific enough to be effective and useful. Regardless of how daunting the task, it is not insurmountable and it is needed urgently. In the UK, whether it takes the form of a revision or an addendum to the existing ABPI Code, or simply an interpretation of how the Code can be applied to new media, companies must be steered if they are to unlock the potential of these new channels of communication.

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How have UK pharma companies responded to the social media revolution?
UK pharma is grappling with social media. A few companies are seeking to explore the best use of the medium in the interests of patients and prescribers. Others are more cautious in their approach because of concerns relating to the regulations (including, but not limited to, the ABPI Code of Practice).

You are heading the PM Society’s working group on digital media. What is this initiative and what are its aims?
The objective of the PM Society digital media project was to identify the burning questions that the industry had and to seek to propose answers. In doing so, we hoped to provide the PMCPA with potential content for the next Code. In short, we hoped that we could obtain clarity regarding some areas of uncertainty in the current Code and suggest future changes for consideration.

Do you think the US FDA draft guidance on social...
media will impact digital communications in the UK and Europe?

The FDA review is interesting, it will obviously have some impact on international considerations in that the FDA is likely to be the first governmental regulatory body to officially clarify its position on social media and other aspects of digital marketing. However the insight for the UK (and Europe) will relate to the manner in which the FDA regards obligatory information (such as prescribing information) in the context of Twitter and search-engine metadata and search engine adverts. Basically, the amount of text allowed for manufacturers is too small to include full obligatory information - the FDA is therefore being urged to allow its provision at the destination of a hypertext link. If this goes ahead, it may encourage the Medicines and Healthcare Products Regulatory Authority (MHRA) and PMCPA to do the same for communications targeted at HCPs (eg. reducing the obligatory content of banner ads in medical journals).

How do you see the scene in five years’ time? How will pharma adapt and evolve? What will communications between the industry and the consumer look like?

The big challenge for pharma/consumer interactions in the UK is simply that pharma is not allowed to proactively communicate product information to consumers. That is, in effect, advertising (which is, of course, illegal).

However, I foresee significant improvements in the use of digital media to facilitate greater support for patients already on the manufacturer’s product, with more effective and targeted patient support programmes that make full use of the digital medium. We have barely scratched the surface of this whole area yet - in fact the Code does not even contain any guidance about how patient support programmes can operate generally, let alone in the context of digital media. The irony is that non-pharma organisations and individuals are allowed to proactively communicate information about medicines (and quite often the information is incorrect); therefore I also predict an increase in pharma responding to inaccurate information posted on the internet - especially if the information would risk patient safety. Of course, one added complication for pharma companies is that the more sites they track and monitor, the more sites fall within the scope of their obligations for adverse event reporting, so increased monitoring may also see an increase in the numbers of pharmacovigilance staff required to process follow-up enquiries.

To be honest, however, in the next two to three years, I think the primary increase in the use of digital media by pharma will be for internal functions. Greater instant messaging communication between pharma employees will probably replace some email traffic. Users will go to clouds where attachments are stored (rather than being embedded in emails). Those in the digital community (and today’s teenagers) have been doing this for some time, of course, but we need to remember that many pharma companies do not yet have the ability to open Microsoft’s .docx files, let alone upgraded to Windows 7 or (heaven forbid) an alternative operating system. These are not limitations introduced by codes of conduct, but by the pace of corporate evolution. In my experience, many companies have firewalls that prevent employees from accessing ‘cloud’ sites to download attachments placed there by their agencies, so even removing barriers such as these would be a big step forwards for some companies; to expect wholesale adoption of cutting edge technology while it is still cutting edge is expecting too much in an industry that is naturally cautious. But there is no doubt that some companies will carve a path of innovation and that the agencies in this industry will continually drive new ideas and seek to use the digital medium in ways that companies and the authorities are comfortable with, whilst offering fresh approaches to presentation.

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NEW GOVERNMENT IMPLICATIONS

Following the recent formation of the Conservative-Liberal Democrat coalition Government, newly appointed Health Secretary, Andrew Lansley MP, has taken responsibility for the NHS and pharma. Although Lansley has advised that divisions between the Lib Dems and the Tories on NHS spending during the general election campaign have been resolved, it is likely that there may be a cooling off period and that this ‘agreement’ may in fact be a moveable feast until a more lasting joint policy position is reached. While the differences in health policy between the Tories and Lib Dems, and for that matter Labour, are not what they were a decade or so ago, there are a number of hurdles for Mr Lansley and his team of ministers to overcome.

Although it is too early to speculate where the two perspectives on health policy will meet, one of the key areas of pharma reform in the Tories’ election campaign was the introduction of value based pricing (VBP) and, with the party holding the majority stake in the coalition, pilots of the system are likely to start soon.

Lansley is a firm advocate of VBP, which he claims “would be a much more rational system than the patient access schemes which are haphazard and random.” The new system would set drug prices according to the value medicines provide and would mean that NICE no longer sets cost-effectiveness thresholds.

He highlighted that pharma companies would be invited to take part in pilot studies of VBP imminently and explore in partnership how the system would work best. The new Government is keen to see a VBP system in place by 2014, the same year in which the current Pharmaceutical Price Regulation Scheme (PPRS) pricing agreement is set to expire. This will have huge implications for industry in the UK.

In terms of spending, Lansley has committed to a rise in real terms in overall spending on the NHS, while stating that in order to do so, considerable savings would have to be made elsewhere, meaning “real pain for the NHS”. It is likely that the only issues that Lansley’s team will concentrate on in the next few months will be those that affect the upcoming budget. However what is encouraging for the industry is that these savings are likely to be reinvested into growth areas of high demand for the NHS, as outlined by NHS chief executive Sir David Nicholson, one of which is the demand for new drugs. While this may spell an opportunity for growth in the UK pharmaceutical industry in terms of an increased demand, the new VBP system may translate to something else entirely.

If the coalition does continue in the longer-term, there is greater scope for joint policy formation.

The Author

The above sections were provided by Lisa Mehigan, a communications consultant based in Dublin, Ireland.