10 ways to improve patient compliance and retention

A practical guide by Sunita Apte and Sarah Hefford

Non-compliance is moving to the forefront of pharmaceutical marketers’ concerns. However, it still has a long way to go before it moves from vague awareness to a point of widespread and decisive action. Yet non-compliance can essentially mean that your brand is losing patients (and with them revenue) who either melt away or switch to other brands.

Even worse, the patients lose the therapeutic benefits of your brand. Why then, even though some companies are taking steps towards improving compliance, is so little being done? Simple. Many pharmaceutical marketers don’t realise that lack of compliance can be dealt with effectively and with good return on investment. So we hope that this guide will provide the answers you’re looking for.
1. YOU MAY HAVE A COMPLIANCE PROBLEM. ADMIT IT.

There’s nothing unusual about poor compliance – Hippocrates first complained about it 2,500 years ago.

If we define compliance as taking medicine as prescribed, then at least half of all drugs are taken incorrectly, be that the dose, the time of day, with or without food, etc. For that reason, 25% of all medicines produce no clinical benefit. As a result, doctors diagnose increased morbidity and, frequently unaware of its real reason, either increase the dose or switch the patient to another brand.

The NHS suffers the increased costs of doctor visits, additional tests, and society suffers absenteeism, a decline in the quality of life and other socio-economic consequences.

And of course pharmaceutical companies suffer reduced revenues. If your brand has roughly the same compliance record as the national average, it’s easy to measure the effect on your sales over time, for a patient lost is a patient seldom regained, so the negative effect ought to be calculated over the lifetime of a patient.

All of this suggests a problem crying out to be solved. Yet not all companies are doing enough. The reason is often low awareness of poor compliance, its cost and the seriousness of the health consequences. There’s also the issue of who should be responsible for what. Doctors, for example, are aware of the dangers of poor compliance but, spending on average just seven minutes with a patient, are unable to do much about it.

2. YOU CAN’T SOLVE THE PROBLEM UNLESS YOU KNOW ITS CAUSES. ANALYSE IT.

There’s no such thing as a one-size-fits-all compliance programme as non-compliance has diverse causes. Only once you’ve analysed the situation with your brand and understood why patients don’t comply as directed, can you tailor a programme designed to address those causes. The situation is similar to that of a doctor who prescribes treatment only after diagnosing the condition. So do your research with both patients and healthcare professionals to understand what’s causing poor compliance on your brand.

Which of these possible causes of non-compliance apply to your brand?

- Side effects leading to dissatisfaction with treatment and/or a negative perception of the brand
- Patients’ forgetfulness
- Social stigma that may be attached to some drugs
- Asymptomatic condition – patients may feel that in prescribing the drug the doctor was overprotective
- Ignorance – due to insufficient follow-up and information flow, patients are unaware of the consequences of poor compliance
- Inconvenience – taking the medicine as prescribed may necessitate, for example, regular visits to the hospital
- Beliefs – some patients just don’t like to take medicines.

Depending on your brand and the condition for which it is prescribed, establishing the actual causes may be more or less difficult. But it’s essential if you wish to improve compliance and benefit all stakeholders.

3. SOME REGULATIONS PREVENT YOU TALKING TO PATIENTS; MANY DON’T UNDERSTAND THEM THOROUGHLY.

It is important to understand the general principles behind all regulations concerning patient communications.

First, a successful compliance programme involves communicating directly with patients. This tends to be scrutinised in most European countries and certainly in the UK, resulting in many barriers erected between you and patients.

Second, these barriers aren’t insurmountable. Guidelines for patient communications give clear direction towards what’s possible. The key principle, however, is that patients cannot be directly sold prescription medicines. So, provided the patient is taking the medicine at the time of the communication, and it agrees with the doctor’s wishes, a direct-to-patient communication to improve compliance is not only legal and acceptable, but also provides a service to the patient and healthcare system.

At the root of the confusion lies unclear terminology. In this case, it may be helpful to split communication to the public into DTC (Direct To Consumer, who may or may not be taking your company’s drug) and DTP (Direct To Patient, who is taking it). When applied to communications about specific
medicines, the former is off limits in most European countries – and you can see why. Drug-focused communications DTC attempt to influence a person to request a prescription-only medicine, which may be inappropriate. This places unnecessary pressure upon healthcare professionals and may confuse or even alarm some patients. In contrast, drug-focused communications DTP are aimed at those who are already taking the medication and need help with it. Much of that help aims to improve compliance, thus benefiting every stakeholder: the NHS, the pharmaceutical company and – above all – the patient. So DTC can be thought of as there to sell or grow a market; DTP is there to help patients. Critically, regulators in all European countries are awakening to the difference.

4. SOME COMMUNICATIONS CHANNELS WILL WORK BETTER THAN OTHERS. CHOOSE THE RIGHT ONES.

There are many communications channels available, and regulatory bodies have more problems with some than with others. Also, some are more effective in addressing particular causes of non-compliance. The correlation between efficacy and regulatory pressures ought to be considered when selecting the channels (see table, opposite).

Nurse-led call centres, possibly equipped with voice-automation technology: Effective, instant support by phone calls either to or from patients – no other communication is as reassuring and interactive as conversation. Where compliance is being adversely affected by patient understanding, call centres can be a critical element of a compliance programme. They also provide a useful perception of distance between the patient and the pharma company. BUT: with the wrong supplier, these can be expensive to set up and maintain, so it’s important to find suppliers who understand pharmaceutical marketing and appreciate the need for a return on investment.

E-mail: Cheap; can be effective in reminding patients to take their medication as prescribed. BUT: forgetfulness may not always be an issue. There are many reasons for poor compliance, and forgetfulness is only one of them. Also, not all patients have e-mail.

Direct mail: Useful, especially in support of call centres, direct mail can deliver information, always provided that the patient has explicitly agreed to receive it. BUT: the written word is not always the best medium to communicate complex issues. Its best use is in support of a telephone-based discussion.

CD-ROM: Can deliver information quickly and, once the cost of generation has been amortised, inexpensively. BUT: the same objection as with e-mail – not all patients have computers. More important, this medium is not sufficiently interactive to act on its own as a compliance programme.

SMS texting: Like e-mail, useful to remind patients of taking their medication, ask for repeat prescriptions etc. BUT: limited to 160 characters and so not suitable for complex messages. Less effective with a senior audience who may not own a mobile.

5. YOU CAN HELP PATIENTS IMPROVE COMPLIANCE. SO TALK TO THEM.

So, though there are challenges in talking to patients, it’s both possible and desirable. You are unlikely to run into patient resistance – most patients have been shown to want drug information to be supplied directly by pharmaceutical companies. And, providing such information improves both patient outcomes and sales, this can only be a good thing.

The GP alone cannot be solely responsible for a constant flow of compliance information to patients, especially with the growing health consciousness of patients across Europe, where 60% rate their medical knowledge as above average. Research also shows that talking directly to patients has other benefits:

- GPs are more likely to prescribe a drug with a support line
- 85% of patients surveyed would welcome a telephone helpline manned by a healthcare professional
- 73% of patients would prefer a medication supported by such a helpline
- 57% of patients said they would stop taking their medication if unable to receive answers to questions.

6. HELPING PATIENTS INVOLVES LONG-TERM RELATIONSHIPS. BUILD THEM.

There’s a distinction between two related terms: ‘compliance’ and ‘concordance’. This relates to the appearance of a new type of patient – The Expert Patient. A new type of patient calls for a new type of relationship, and the difference between the two words above reflects this.

‘Compliance’ describes the traditional doctor-patient relationship. The doctor issues a prescription, and the patient dutifully complies. As statistics show, this approach always was flawed even in the past when The Expert Patient was a rarity, rather than a commonplace phenomenon.

‘Concordance’ describes a new, more effective relationship. While a certain hierarchical element is still there, partnership begins to play a role whose importance is growing in proportion to the increasing sophistication of the patient. Rather than issuing orders to be complied with, the doctor treats the patient as a partner, explaining what benefits and side effects the patient can expect from the drug. The doctor and the patient thus enter into an arrangement wherein the patient agrees to take the drug as prescribed.

Given GPs’ workload, they can use all the help they can get to turn compliance into concordance – without this, it would be difficult both for GPs and pharmaceutical companies to form a long-term relationship with patients. This is where an effective compliance programme comes in. In fact, turning compliance into concordance is its ultimate objective.

7. HEALTHCARE PROFESSIONALS KNOW HOW TO HELP. USE THEM.

Nurse programmes have been shown to improve compliance by an average of 30% in a year. One reason is that nurses, being more keenly attuned to patient, rather than disease issues, know how to gain patients’ confidence and provide valuable understanding and support. In the patients’ eyes a nurse can also seem less threatening than a GP, and they are often more prepared to open up to a nurse about their concerns.

For many patients, this reassurance makes the difference between complying and not complying. In fact, a professional nurse used to managing compliance often seeks concordance almost subconsciously.

8. THERE ARE THINGS YOU MUST DO. DO THEM.

The regulations governing compliance programmes may be equivocal; things you must and must not do so as not to transgress upon the spirit of such regulations aren’t. Things you must do:

1. Inform patients in advance about every detail of the programme, its aims and the communications channels that you propose to use
2. Obtain written/recorded/oral consent from the patient (you may have to enlist the help of GPs or nurses to pass enrolment forms on)
3. Store all personal data in accordance with data protection legislation, with only authorised personnel having access
4. Keep the relevant medical professionals ‘in the loop’
5. Only talk to patients about your brand if they are currently taking it
6. Make sure you have a strict process for approval of all communications and maintain clear audit trails
7. Have a system to deal with adverse event reporting.

9. THERE ARE THINGS YOU MUSTN'T DO. DON'T DO THEM.
Things you must not do:
1. Fail to follow any of the ‘must do’ steps
2. Interfere with the doctor-patient relationship (eg, discuss changes to medication)
3. Sell your medication to patients.

The use of organisations experienced in compliance programmes can help you through these challenges so you can reap full benefits.

10. IS YOUR COMPLIANCE PROGRAMME WORTH THE COST? MEASURE YOUR ROI.
While assessing the clinical benefit of compliance is easy, evaluating the Return On Investment (ROI) isn’t. Models involved have to be customised, and they can get complex. Yet such an evaluation is necessary, as no company will knowingly run a compliance programme at a loss. The model below will prove useful – if not in detail, then at least in the solid principles behind calculating ROI.

Business case
Brand X reduces blood pressure. It costs £20 per month, but 50% of all patients started on Brand X stop taking it within six months.

36,000 new patients are started on Brand X evenly across every year, 3,000 new patients every month.

Of the 3,000 patients who start in January, 1,500 will have stopped by July, representing a loss of £90,000, leaving an adjusted worth of £540,000 (ie, the same net value as having no programme or a break-even situation).

In terms of ROI the more effective a compliance programme is, the better the financial rewards will be.

<table>
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<th>At the end of Year 1:</th>
<th>At the end of Year 2:</th>
<th>At the end of Year 3:</th>
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<td>3,000 patients with perfect drug compliance would be worth £720,000.</td>
<td>3,000 patients with perfect drug compliance would be worth £1,440,000.</td>
<td>3,000 patients with perfect drug compliance would be worth £2,160,000.</td>
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<td>3,000 patients with real-world compliance (as above) would be worth £540,000.</td>
<td>3,000 patients with real-world compliance would be worth £1,080,000.</td>
<td>3,000 patients with real-world compliance would be worth £1,620,000.</td>
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<td>3,000 patients with boosted drug compliance as a result of the programme would be worth £630,000, but would cost £90,000, leaving an adjusted worth of £540,000 (ie, the same net value as having no programme or a break-even situation).</td>
<td>3,000 patients with boosted compliance as a result of the programme would be worth £1,260,000, but cost £90,000 leaving an adjusted worth of £1,170,000.</td>
<td>3,000 patients with boosted compliance as a result of the programme would be worth £1,890,000, but cost £90,000 leaving an adjusted worth of £1,800,000.</td>
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<td>ROI of £1,170,000 minus £1,080,000 (value if doing nothing) divided by £90,000 (the cost) which equals 100 per cent.</td>
<td>ROI of £1,170,000 minus £1,080,000 (value if doing nothing) divided by £90,000 (the cost) which equals 100 per cent.</td>
<td>ROI of £1,890,000 minus £1,620,000 divided by £90,000 which equals 200 per cent.</td>
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while this programme since it’s impossible to predict who will not comply.
So the cost of this programme is £90,000. To cover the cost and reach the break-even point within the same year, half of those patients who would have failed to comply must comply.
Attrition curves with many chronic therapies show that attrition all but stops after six months. Therefore, it’s reasonable to assume that most of the 750 patients saved by the programme will continue to take their therapy for the rest of their lives, in which case the two, three, four and five-year return on investments looks healthy (see table above).
In other words: ROI improves as timescale measured extends.
This example looks at January’s patients only. More detailed modelling would be required to look at annualised ROI. However, the principles are the same.
The conclusion is unequivocal – compliance programmes can be exceptionally successful both in clinical and fiscal outcomes.

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There are better ways to improve compliance.