Pharma and the NHS – a partnership of necessity

A new strategic positioning

Great imperative has been placed recently on pharmaceutical companies to shift away from product-centric marketing strategies and move towards value-based propositions. While not new, the concept of quantifying additional value has become a key focus for pharmaceutical companies in response to the demands of the Department of Health, wider government and NHS providers. The issue of defining value has proved challenging, however success has been demonstrated in a number of initiatives and many companies have now positioned themselves strategically as patient-centric and value-based organisations.

Yet the question remains: in a dynamically changing NHS and European healthcare market, how are these strategies best implemented to protect and develop a pharmaceutical franchise effectively over the short, medium and long term?

The end of the NHS as we know it

The passing of the 2012 Health and Social Care Act paves the way for part privatisation of the NHS. The NHS will remain predominantly 'free at the point of access', but the change in legislation brings with it the entrance of a number of private providers. Significant changes within the act have, while causing much consternation among traditional NHS providers, redefined those responsible for the healthcare of local populations and significantly, in a break from tradition, opened the doors to non-traditional providers in a bid to create value-based competition within healthcare.

The Health and Social Care Act repeals the Secretary of State's 'duty to provide' specific services. Instead, a 'duty to arrange' provision is imposed on each of the many CCGs that will also have transferred to them the power to determine what care is necessary to meet all reasonable requirements. Critically, the change from provision to a 'duty to arrange' provides the vehicle in which new providers can enter the healthcare market. Unlike PCTs, CCGs will not be responsible for all residents within contiguous geographical areas. CCGs select patients, initially assembling their patient populations on the basis of GPs' lists; they will not have to cover everyone in a geographical area but only persons for whom the CCG has responsibility.

These changes present obvious logistical challenges to pharmaceutical companies in defining territory structures and executing key account management principles. They could also potentially make the delivery of certain value-based programmes difficult within a geographical boundary due to the number of authorising CCGs involved. In fact, it is already noted that some practices are reporting populations covered by numerous CCG boundaries.

This situation will create challenges for pharma and data providers. The critical challenge will be to understand the business aims of the new CCGs and the identification of emerging providers, or customers within the localities. In essence, account management based on geographies alone will not necessarily cover key stakeholders and decision makers.

The 'Any Qualified Provider' model – added complexity for pharma

Any Qualified Provider (AQP) is the government's policy to extend patient choice. Put simply, where services offer a a choice of AQP patients can choose where to have their treatment from a range of providers who meet NHS standards and price, and are 'Choose and Book' compliant. These providers can be from the NHS, private or voluntary sectors.

The government hopes that patient choice will drive up quality if patients are able to choose their provider based on outcomes or waiting times. The Department of Health has said services put out to AQP will remain free for patients

to use and that access will be based on clinical need, in line with the NHS Constitution. From next April, England's 212 CCGs will be responsible for commissioning and will have to open up some services to AQP. The services that are tendered under AQP will vary from area to area.

In theory, AQP can benefit GP practices because they can bid to provide some of the services put out to tender. However, in practice, the significant benefit is the removal from NHS budgets of all costs associated with maintaining the necessary infrastructure to deliver clinical services.

AQP providers are paid on activity or successful outcomes only and therefore have to invest in infrastructure and marketing their services to ensure patient capture. The AQP provider is often required to finance drugs and therapy costs from within the activity payment therefore putting costs of drugs within a service under close scrutiny.

The roll out of AQP started in April 2012 with a selection of community and mental health services. It will extend further this year – in October the Department of Health said it was on track to put a further 39 services to AQP through PCTs in the autumn. Within a few months of announcing shortfalls, many NHS-led services performing below target have already seen their services tendered out and private AQP companies entering the market. This has resulted in some quality and continuity issues for patients.

Therefore, the shift in customer base for pharma is already underway and poised to accelerate from November 2012 onwards – and this will impact significantly on pharmaceutical companies when it comes to designing strategies to promote their products and services.

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While the attempt to put competition and patient choice at the centre of policy is admirable, many entrants into the AQP market – and previously many PCTs – have focused on minimising short-term costs, for example, through the drugs used within the service.

If all providers compete on value, then value will improve dramatically. However, the focus on minimising short-term costs – and battling over who pays for what – has resulted in many of these services, organisational structures and practices, across both traditional NHS providers and new entrant AQPs, becoming misaligned with value for the patient.

In line with the current agenda, pharma has long made the argument that a drug's 'value' is the health outcome in relation to the each pound spent. While this assertion is true, it is only part of creating value in healthcare. True value is determined through addressing the patient's specific medical condition over the full cycle of care, from monitoring and prevention to treatment, to on-going disease management and patient education. Therefore within the context of a full cycle of care, both the NHS and pharmaceutical companies have an aligned agenda in strengthening the competitiveness of traditional services within the NHS where they are trying to achieve a common goal of improved patient outcomes.

Supporting the NHS in specific care pathways to drive patient value

Traditional NHS Primary Care providers offer a broad spectrum of services and are geared up to handle any patient who walks through the door. The breadth of services provided has little impact on patient value – it is the ability to deliver value in each medical condition that really matters.

Pharmaceutical companies, by nature of their portfolios, have for a long time focused on clinical outcomes within a medical condition and therefore, within an effective cycle of care or care pathway, can demonstrate real value within healthcare. The key issue is how does pharma support effective care pathways? Or put another way; how does it support its traditional NHS customers to compete on a value basis whereby the determinant of value is results?

Traditional NHS providers are by design, non-commercial organisations. They now face their biggest challenge to date in adapting to a market economy and competing on value against the entrance of private healthcare providers. For the NHS to be successful they have to realign competition with value for patients. Pharma and the NHS now have a shared agenda in creating value for patients and have a strong interest in maintaining and protecting its customer base having spent years and much resource in developing these relationships.

Pharma has expertise and many skills in defining its drugs in terms of 'patient value' or improved outcomes. Bringing these skills and knowledge to bear on the full cycle of care in partnership with NHS providers will enable them to compete on a value basis that is defined by results.

In my final article we will go on to explore in-depth the strategy, account management function and tools required to successfully implement a value-based strategy in partnership with the NHS.

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