Marketing Masterclass

A consistent approach for assessing the value of prescribing and non-prescribing customers

Meike Meyer
is a manager at Executive Insight. She has been working as a consultant for over seven years, primarily focusing on CRM in the pharmaceutical industry. In working with leading pharmaceutical companies she has developed substantial expertise in the area of defining and implementing customer-centric concepts.

Marc Pesse
is a manager at Executive Insight. He has completed a number of projects across Europe with leading pharmaceutical clients, focusing on the areas of CRM strategy, salesforce automation and analytical CRM.

Meike Meyer and **Marc Pesse**
Executive Insight
Metallstrasse 9
CH-6034 Zug, Switzerland
e-mail: meike.meyer@executiveinsight.ch
e-mail: marc.pesse@executiveinsight.ch
website: www.executiveinsight.ch

INTRODUCTION

For some time now, there has been an increasing awareness that the prescription decision is influenced by a number of actors besides the physician, and that their influence is growing.[1] As cost-containment pressures on drugs intensify, these 'non-prescribers' are becoming involved in defining and enforcing increasingly coercive positive or negative drug lists for prescription, as well as making policy decisions concerning reimbursement and generic substitution. Together with prescribers, these new customers form a web of relationships, often referred to as the 'healthcare network'. Pharmaceutical firms, who have traditionally focused on physicians and have developed increasingly robust approaches to improve targeting accuracy, are now taking steps to address these new audiences. The emergence of new customer groups however, is coinciding with an industry-wide trend towards trimming field force budgets. After years of build-up, pharmaceutical field force numbers are expected to decrease. Consequently, there is a need to systematically assess the value of non-prescribers in order to optimise the allocation of scarcer promotional resources. Concretely, since the field force remains the largest share of the promotional spend, the question for marketers is whether to send the field force to see yet another doctor, or a nurse, or a health insurer, and if so, which one? This paper proposes a pragmatic model to start answering this question in a European context.

A CONSISTENT APPROACH

At a high level, the customers of a pharmaceutical company can be divided into prescribers and non-prescribers. The first group is mostly made up of general practitioners and specialists. The non-prescriber group is made up of all parties who do not write prescriptions themselves, but have a direct or indirect impact on the prescribing process. Examples of non-prescribers and how they influence the process are:

- Formulary committees and regulatory bodies that maintain binding or non-binding lists of drugs to be prescribed for a certain condition
- Private or state-funded health insurers, who

decide which products are reimbursed and at what conditions
- Administrators, either in public or private healthcare providers, who control the allocation of budget to certain disease areas and treatment options
- Pharmacists, who, under certain conditions, may substitute the prescribed drug for the corresponding generic
- Nurses, who play a vital role in the screening and diagnosis of the disease as well as in prescription compliance
- Patients, the largest non-prescribing group of all, who are gaining a similarly growing role in the prescription decision by consulting online medical education and suggesting a brand name to the physician. This group is however outside the scope of the proposed valuation approach as it will continue to require fundamentally different targeting and promotional approaches.

Prior to considering a valuation model that includes both prescribers and non-prescribers, let us consider the approaches used by pharmaceutical firms in the targeting of prescribers. Traditional value drivers of prescribers are sales and potential. Sales are a measure of the amount of the company's product prescribed by a specific physician. Given European regulatory restrictions on access to individual prescribing data, increasingly sophisticated models have been developed to approximate scripts associated with individual prescribers. Various dimensions can be used to evaluate potential, including the total amount of prescription for a therapeutic class, local incidence and prevalence data, practice size and doctor behavioural factors. As targeting models mature, prescriber influence level is often added to the value mix. The influence level is an estimation of the degree to which a physician can change the prescribing behaviour of his or her peers.

When applying the above value drivers to non-prescribers, it is clear that prescribing data cannot be used to evaluate sales and potential. In addition, the heterogeneous nature of the non-prescribing actors complicates the task of developing a consistent model. Finally, while a great deal of data concerning prescribers is currently made available by third parties or collected by the salesforce, very limited data is available for non-prescribers at this point in time.

While there are some challenges to overcome, the approach to value prescribers and non-prescribers can be aligned. First, common value drivers, the components that make up the valuation, need to be agreed. In the model described, the two proposed value drivers are the individual influence level and patient reach. Since no direct measurement is possible for these value drivers, suitable proxy indicators need to be proposed for each customer group. Value ranges (ie the scales that are applied to describe the possible values to quantify each indicator) need to be determined and the value of each individual customer needs to be calculated.

As a principle, and for the purpose of this paper, the proposed model is kept simple to preserve clarity and ease of implementation. Further refinements can be introduced subsequently based on the availability and granularity of the underlying data.

INDIVIDUAL INFLUENCE LEVEL

As in the case of prescribers, the influence level should capture the type and strength of the relationships an individual customer has with the other actors in the healthcare network. Influence has been defined as the ability of making others behave differently.[2] Since this data is not available as such, it is proposed to use customer 'roles' as an indicator for measuring their level of influence. Indeed, while customers have one 'profession', such as nurse or pharmacist, their roles can be defined as the different sets of responsibilities they have to fulfil in the broader context of that job. Across the prescriber and non-prescriber groups, examples of such roles are:

- *Policy influencer*: Role in influencing national healthcare legislation, especially in the area of pricing, reimbursement and budget allocation, thereby indirectly influencing treatment options
- *Pharmaco-economic advisor*: Responsibility in delivering recommendations based on the cost-benefit of a product or therapy in relation to alternative options, thereby actively influencing pricing, prescription and reimbursement decisions
- *Key opinion leader*: Recognised thought leadership in a disease area and its treatment, potentially actively promoting one or more treatment options
- *Formulary committee member*: Membership of a body, making decisions about binding or non-binding drug lists and/or treatment guidelines
- *Educator*: Responsibility for continuing education and training of medical professionals, or in the general training of other stakeholders in the healthcare network, including patients
- *Budget holder*: Responsibility in the allocation of financial resources for the prevention, screening and treatment of a condition at a national, regional or local level, thereby influencing the focus on one or more therapy areas and actively or passively favouring treatment options
- *Diagnoser*: Responsibility in identifying a disease and selecting the appropriate treatment course
- *Prescriber*: Responsibility in selecting a drug, by brand or generic name, based on the identified diseases and selected treatment course
- *Drug dispenser*: Responsibility in delivering the prescribed drug, either a specific brand or the corresponding generic.

All of these roles have an impact at one or more stages of the drug commercialisation process, from broad disease awareness creation through to prescription,

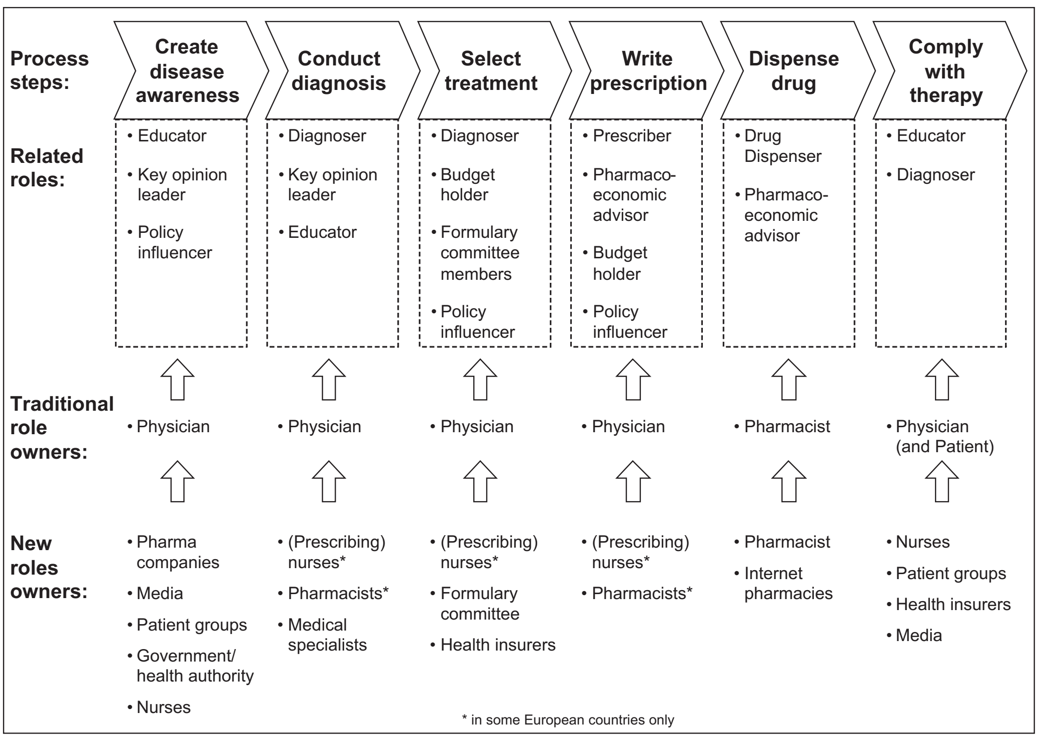

Figure 1: How roles and role owners influence the drug commercialisation process

distribution and compliance (Fig. 1). While most roles were traditionally held by the physician, non-prescribers are increasingly taking over these roles and the associated influence.

Stakeholders in the healthcare process can combine one or more roles simultaneously. They will also have different levels of involvement in that role. To simplify matters, these levels of involvement can be defined as high, medium and low, respectively associated with a 3, 2, 1 point scale. For the valuation model to remain objective, these levels need to be defined in detail, capturing the actual influence level. For example:

- For the 'drug dispenser role': A high score could be someone with the freedom to decide which drug to dispense, such as an independent pharmacist. A medium score is someone who has to comply with a group policy for drug dispensing, such as a pharmacist in a chain. A low score could be someone who has no flexibility during the dispensing process, such as a pharmacy with a general contract with a wholesaler. In that case, typically, the wholesaler even decides which generic products are ordered and kept in stock for a given disease.
- For the 'prescriber' role: A high score can be attributed to someone with the complete freedom to select the drug to be prescribed, a medium is someone with a limited ability to prescribe within a formulary, a low is someone with very limited prescribing scope, such as a prescribing nurse.[3]

Therefore, as an indicator of the overall level of customer influence, it is proposed to inventory all the roles each customer has, and the level at which that role is fulfilled. This is a task that can be undertaken by the field force, based on clear definitions. The result is a matrix with a total numerical value attached to each customer (Table 1). Actual roles, associated definitions and point scales need to be adapted to the specific healthcare network each company is dealing with. These can vary by country, region or therapeutic area.

PATIENT REACH

The second value driver proposed in this model is the patient reach. It can be defined as the total number of patients that are directly exposed to the behaviour and decisions of an actor in the healthcare network. The indicator for patient reach cannot be the same for each stakeholder group in the healthcare network. Unlike the influence, however, it is proposed to use the customer's primary 'profession' to evaluate this indicator. While customer roles serve as a good indicator for the

Table 1: Individual influence score matrix

		Customer roles													
		Budget holder			Key opinion leader			Educator			Formulary committee member			...	
		Role level			Role level			Role level			Role level			...	Total role score
Customer name/ID	Profession	1	2	3	1	2	3	1	2	3	1	2	3	...	
A	Cardiologist	X			X			X				X			5
B	Nurse									X					3
C	Pharmacist		X						X			X			6
D	Health insurance employee			X											3
...	...														

influence dimension, they do not lend themselves to an objective measure of reach. Ultimately, the choice of the reach indicators per customer group will depend on the national healthcare market conditions and data availability. Examples of reach indicators that can be used are:

- *For general practitioners*: The indicator of reach can either be an approximation of practice sales or the number of patients that are registered with the practice. Alternatively, if the valuation focus is on a specific therapeutic area, therapeutic class sales, the number of registered patients suffering from a certain condition or the local disease incidence and prevalence data could be envisaged as indicators.
- *For specialists*: For specialists with their own practice, the indicators can be the same as for general practitioners. For specialists working in a clinic, the number of new patients per year, the total number of patients or the number of beds can be used depending on the specialty.
- *For hospital pharmacists*: If the data is available, the reach can be measured through the total hospital pharmacy sales. Alternatively, the total number of beds in the hospital could be used.
- *For pharmacists*: Again, if available, the reach of the pharmacy can be estimated from the pharmacy total sales. Should this data not be available, the demographic data associated with the catchment area of the pharmacy can be used.
- For health insurers: The proposed indicator is the number of policy holders. In state-funded health insurance systems, this will automatically result in a high valuation in terms of patient reach. The analysis can however also be conducted for the complementary health insurance policy holders.

In the case of patient reach, the value ranges for each indicator will be different. Again, based on the principle of simplicity, it is proposed to use a high/medium/low value scale, allowing the different reach indicators to be compared. Underlying each proposed indicator, there is a distribution of values that can be used to identify, for example, the low and high reach customers. In the example below (Table 2), the cut-off points were set at approximately 15 per cent at both ends of the distribution. Based on available data and the shape of the distribution, the point scale and actual cut-off points can be further refined to increase the valuation granularity.

APPLICATION AND LIMITATIONS

Once the data has been collected for the individual influence level and the patient reach, the customer valuation matrix can be populated for all customer types (Fig. 2). High value customers can be identified and targeted across customer groups. This allows an optimisation of promotional resource allocation such as salesforce visits and campaigns. The return on these promotional activities will be increased as the network effect of high-value customers is leveraged.

While the proposed model is a first step towards the harmonisation of prescriber and non-prescriber valuation, some limitations should be considered. First, there is a degree of subjectivity that is introduced in the valuation through the identification of the roles. This can be compensated by clarity in the role definitions and role levels. Secondly, the

Table 2: Physician patient reach (sample data)

Practice size categories (No. of patients)	< 500	500–1000	1000–2000	2000–2500	2500–3000	> 3000
Percentage of physicians in category	2%	6%	10%	55%	12%	15%
Patient reach levels		18% (Low)		76% (Medium)		15% (High)

Influence and reach scores:

Customer Name/ID	Profession	Total Role Score	Reach Score
A	Physician	2	Low
B	Physician	9	Low
C	Physician	7	High
…	…	…	…

Customer Name/ID	Profession	Total Role Score	Reach Score
A	Pharmacist	5	Low
B	Pharmacist	6	Medium
C	Pharmacist	3	High
…	…	…	…

Customer Name/ID	Profession	Total Role Score	Reach Score
A	Health Insurer	8	Medium
B	Health Insurer	3	High
C	Health Insurer	5	High
…	…	…	…

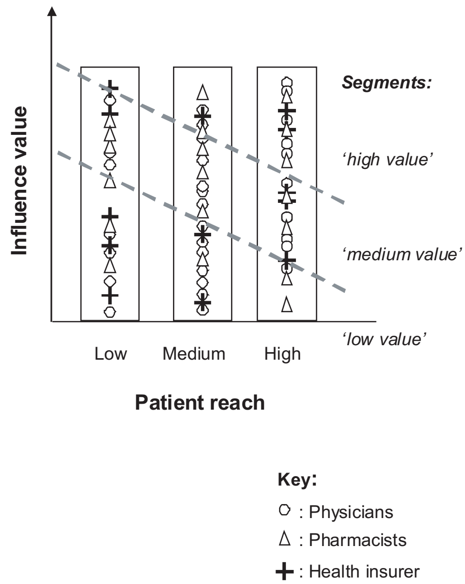

Figure 2: Example of populated customer valuation matrix (only including three customer groups)

proposed model would 'co-exist' with the existing valuation model for prescribers, without actually integrating it. This allows a validation of the classification of prescribers in the new model. A practical implementation of the proposed model resulted in most high-value prescribers from the existing model also being identified as high-value in the new model. It also led however, to the identification of new high-value prescribers, especially based on their numerous different roles. In the long run, it is expected that as the pharmaceutical companies increasingly target the healthcare customer network, an integrated valuation model will replace discrete valuation approaches.

CONCLUSION

The proposed approach provides a pragmatic way to coherently identify high-value prescribers and non-prescribers across the healthcare network. The ability to better target customers will become more critical for pharmaceutical marketing departments as pressure increases to optimise promotional budgets, especially that of the field forces. However, designing and adapting the model is only the first step. Practical challenges need to be addressed to collect, validate and maintain the data to populate the model. Furthermore, once high-value customers have been identified, appropriate value propositions need to be defined to gain their trust and leverage their influence. Interestingly, the role-based approach provides a concrete starting point to articulate these value propositions. Customer needs are indeed more associated with their role than their profession.

References

1 Wilson, A.L. (1994) 'Influencing prescribers', *Topics in Hospital Pharmacy Management*, **14**(3), 40–46.

2 Mintzberg, H. (1983) *Power In and Around Organizations*, Prentice-Hall, Englewood Cliffs, New Jersey.

3 Luker, K.A., Hogg, C., Austin, L., Ferguson, B. and Smith, K. (1998) 'Decision making: the context of nurse prescribing', *Journal of Advanced Nursing*, **27**(3), 657–665.