Session 2

Addressing the trust issue: From share of voice to share of care

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Abstract The pharmaceutical industry is looking for answers to the trust and public image issues it is facing. Public relations and corporate social responsibility initiatives fail to address the root causes of those issues. Using networks as a framework to understand the changing nature of the healthcare environment, the paper proposes a shift from the traditional marketing metric of share of voice to a more balanced approach to measure the value the industry is creating: share of care. The paper outlines the high-level organisational implications of implementing this change.
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A GROWING DISCONNECT

While a couple of decades ago, pharmaceutical representatives were often the primary source of information on medical and pharmacological developments for physicians, the value added of those interactions has significantly deteriorated as representatives focus on maximising their coverage and frequency. The erosion of the physician–representative relationship is symptomatic of a wider disconnect between the pharmaceutical industry and the healthcare system as a whole. Decreased levels of trust and a deteriorating public image are empowering governments, themselves struggling to sustainably fund the delivery of health, to increase the pressure on the industry's margins.

Short-term corporate initiatives to address the trust issue are only 'skin-deep'. They are often driven by noncore functions such as corporate communications or corporate social responsibility departments or in some cases are even outsourced. These projects will change the discourse, but not the behaviour of the customer-facing staff. At best, the impact on the long-term perception of the environment will be limited. At worst, these initiatives are seen to further widen the gap between the industry's communication and the perception the consumer environment has of its business behaviour.

Looking at the market as a network of stakeholders, this paper proposes a shift in the way companies measure the value they create as a first step for long-lasting change.

AN OVERUSED METRIC?

A traditional metric for pharmaceutical sales and marketing organisations has

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been that of 'share of voice', that is the exposure physicians get to the representatives detailing a certain product, relative to the total exposure they are getting to the all representatives detailing products in the same therapeutic class. Meant as a leading indicator of sales, the use of the share of voice metric drove a relentless focus on prescribers. Pharmaceutical representatives are incentivised to maximise the quantity of product-centred, transactional interactions with physicians. Measured on their ability to convey a standardised marketing message, representatives have little incentive to identify and respond to customer needs beyond that specific product, reducing the value of the sales call.

The management attention given to that metric has provided the rationale for the surge in sales force numbers observed in the last two decades. Predictably, the growth in the number of representatives led to access problems. Physicians, overwhelmed by the number of representatives in their waiting rooms (sometimes for the same product), disappointed by the short tenure of these representatives and in some cases, by their lack of experience, started to limit the time they spent with each representative. An increasing number of prescribers now simply refuse to see representatives. More worryingly, some medical institutions and even some governments have taken steps to limit industry access to medical staff. While the pharmaceutical representative was seen as a trusted, respected knowledge provider, they increasingly seem to become part of the trust problems the industry is facing.

Ultimately, there are signs that the correlation between share of voice and sales is fading. Some companies have seen their sales stagnate while they have increased their share of voice. Partly in response to these diminishing returns, partly as a result of external cost pressures, key players in the pharmaceutical industry have recently taken steps to reduce the size of their sales forces.

The question facing sales and marketing executives is whether to continue to do the same with fewer people. One answer is to improve targeting models, focus on the 'high-value' prescribers and continue to maximise the number of product-focused interactions. What should be examined, however, is whether the share of voice concept, with such a successful track record, is in fact the right model for the future. To address this question, it is necessary to consider how the healthcare environment has evolved.

THE NETWORK IS THE CUSTOMER

The healthcare environment has always been a network. In its simplest expression, the network consisted of doctors diagnosing and prescribing, a pharmacist dispensing, a payer footing the bill and a patient complying. Direct interactions between these players were limited in number and intensity. The environment is however becoming more networked in two key ways. First, the number of stakeholder types involved in the network is diversifying. Secondly, the frequency and speed of interactions between stakeholders is increasing. This change is in part driven by the following factors:

- *Economic pressure*: As payers face growing difficulties in footing the healthcare bill, reforms of the healthcare system are being implemented. While patterns differ, European governments are taking steps towards partial deregulation of healthcare systems in the hope of achieving a degree of market-driven efficiency. A side effect of these changes is to increase the interaction level between network stakeholders as they are forced into collaboration. Examples of this are the German Diagnosis-Related Groups (DRG) or the English practice-based commissioning,

which are both resulting in more frequent interaction between primary and secondary care players. Another result of these reforms is that nonprescribing stakeholders are gaining influence in terms of the prescription of drugs. Institutions such as the UK NICE or the German IQWiK have now established themselves as major influencers in their respective healthcare systems. Lower down the decision-making process, administrators in regional health authorities and insurances are also increasingly impacting the prescription process, or at least restricting physician freedom to prescribe.

- *Technological evolution*: Technology is enabling more frequent direct interactions between peers (eg physician online forums) at practically no cost. Whereas the role of connecting physicians with common interests was in the past in part played by the pharmaceutical representative, doctors can now more easily connect and interact online. In addition, their ease of access to independent medical information has improved drastically as platforms such as the Cochrane Collaboration for Evidence-based information have multiplied.
- *Social changes*: In conjunction with the access to information enabled by technology, there are changes in the relationship of society to healthcare. More informed patients are taking a more involved role in the decisions concerning their own health. Patient advocacy groups have become an increasingly important stakeholder group in the healthcare network. They have learnt how to effectively influence decisions such as treatment guidelines and reimbursement.

These are just some examples of how the complexity of the network is growing. The key consequence is that the single, centrally important decision maker, the target of share of voice-driven activities is actually less important, giving way to a network of tightly interrelated professionals, advisors, informants, budget holders and policy makers. These stakeholders influence the prescription of pharmaceutical products, but they have different motivations for doing so. In addition to treatment decisions for individual patients, they are responsible for improving the overall health of a given population and containing the costs of healthcare provision. For both these new stakeholders and the prescribers, the industry is looking for new ways to create value by bundling products with services, going beyond the product alone and addressing the needs of the healthcare network.

BALANCED VALUE CREATION

At the core of the discussion lies the question of the value pharmaceutical comapanies are providing to the healthcare network. The industry focuses much of its communication on its track record of bringing to market innovative products. If, however, sales and marketing executives have a clear understanding of their market share and share of voice, they are less able to articulate what impact their products are having on the healthcare environment, in terms of improvement of patient population outcomes and cost. To address these diverse needs of the network, it is proposed to adopt a more complete model to capture the full value the industry is creating, a 'share of care' set of metrics:

- *Health effectiveness*: The improvement of health outcomes is part of every pharmaceutical mission statement. Beyond the somewhat serendipitous process of bringing to market the best drugs, there is a real need for pharmaceutical companies to create transparency around the health outcomes of their products. The collection and communication of evidence has to extend beyond the data required for the approval and reimbursement process.
- *Health efficiency*: One way or another, the cost of providing healthcare will come under control. So far, most stakeholders have been working on how to shift these costs onto other players, in essence playing a zero-sum game. Pharmaceutical companies usually defend this position putting forward their

high R&D spending, their driving role as innovators, the relatively short period of patent protection and their commitment to shareholders. If companies do however want to be seen as partners by the healthcare system, and as truly integrated into the healthcare network, there is a need for them to develop solutions that can control the cost of care for the network as whole. These solutions will need to go beyond the provision of products and address the full cycle of care, from prevention to diagnosis and compliance.

- *Profitability*: Pharmaceutical companies, like any other company, are valued on their ability to generate profits. Logically, most internal metrics are geared to incentivise staff accordingly. This will continue to be the case, but to draw a parallel from corporate social responsibility field, the point is that profitability, transparency around health outcomes and evidence of the ability to keep costs under control are not mutually exclusive components of the value pharmaceutical companies are creating in the long run.

It is argued that companies that can actively balance and measure their efforts across all three proposed dimensions of value creation will be more successful in the long run than those which focus their efforts on one or the other dimension. Companies that strive for this balance internally will be more responsive to customer needs, enabling them to develop superior value propositions and laying the foundation for more trust-based relationship. In turn, this will allow for a more grounded communication of the value the industry is creating. Shifting this focus in practice does however require some fundamental organisational changes.

ORGANISATIONAL IMPLICATIONS

First of all, there is a need to develop new organisational capabilities. For example, developing the ability to understand and map existing and emerging healthcare networks is not something that is systematically done within pharmaceutical companies. Given the adequate tools, it can be achieved internally through the sales force, thus generating proprietary knowledge for a true competitive advantage. That will however require a change in the way the field force interacts with customers. From purely transactional, the interaction needs to become more consultative. From pushing a product message, representatives will need to learn how to listen to customer needs. From product-centred solutions for prescribers, representatives will need to co-develop solutions with a range of stakeholders within a given network or account. These changes in capabilities require a significant amount of re-training and in some cases the recruitment of a different type of representative.

Secondly, there is a need to redesign the organisational structure. Healthcare networks are by definition local in nature. Identifying and addressing their needs will require higher degrees of autonomy and regional focus. While most organisations subscribe to the concept of empowerment, field forces are still very much centralised, operating in national brand teams across entire markets. A network-centric model would have one central point of contact or owner of a healthcare network, owning a portfolio of products and supported by a multi-capability team, including marketing and medical.

Finally, there is a need to rethink the metrics that drive organisational behaviour. The focus on quantity, such as the coverage and frequency metrics, has in part created the trust and access problems the field force is facing. Ultimately, there is a need to align the internal performance indicators with the value objectives the company has defined. Following the 'share of care' approach for example, would result in including metrics on the evolution of

health outcomes for a given population and the cost of providing those outcomes. Including such metrics at all levels of the organisation will help align organisational behaviours with the needs of the company's customer base.

FROM SHARE OF VOICE TO SHARE OF CARE?

Many pharmaceutical executives are searching for solutions that address their access, cost, trust and public image issues. Quick-fix solutions such as corporate social responsibility initiatives, plain headcount reductions and more targeted call drives are unlikely to help as they do not address the diverse needs of an increasingly networked customer base. For long-term change, companies need to re-think the way they measure, drive and communicate the value they create. Shifting away from quantitative metrics such as 'Share of Voice' to a more balanced measure of the value created, such as the proposed 'Share of Care', is a concrete step in this direction.