KAM in the pharmaceutical industry

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Is the pharmaceutical sector different from others?

There are broadly speaking two different approaches adopted in the Pharmaceutical industry, and whilst they have the same customers and operate in the same market place the business models are fundamentally different. The big names you are likely to know, like Pfizer, GSK, Novartis and Roche, spend billions of dollars on R&D to produce innovative medicines which they patent. They then have 10-15 years of exclusivity, during which time the focus of their promotional effort is on healthcare organisations, senior physicians and others to ensure the new medicine is understood, available and utilized in the most appropriate patients.

Being patent protected the brand is strong and customers can only obtain the medicines from the original manufacturer. Governments encourage innovation in the pharmaceutical industry and as such support higher prices during the patent protected years in order to allow the innovative companies to recoup their R&D investments.

In contrast, once innovative medicines lose their patent protection. 'generic' pharma companies can manufacture and distribute their own 'generic' version of the off-patent brands. There is no limit to the number of companies that can manufacture generic versions, so competition can be fierce, prices and margins are much lower and branding is much weaker. Which explains why the top names like Teva, Sandoz and Mylan are probably much less familiar, even though they are also multi-billion dollar global companies.

How does the marketplace drive the KAM approach?

Both types of pharma companies are promoting prescription medicines to the same customers and organisations, like hospitals, general practice, pharmacies and payers (insurance companies, government organisations and healthcare systems). It is a curious feature of the pharma marketplace that the point of purchase may be far from the prescription decision point. The doctor or nurse writing a prescription may have made the selection decision, but is rarely paying for the product and may well not be aware of how much it costs. I don't think that's intrinsically true of many other sectors.

If the medicine is off patent and the prescription is by INN (International Nonproprietary Name) the dispenser (hospital or retail pharmacy) can generally select any manufacturer's version of the medicine. Generics manufacturers have long operated in a price competitive marketplace and are well aware that they have to appeal to their customers in different ways, because clinical differentiation in the product characteristics isn't available.

Traditionally, the reverse has been true for patented pharma companies, particularly in the days of the big blockbuster drugs. The primary focus was the point of prescription and the promotional effort was centered on the clinical difference between one treatment and another for any given medical condition. One company could score a breakthrough on a unique treatment for a large volume disease or condition. But things are changing. Most of the common disease areas like cardio-vascular, respiratory or diabetes have a range of very good treatments now and it is difficult to develop innovative medicines which make a significant difference. So governments and others are less likely to agree to fund them. Innovation in more complicated, less common diseases is still strong but populations of potential patients are relatively small. Therefore prices can be high and are not automatically accepted by those who are paying for them.

KAM is misunderstood and mis-applied in big Pharma

How does this affect pharma's approach to KAM?

Historically the prescribing doctor or the dispensing pharmacist had significant freedom to choose which medicine they used for their patients, but this has changed significantly over recent years. Nowadays governments, health authorities, insurance companies, pharmacy chains and

KAM in the pharmaceutical industry *(cont.)*

others in charge of large healthcare organizations are making the decisions about what medicines are used throughout their organizations. The individual doctors, nurses and pharmacists have to select from a pre-determined list. This has meant pharma companies have had to get better at influencing organizational decision making rather than the individual, and they have tended to appoint Key Account Managers to lead this.

Overall, KAM is mis-understood and mis-applied in big Pharma. In branded pharma companies generally the title of Key Account Manager is used to differentiate people from the clinical representative role. Key Account Managers tend to be 'commercial' representatives who have a price offer where required. Or they may be 'access' representatives who use health economic data to encourage payers to allocate funding for the use of their particular medicine. Branded pharma is further hindered in KAM by its historic success with big brands.

Key Account Managers tend to have single brand or small portfolio responsibility and there is seldom anyone responsible for true KAM, i.e. strategic responsibility for the entirety of the business between the pharma manufacturer and the customer organization.

Furthermore, KAM in big pharma is not 'professionalized': it tends not to be an optimal route for career progression and doesn't attract the grade and salary that Key Account Managers in other industries are familiar with.

Finally, because branded pharma has always focused revenue and expenses around the big brands, they have traditionally 'given away' many added value services free of charge. This can be problematic when they try to adopt a KAM approach and attribute value to goods and service previously given for free.

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So, if you consider a big branded company's approach to a large hospital institution, there may well be in excess of 15-20 people from the pharma company who interact with the hospital, most with their own agenda and with little co-ordination. This is confusing and unpopular for the customer organization and inefficient from a KAM perspective.

Generally, the generics companies have been more successful with their KAM approach because they don't have a 'big brand' mentality, they more easily adopt a portfolio approach and they don't have to think about clinical differentiation.

That sounds expensive, how can it be afforded?

It is expensive, for both sides. Physicians are very busy people and the trend is for them to allow less access for pharma company representatives. However, even though the pipeline of blockbusters has dried up, patented pharma is still a profitable business. Bringing a new drug to market is an extraordinarily expensive undertaking: 10-15 years of patent protection to recoup costs may sound like plenty of time, but years of R&D costs have to be covered, including the costs of all the failures and dead ends.

So branded pharma companies usually stick to tried and tested approaches when launching a new medicine. They will tend to recruit a completely dedicated sales and marketing team and send as many reps as they can afford to hire, to see as many doctors as they are able to access. The approach has been modified a little in response to the more specialised drugs which are now the norm, but branded pharma doesn't seem to see a 'burning bridge' that would demand a change of approach.

Patent pharma companies are, in fact, one of the last sectors to persist with large salesforces. Other sectors have segmented their customers and recast their approach, taking advantage of technology and optimising the competencies of their people, using fewer, more broadly and differently-skilled people for their customer interfaces.

A branded PharmaCo in Ireland was rather surprised to be invited to meet the senior executives of a large pharmacy co-operative, which wanted to them to consider a more strategic relationship. However, they went from that meeting to work together on a number of initiatives that originated in this more strategic approach and they worked together on a number of initiatives. Whilst it was difficult initially to quantify the benefit, the PharmaCo noticed that the customer had not asked for a price review in over a year, when historically prices had been challenged every quarter. Furthermore, because this customer had not had price reviews they noticed other customers were not seeking them either.

For small and medium customers and in some parts of the world, it continues to make sense to sell direct to the doctors. But key accounts like big hospital groups, insurance companies, health care systems, wholesalers and retail pharmacy chains are asking, increasingly loudly, for a change in the approach and a change in the conversation. I think it's risky for pharma companies to go on blocking out the message. It's not as if these customers don't know what KAM is – they get it from generics pharma companies and other suppliers too.

KAM in the pharmaceutical industry *(cont.)*

So is KAM changing in Pharma?

To some extent the 'chicken or egg' conundrum comes into play. People are unwilling to leave the safety of the old ways until they see specific examples of how KAM can work and offer more benefits. (Ed. Quote from another pharma company "Nobody ever got fired around here for doing the same thing in the same way.")

It's always easier to stick with what you know. If all the conversations you've ever had with customers have been about products and patient pathways, it's difficult to imagine what else could come into play. And that's the deeply-established experience of senior management as well. Old habits make people sceptical about new ideas and rob them of the confidence to open up new conversations. Nevertheless, there are some great examples (see panel). But even these are sometimes downplayed, labelled as one-offs or unsustainable or insignificant. Why?

- Senior management sees the value of meeting senior physicians but not their senior management.
- The pharma industry is rightly subjected to very strong compliance requirements which can be over interpreted to block new ideas.
- Pharma does a lot to help healthcare professionals improve patient outcomes, but neither side has put a value on that support, so it has been effectively burned as part of the benefit of a closer relationship.
- Everyone in sales, KAM, marketing etc is geared up to produce materials focused on clinical benefits for doctors. A mind and culture shift is required to recognise that different accounts like wholesalers and retail pharmacies require different messages in different forms.
- If you're a senior manager whose importance is evidenced through a substantial budget and staff, would you welcome a new approach that might mean rearranging responsibilities and budgets, and even downsizing your department?

What about the future?

Nevertheless, the future for KAM in pharma is strong - large healthcare organizations are looking for support from suppliers to help them achieve their goals. Decision making is shifting away from individual healthcare professionals to the organizations that employ them, and the innovative pharma model is moving away from blockbusters to niche medicines. Whilst these factors don't quite constitute the 'burning bridge' that will drive a sudden and significant change of approach, the trajectory is clear to see.

Big Pharma is well placed to adapt to these changes, but it will require a significant review of traditional approaches. KAM needs to be made a more senior role with a strategic focus, portfolio responsibility, budget ownership and authority to make decisions. The value proposition needs to shift from brand centric to customer centric and the organization needs to adopt a holistic, coordinated and co-operative approach to working with the world's largest healthcare providers.

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