Marketing Communications in the Pharmaceutical Industry

Edited by Peter Holden

FOREWORD BY JAN LESCHLY

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TO MATTHEW AND DOMINIC

ACKNOWLEDGEMENT

The editor would like to express his sincere thanks to June Smith for her help and advice during his writing and editing of this book.

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Foreword

The pharmaceutical marketplace is a dynamic, rapidly changing environment. Change is occurring at a pace, driven by internal and external forces. The restructuring of health services around the world, the establishment of the EEC, the opening up of global markets, the need for cost benefit studies and quality of life assessments are all putting pressure on pharmaceutical companies. Greater effectiveness and efficiency will be required, and there needs to be a particularly significant emphasis on total quality.

The need for a reappraisal of traditional marketing is of paramount importance. More than this, however, is the absolute requirement for coordination and integration of all aspects of the marketing mix. Thus marketing, medical, sales, communications, training, PR and advertising disciplines should all be meeting and exchanging vital information on a regular basis. Only those organizations which successfully manage all aspects of the marketing mix will be able to respond to the changing environment.

Marketing Communications in the Pharmaceutical Industry examines the principal elements in the marketing communications process. The various authors, with a depth and breadth of experience, give a fascinating insight into all the activities involved.

I welcome this unique book, which will be valuable reading for all those involved in marketing communications in our industry. The better understanding of the processes described can only lead to more successful business practice.

Jan Leschly
Chairman
SmithKline Beecham Pharmaceuticals

List of authors

Peter Holden is Managing Director of the Healthcare Division of Group Public Relations PLC and was previously Managing Director of Ethical Communications. He began his career in the pharmaceutical industry in 1969, as a representative with Schering AG. Following various jobs in sales and marketing, he moved in 1985 to Fisons where he set up their Communications Department and then became Head of Marketing and Communications.

Val Seddon founded Output Communicators in 1990 and advises clients in the pharmaceutical, chemical and healthcare sectors. Her internal communications work includes the creation and implementation of bespoke programmes to address the issues arising from relocation, reorganization and rebranding. She has worked extensively in corporate communications both in-house and in consultancy in Manchester and London.

Victoria Elegant is Medical Director with Nihon Schering, the largest subsidiary of Schering AG, based in Osaka, Japan. She moved to Schering in October 1991 from Fisons, where she was Medical Director in charge of a department of 35 people responsible for clinical research, medical services and regulatory affairs in the UK, Africa and the Middle East.

Alec Stewart worked in sales management in the pharmaceutical industry for over 25 years, latterly as UK Field Force

Manager with Geigy Pharmaceuticals. Since 1985 he has been an independent management consultant. He has initiated and helped to develop national training courses for the primary healthcare team, several of which have provided major sponsorship benefits to a number of pharmaceutical companies.

Phil Welch's ten-year career in advertising has seen him running two top healthcare agencies – Suddler & Hennessey and currently HealthCom London where his responsibilities range across the full spectrum of healthcare communication, from hospital products through to consumer-driven non-prescription drugs. He was originally a sales representative with Mead Johnson and subsequently worked in product management with Wander Sandoz.

Neil Kendle is Managing Director of Fusion Communications, the first healthcare agency to win *PR Week's* coveted 'best small consultancy' award. He spent his formative years in the pharmaceutical industry and was one of the first to recognize the potential of PR in this sensitive environment. In his ten years in healthcare PR he has helped establish this discipline as a vital element in the marketing mix.

Chris Ham is a Fellow at the King's Fund College and Professor of Health Policy and Management at Birmingham University, and works closely with chairmen and members of health authorities and trusts, and with senior managers. He has previously held posts at the universities of Bristol and Leeds, and at the King's Fund Institute, and as well as his work in the UK, has been involved in health services in many other countries.

1

Pharmaceuticals - the Ultimate Gamble?

Peter Holden

Britain's pharmaceutical industry is one of the great success stories. Whilst industry in general is in the doldrums of recession, the pharmaceutical industry moves ever onwards. In 1990 it earned a record trade surplus of £1 billion, a 15% increase over the previous year, and there is no reason to believe that this trend will not continue into the next century. 13 of the 50 most widely prescribed drugs in the world were developed in Britain; three of the six best selling drugs in the world were developed by British companies; and four of Britain's biggest companies by market value are involved in pharmaceuticals manufacturing. A great success story, but despite its successes the pharmaceutical industry faces increasing difficulties. As we approach the twenty-first century these are twofold: on one side there is pressure on prices from the National Health Service (NHS) management changes; on the other, drugs are becoming more expensive to research and develop.

Current estimates are that for every 10,000 compounds investigated by the industry for possible development into a new drug, only one emerges through all the trials and reaches the marketplace. With such odds stacked against it, the pharmaceutical industry is involved in a constant gamble. The stakes are indeed very high and so are the rewards if the gamble pays off. It takes an average 12 years and £120 million to bring a new drug to the market. This leaves only eight years of patent protection to recoup the cost and make a return on the investment. After this time the patent expires and any one of the generic manufacturers may copy the original compound; and having not had to bear the research and development costs they can sell the generic drug much more cheaply.

The nature of the gamble in pharmaceuticals is serious. Only eight years to recoup the cost and maximize the return with a healthy profit means incredible pressure on the business end of the company in order to get the marketing absolutely right. Many very good new drugs have failed to meet their full potential because of poor marketing, missed opportunities or changes in the market environment which were not forecast.

If a company fails to produce enough big new drugs it will not be able to grow in real terms. Such a company will stagnate and be a target for takeover or merger. As new chemical entities become more scarce and take longer to develop, more and more strategic alliances are taking place. Co-promotion and co-marketing deals are becoming frequent, allowing companies to carry extra weight and make more noise in the marketplace.

Selling to a single customer

A unique factor influencing the pharmaceutical industry in Britain is that it has in the main only one customer, the National Health Service. In 1990 the total expenditure on healthcare services was estimated to be about £32 billion; in 1995 this is estimated to be in excess of £40 billion. The NHS

accounts for 90% of healthcare expenditure, the balance being in the private medicine sector.

Expenditure on healthcare has increased significantly in recent years: there was a near eightfold increase in per capita health spending in the last 15 years. A major factor contributing to this dramatic rise in healthcare expenditure is the increase in size of the ageing population, which places a more frequent and greater demand on services. Additionally, the cost of manpower services within the NHS is significant: more than half of the total NHS costs are accounted for by the wage bill.

The Government has responded to the twin threats of escalating costs and growing demands on services, and major reforms have been introduced. In January 1989 the White Paper *Working for Patients* was published, which signalled the Conservative Government's intention to instigate wide-ranging reforms in the NHS. *Working for Patients* came into operation in April 1991.

The government reforms have been founded upon the tenet of market forces. In effect, an internal market has been created which is intended to shorten the lines of communication between doctor, patient and the Government. Competition is the main ethos, with the appointment of business managers to implement the competitive process. The principal targets for the NHS reforms are the control of the rising costs in the hospital sector, and the increasing costs of drugs.

Pharmaceuticals represent a relatively soft target for the Government compared with other forms of expenditure. The pharmaceutical industry is policed by its own organization, the Association of the British Pharmaceutical Industry (ABPI). To date the ABPI has been none too successful in pleading its members' case to Government and it is doubtful if it will ever be more than the reactive moribund body into which it has developed.

The NHS reforms, prescription analysis and cost data (PACT), indicative drug budgets, practice budgets and formularies will all place a downward pressure on drug expenditure.

Impact on industry

There will be many and various effects of the NHS reforms on the pharmaceutical industry. Companies have already begun to realize that, whereas they had previously sold their products to doctors, now a whole new customer audience needs to be addressed. This new audience will comprise not only the medical profession, ie prescribers, but also key decision-makers in the new NHS. Family Health Services Authority (FHSA) managers and medical advisers are of fundamental importance to companies, as are regional pharmaceutical officers and members of formulary committees.

Already companies are realizing that communications to the new audience cannot be facilitated merely by increasing the size of their sales force. Communications have to be specifically targeted and focused on the key decision-makers and skilled negotiators are needed. Business managers focused on NHS managers are now becoming commonplace in those companies who are 'ahead of the game' in their response and reaction to the changing environment. It is becoming apparent that specific 'high-cost' areas are being targeted by the new breed of NHS managers. Non-steroidal, anti-inflammatory drugs (NSAIDs), antibiotics, cardiovascular and anti-ulcer therapies have been identified as areas where doctors believe that treatment is unjustifiably 'high-cost'.

Those companies involved in the above therapeutic areas will need to respond to the downward pressure by skilfully using cost benefit data, quality of life studies and educational initiatives in order to make their position viable and continue to thrive in a hostile environment.There can be little doubt that in the current 'anti-pharmaceutical company' environment the speed of new product uptake will slow, and there will be an increased move to generic prescribing.

Response to change

Change is a stimulant or a narcotic. Depending on your response or viewpoint you can either be a rat or a squirrel. When changes in the weather become apparent the squirrel heads for its hole and hibernates for the winter; the rat meanwhile goes about its business and produces more rats with no regard at all for the weather. It has been said that a squirrel is only a rat with good PR!

Pharmaceutical companies will need to respond to the changing environment by a proactive response and a shift in emphasis of their promotional machines, and the need to respond to the downward pressure of indicative budgets and formularies will lead 'thinking companies' to question and reconsider their marketing mix. Advertising and sales as direct promotional activities will be there but they will not be so much in the forefront. 'Below-the-line' communications activities involving a whole panoply of activity will begin to predominate. Educational initiatives, media relations, third party endorsement, marketing communications through symposia, seminars and publications, will become a more significant force.

Marketing communications in the pharmaceutical industry will be the main pieces which make up the jigsaw which gives the big promotional picture.

2

Internal Communications

Val Seddon

The importance of the internal market

Issues surrounding the pharmaceutical industry

From animal experimentation and profits to side effects and 'wonder drugs' there is much about the pharmaceutical industry to stimulate comment, if not actual motion. The media's love-hate relationship with the industry is a passionate one and acres of tabloid coverage are readily devoted to perceived successes and failures, particularly the latter.

People working within such an industry, which provokes very strong views – both positive and negative – among the general public, can often feel challenged. In addition to reacting to the views expressed by family and friends, employees also have their own prejudices and preconceptions. They need information in order to respond positively,

and it is only by being well informed about their employer's business and the issues surrounding it that they can defend and even champion themselves, their employer and ultimately the industry.

A heritage of secrecy

For many years the industry's response, both corporately and in terms of individual companies, was to stay as far below the parapet as possible. In external relations, tactics have been changing for some time: this is reflected in the increasing importance attached to public relations teams and the developing sophistication of the external advisers available to them. Like all good salespeople, pharmaceutical companies have begun to address objections directly. Nevertheless, while marketing and communications professionals have pushed forward the boundaries of external relations, the heritage of secrecy is still strong and internal relations may be its last bastion.

It is still possible to find otherwise well-produced house journals, the content of which bears little relation to the business of the company which produced them, and in which working life is depicted as a jolly round of parties, presentations and carefully back-lit managing directors. The pharmaceutical industry is by no means alone in contributing to that bland and sanitized view of internal communications, but it is a regular offender. Even when international corporate policy advocates openness and debate, local management may take the view that the less said the better.

Every employee a PRO

The mythical target of 'every employee a PRO' is just that. Even pharmaceutical companies are not stuffed from delivery bay to boardroom with skilled presenters, each with a broad

grasp of the company's position on a range of complex issues. Yet it is not unreasonable to suggest that the warehouse foreman should know the main disease areas in which the company specializes, that the sales secretary should understand the timescales involved in clinical trials, and that the representative in Caithness should be aware of business initiatives in Cairo.

If internal communications helps employees to do their jobs better, and to feel better about the jobs that they do, then its costs are justified. In any industry a well informed workforce is conducive to better business performance.

> The internal communications process should make every employee feel that he wants to speak positively about the company.

Defining ownership

Own the system or use it?

If internal communications is about helping people – and hence companies – to understand and achieve targets, we might make the assumption that responsibility for internal communications automatically falls within the marketing function. This is not necessarily the case. From personnel to finance, from local site manager to the corporate parent hovering in the background, there are many who have an interest in and seek influence over the internal communications function. Internal communications involves access to and control over information and in any company this equates automatically to power.

> The first question which any marketeer considering internal communications must answer is whether he wishes to own the system or simply use it.

Contenders for ownership

A well-structured and professionally managed communications programme should meet the needs of all senior managers since, ideally, both system and managers are geared to the common goal of meeting the company's objectives.

The realities are often rather different: responsibilities for communicating with staff can be fragmented and parent companies, individual sites, training departments and personnel departments all muddy the waters. In addition, the presence of so many European and American companies within the industry means that there is often a strong flavour of other cultures in corporate communications which then sit uneasily alongside the local product.

The marketing manager with a message to deliver to the internal market will review the media currently available within the company, and his access to them. If the vehicles available do not suit his purpose, he must seek to introduce tactics which are as measurably effective as the rest of the marketing programme. The politics of such a manoeuvre will vary greatly according to the size and culture of the company, but the mechanics are logical, quantifiable and can be practically applied.

Establishing and agreeing objectives

Communications planning is as precise as any other aspect of the marketing mix and to embark on internal communications

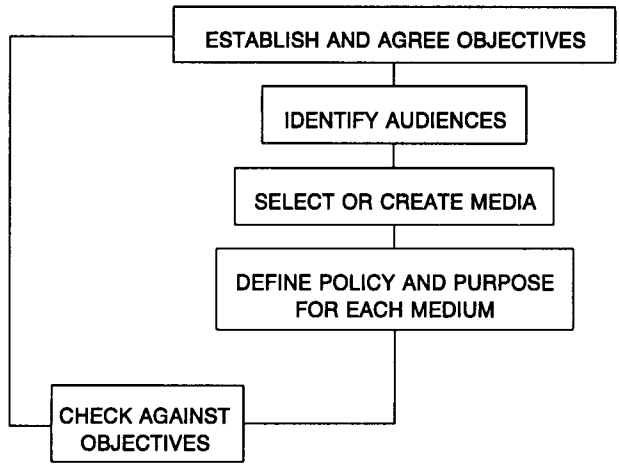


Figure 1. The communications process.

without specific objectives is to court disaster – or failure at the very least. The very worst examples of internal communications are the house journals produced 'because a company as big as ours should have one'. Such publications do tend to have their roots in corporate rather than marketing communication, but marketeers are not immune from such ills. Without clearly defined objectives, agreed at appropriate levels, it is relatively easy for a publication originally conceived as a motivational tool for the sales force to end up as a low-level information sheet distributed throughout the company.

Stating and agreeing communications objectives is vital when introducing new media, but equally important in order to assess the effectiveness of existing media.

Communications objectives range from the broad and long term, eg 'to provide the workforce with a regular overview of the company's operations and its position within the

marketplace', to the very specific and short term, eg 'to educate and motivate the sales force prior to the launch of Product X'. At this stage it is not necessary or even desirable to specify the media to be used.

Time spent drafting and agreeing communications objectives is time well spent. It is the yardstick against which the effectiveness of both individual tactics and overall programmes can be assessed. However, even the most carefully crafted objectives only become valid once they have been agreed. With those objectives agreed at senior management level, it should then be left to communications specialists to devise and recommend the means of delivery in order to meet objectives within budget.

Identifying the audience

All internal communications make demands on the recipient's time and compete for attention against all his other business tasks and leisure activities. Both the secretary reading the house journal over a lunchtime sandwich and the representative listening to a marketing update tape while driving down the motorway have a choice, and could read and listen to something else; they will only select the company's communication if they perceive it to be interesting and relevant. To meet these criteria, internal communications media must be tailored to their target audiences.

Audiences can vary widely within the industry, drawn from elements of the following:

- sales and marketing
- production
- medical
- research
- administration.

Add the various types of job within each function, from product manager to machine operative, from sales secretary to marketing director, and the result is a complex matrix of specialities and interests.

> Accurate identification of the target audience is a key step towards tailoring both the style and content of internal communications media.

Selecting the communications media

Publications

The printed medium, from lavish quarterly magazines to photocopied briefing sheets, is a classic communications route. As with all other communications tactics, the principles are the same: establish objectives, audience, policy and purpose and all else will follow – including design.

It is particularly important that design should follow, and not lead. Too often house journals, newsletters, product bulletins etc are designed into existence rather than being the result of a planned communications strategy. This is a particularly easy pitfall within an industry accustomed to striking, not to say lavish, print work. Design, especially for those who are not full-time, professional communicators, represents an area of light relief, a break from routine.

> Do not rush into design concepts which satisfy aesthetic desires but not practical communications needs.

Printed material can be equally suitable for wide-ranging or very selective distribution and like all internal communications tactics, may find its way 'outside' the company; certainly it is often perceived as the most likely to get into public areas, and is therefore regarded as the most sensitive.

Audio communications

Audio tapes can provide a fast, effective and relatively low-cost communications route. They are especially useful for communicating with representatives, who have both opportunity and facility to listen to tapes in their cars.

It is particularly important that audio tapes are professionally produced. Writing and recording for audio is a specialist technique, even more than the printed word, and pace, duration, length and style of sentences, and tone of voice are all critical factors. Tapes are particularly well suited to sales messages, but the product manager who undertakes to create his own tape without expert involvement may never be allowed to forget it.

The role of audio in communicating with a sales force is well established but its on-site equivalent, the telephone message line, can also be useful, particularly at times of change such as mergers, relocation or launches when news needs to be updated regularly. By listening to a taped message, on a specific extension, callers from a number of locations can access news bulletins which are regularly updated.

Video

Even now, after nearly 20 years, video remains the glossy toy of the communications industry. It is still expensive to execute properly, yet the cost of doing it badly is almost incalculable. It invariably gets cut at the first sign of financial stringency, which raises the question 'Need it have been used at all?'

Yet, like every other communications tool, video has functions to which it is well suited: the employee annual review, new site openings, a major product launch. It can also perform well on international communications, conveying locations and personalities to audiences who would not normally expect to see them.

As with audio, the key is to use professionals with appropriate experience and, in this case, to resist the temptation to reduce the budget below the point at which the savings start to show on screen.

Briefing systems

The theory is that team briefings, cascade systems and the like are all part of a well coordinated matrix which links the internal calendar of detail cycle, sales conferences and board meetings to the external activities of product launches, external media relations etc. The politics of why team briefings so often take on a life of their own are beyond the scope of this chapter. Suffice it to say that they are all too often about access to and control over information rather than its effective dissemination.

'Management by walking about', top-down communications, flat pyramids, matrices, networks, team briefings etc all have their place as part of a system of management. However, they should not be used as justification for constant navel gazing. There is a danger that those who have access to communications channels become obsessed by their own role, and seek to elevate some laudable mechanics of good communications beyond an art form and into a religion!

If they are to play an effective role in internal communications, briefings should conform to the same criteria of policy and purpose as all other media. Furthermore, the managers preparing them should maintain close liaison with the company's professional communicators to ensure that tone of voice, timing etc are well synchronized.

Defining purpose and policy statements

Almost every medium of communication embodies a chameleon-like quality, prone to take on the shades of its environment. Many external influences can impact on it, not least the personalities of individuals involved in its creation. Strong personalities, not unknown in the fields of marketing and communications, can mould a publication or other communication into a vehicle for their own ego or use it to fulfil some unwritten agenda.

The purpose and policy statement clearly sets out what a publication, tape or video is intended to achieve and how it will achieve it.

PURPOSE	POLICY
Communications objectives	Frequency
Target audience	Format/design
Scope	Outline content
Style	Ownership/clearance
	Distribution

Figure 2. The purpose/policy statement.

Purpose

Communications objectives and *target audiences* have already been addressed; both fall fairly readily within the marketeer's remit. *Scope* and *style* represent the point at which the skills of the communications professional, and also the corporate politician, come into play.

The *scope* of, for example, a newsletter will determine many things: who contributes to it, who has to see it before publication, who pays for it. When setting down the scope of a publication, the editor would do well to consider the extent to which he wishes to encourage the involvement of others.

- Will it have an international dimension – in which case will corporate relations want to see it?
- Will it have an educational function – in which case will training want to approve it?
- Will it have any role outside the company – in which case will medical have to sanction it?
- Will it be geared primarily with the detailing cycle – in which case sales can pay for it!

The *style* simply sets out the tone in which the article is to be written or produced. For example, the specified style for an audio tape series may be 'a fast-moving masking programme, interspersing extracts of recent press comment with sales force interviews and up-beat music'. In contrast, the style guide for an international research bulletin may read 'an elegant, thoughtful publication, using spacious, modern design to convey values of innovation and professionalism'.

Having established these parameters, the statement then moves on to define an editorial and production policy.

Policy

Frequency is vital not only as a guide to the topicality of the publication, but also as an aid to budgeting.

Format and design will normally be produced by a professional designer and will set out all the physical characteristics of the publication, eg:

- title
- size (pages or duration)
- use of colour
- typography and layout
- visual images.

Outline content sets out in broad detail the content of a typical issue, including any fixed features such as editorial, product reviews, cartoons, external contributors. It is at this point that a balance between product areas, sites, businesses should be specified, eg 'Although the balance may vary in any one issue, overall the magazine should reflect the relative sizes of our anti-rheumatic and cardiovascular product groups'.

The *ownership/clearance* statement should specify the rights of access which the editor has to individuals within the company and the system which will be followed in order to sign off copy/visuals as being approved.

Specifying *distribution* is a useful final check on the efficacy of the medium; many a good video, for example, has gone unviewed because the intended audience tended to use the pub rather than the staff restaurant where it was on show. Distribution also has an effect on production timetables and budgets.

A commitment to communication

Professionalism at all times

Having identified the need and specified the precise communications solution all that remains is to implement it. Communications is a specialist job, requiring skills which unfortunately are sometimes marginalized by the plethora of office technology scattered around most pharmaceutical companies.

> Not everyone who uses a word-processor is a writer. Not everyone who uses a desk-top publishing system is a designer.

Technology provides the communicator with useful tools, but they must be in skilled hands. Anyone with a commitment to internal communications must resist the 'painting by numbers' approach which will create something which looks like a newsletter, or sounds like a motivation tape, but in reality has no bearing on the company's real communications needs.

This raises the question of internal versus external specialists. There are many arguments for and against, but the frequency with which companies move from one arrangement to the other, and back again, suggests that either can have its problems. Broadly speaking, a dedicated in-house communications team responsible for strategic direction, origination and production of materials is a rarity, even in the pharmaceutical industry. Doing the job properly demands such a range of talents and experience that remunerating and then fully employing such a team on internal communications alone can only really be justified at international headquarters.

Like external public relations, internal communications calls for a manager who is sufficiently senior and experienced to develop and expedite policy initiatives through to relatively junior copywriters. In practice, there is an increasing tendency for in-company managers to decide overall communications strategy and then buy in expertise from a range of external suppliers who work to a brief on a newsletter or video. This is often beneficial to companies as it has the effect of breaking the stranglehold of the large agencies working on exclusive contracts with their variable strengths and weaknesses. As managers gain a greater understanding of internal communications, enabling them to source production or strategic services at will, this trend is likely to continue.

Do we really have to talk about this?

Once established, any internal communications vehicle has a duty towards its audience, in good times and bad. A commitment to communicate means that product withdrawals, accidents and midnight raids on the bunny laboratory need timely explanation. It is on the difficult issues that communicators win their spurs and once again a well thought out communications structure, with a proper role for every vehicle, will be advantageous.

It is, of course, an inescapable fact that internal communications often reflects the personalities of opinion formers within the company, particularly the chief executive. It is also a fact that those opinion formers change and that the change itself becomes a communications issue. A change of senior manager can undo, for good or bad, the ethos of an established system overnight.

When the policy and purpose statements no longer reflect the communications vehicle which is being produced, then they must be revised to reflect current thinking.

Liaising with other communications professionals

If every employee is deemed to have a potential public relations role, then this is a good point at which to consider the relationship between internal and external relations. The two must work closely together, even though internal relations is almost invariably considered to be the junior partner. External public relations gets the budgets, the high profile press conferences (and probably the agency), yet both internal and external relations are essential to the success of the marketing communications programme. Cooperation between the two should be built into the system so that, for example, all press releases are fed into the internal communications system and the timing of internal announcements is synchronized with the external programme.

3

The Role of the Medical Department

Victoria Elegant

Internal and external communication are equally important to the success of any industry, not just to the pharmaceutical industry. This chapter deals with the role that an efficient, effective medical department can play in ensuring that knowledge is disseminated within and outside the company in an optimum manner, outlining the structure, function and composition of a typical department in a local operating company, and some common problems and opportunities.

A central focus for communication

The medical department can act as the central focus for internal communication by virtue of its regular need for interface with almost every other department in the company. These functions range from the commercial focus of the business, such as sales and marketing, to basic research, finance

and legal functions. Ensuring that information flow occurs smoothly is an integral part of the work of the medical department, as key dates such as trial completions, product licence application submissions and expected approval dates are necessary for essential planning, which includes the preparation of production schedules, marketing campaigns and financial forecasts.

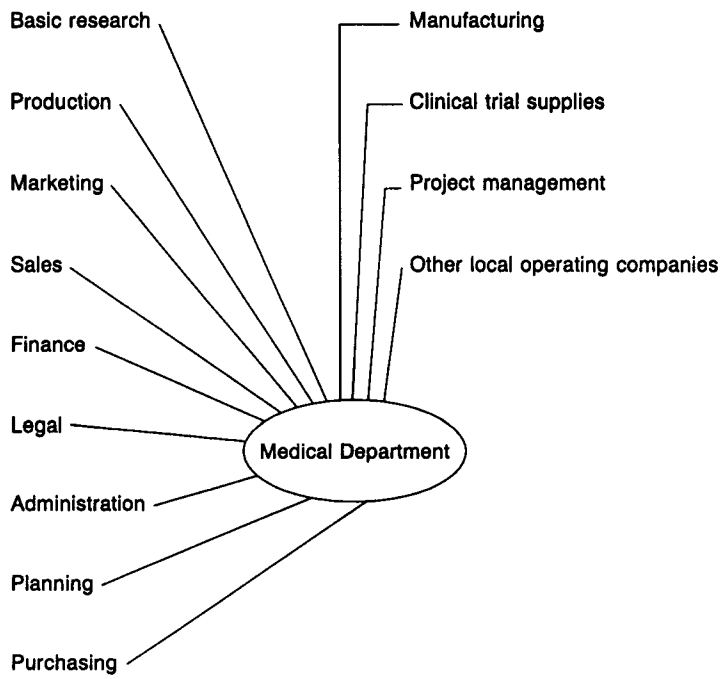


Figure 1. Internal interfaces.

Externally, the many contacts of the medical department may remain an under-utilized resource. Members of the department may be the first contact a potential prescriber has with the company, and the investigator's brochure the first written information he gets about a compound. This is often forgotten, to the detriment of the company. Carefully managed, these initial early contacts are extremely important in order to generate feedback, as a source of influence and information, and to nurture a group of product champions.

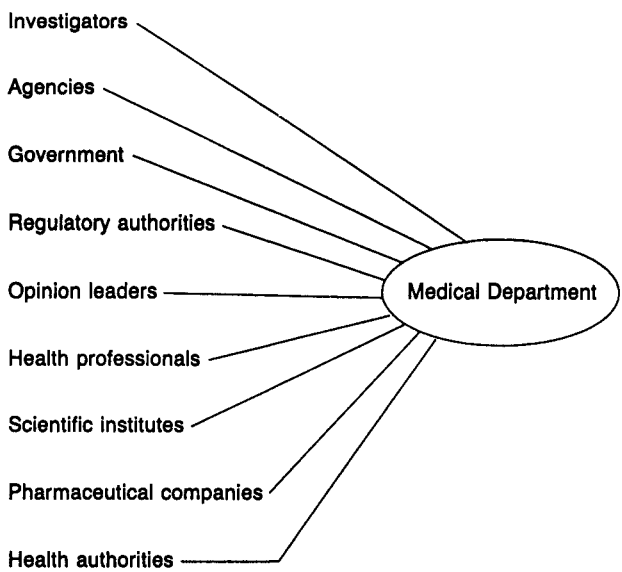


Figure 2. External interfaces.

The size of the department varies considerably depending on the size of the company; the example used here is of a medium-sized operation which is expected to be relatively self-sufficient, and where all necessary services should be provided with minimal input from central headquarters. Most of the examples cited refer specifically to activities in the United Kingdom, although generalities are of course applicable elsewhere.

Size is determined by resource requirements, which are in turn dependent on the products in development, the numbers of products being sold and promoted and, last but not least, in-company headcount and budgetary constraints. In practice, the latter often has more influence on departmental size than reasoned resource calculations. The department is a cost centre rather than a profit centre, and therefore headcount is kept to the absolute minimum, if not below needs. Good working relationships with other departments and a helpful rather than obstructive image can often influence decisions concerning staffing.

Structure and responsibilities

The department is managed by a medical director. A medical qualification is necessary in order to act as the final signatory for all promotional copy, and in this capacity the medical director has final legal responsibility for the marketing and promotional activities of the company, thus ensuring that the ABPI Code of Practice and the Medicines Act are observed. A constant reminder of the implications of this is the fact that he is the one to go to gaol should problems arise, and this can be a powerful reason to change promotional copy! The medical director, as the ethical voice of the company, has the often difficult task of balancing patient needs and safety against the company's commercial priorities.

The medical department is responsible for:

- clinical research and clinical trials
- medical services, ie dissemination of scientific and product information and technical aspects of training
- safety, ie adverse event monitoring and reporting
- regulatory affairs.

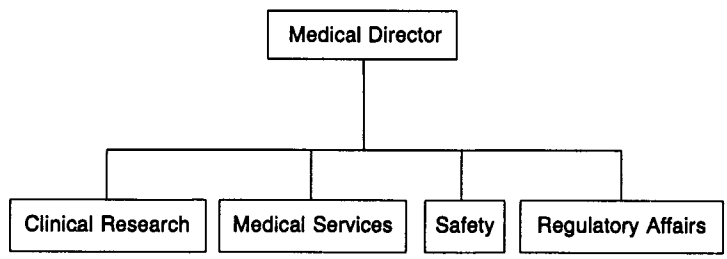


Figure 3. Typical structure of the medical department.

Some companies include responsibility for meetings and symposia within the medical area, and this is becoming increasingly common with the necessity for PGEA (Postgraduate Education Allowance) approval and a general raising of the standards and content of meetings. Certainly the department would provide a large input to the planning and preparation, particularly with respect to scientific briefings and content.

All these different functions, by virtue of the regular contact of departmental staff with opinion leaders, and their necessarily expert knowledge about products and product areas, provide essential support to the marketing, sales and communications departments.

Clinical research and clinical trials

Clinical research encompasses:

1 producing clinical development plans
2 carrying out clinical trials to good clinical practice, ie writing protocols, initiating, monitoring and closing down trials within pre-agreed budgets and timeframes
3 providing input to publication of the trials
4 providing medical expertise to the company.

Those responsible for clinical research are physicians, pharmacists and clinical research associates (CRAs). Physicians are generally expected to hold a postgraduate qualification and are employed for their medical expertise, whilst clinical research associates usually have a science degree and a postgraduate qualification and/or experience.

Clinical trials are divided into four phases and the end of each phase usually marks the point at which a review of the project is carried out and decisions and revision, if necessary, are effected.

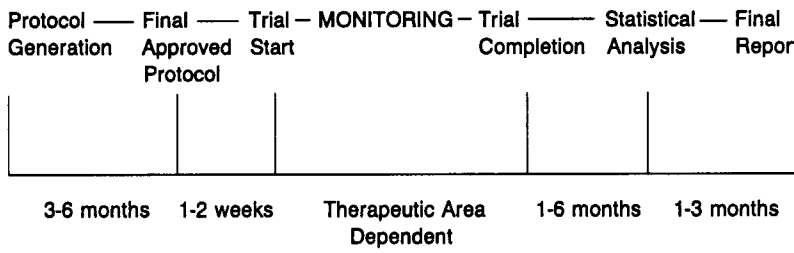


Figure 4. Time course for clinical trial progression.

Phase I

In Phase I pharmacokinetic and pharmacodynamic studies are carried out on human volunteers in order to confirm the profile of the drug as ascertained by preliminary animal models. These studies may be carried out in-house, if such a facility exists, or outside the company, either in a contract research facility or in a hospital setting specializing in a particular therapeutic area. A programme of basic research should be planned in conjunction with this early work. Most experts have both basic and clinical research interests, and a carefully planned programme of necessary basic research, designed to complement the clinical development plan, provides several positive returns:

- Relationships can be developed early with experts who may well later carry out larger clinical trials.
- Essential information about the mode of action of the compound in different models can be gained.
- Results of the basic research can be presented at meetings in a much shorter timeframe than is generally the case with clinical research, thus allowing a

continuous flow of early information about the drug, which can later be used for promotional purposes.

- Goodwill is generated as a result of providing funding, particularly at a time when research grants are becoming scarcer, as the models used will have been developed by the clinician concerned. The funding of basic research tends to be less costly than clinical research.

Opinion leaders often prefer to carry out basic research, for all the above reasons and because they may not have available the large patient pools necessary for clinical research. Thus, funding of this sort represents excellent value for money.

Phase II

Once the preliminary pharmacology and safety of the compound has been confirmed in Phase I studies, the compound moves into Phase II. The drug is administered to small numbers of patients suffering from the medical condition the drug is postulated to treat, in order to confirm the activity of the compound in patients and to determine the correct dose. The size of the programme and the numbers of patients needed depends on the proposed indications for the compound. It is clear, for example, that a compound intended to treat a chronic condition such as asthma will need larger numbers than one intended for short-term administration, such as an intravenous vasodilator.

These studies are carried out at centres of excellence which are expert in specialized investigations in particular groups of patients to show pharmacological effects, such as 24-hour blood pressure monitoring. They can be completed relatively quickly and thus are opportunities for both targeted contact and the presentation of data.

Phase III/IIIB

Large-scale trials, generally double-blind placebo controlled, are carried out in a large number of centres. As in the Phase II programme, absolute numbers depend on the proposed indication for the compound. As a general rule, at least two positive well-controlled therapeutic studies will be needed for registration. These trials are designed to confirm efficacy and safety in large numbers of appropriate patients. Increasingly, trials against competitor compounds are carried out at this phase of development in order to obtain comparative efficacy data and to have data available to market the product at launch.

It is also becoming increasingly common to include at this stage both quality of life and economic analyses. In the present climate, with spiralling healthcare costs throughout the world, most governments are looking for ways of reducing the cost of healthcare provision without being seen to be rationing treatment. Reducing the amount of the overall budget spent on pharmaceuticals is one relatively easy way of doing this without antagonizing the general public, whose perception of the pharmaceutical industry is still that of a cash-rich uncaring experimenter on animals and people. An economic analysis showing overall cost savings will help to argue for registration or, equally important, inclusion for reimbursement. These studies are mandatory only in France and Australia at the moment, but will become an important part of the registration process, either formally or informally, in most countries in the near future.

The requirement for large numbers of patients leads to contact on a scientific footing with large numbers of investigators, and provides the opportunity for 'hands-on experience' with the compound in the potential marketplace. It is an opportunity which must be carefully planned and managed, both from the external communication perspective, and to ensure that the proposed marketing concept and positioning of the drug are reflected.

Phase IV

The distinctions between Phase III and Phase IV trials are becoming increasingly blurred. Phase IV trials are generally held to be marketing support trials, traditionally against competitor compounds already on the market, but they are increasingly being performed prior to approval in order to provide data for launch, and are sometimes known as Phase IIIB trials. Post-marketing surveillance studies are carried out in Phase IV, as are all trials carried out within the terms of the product licence following approval of the drug. A better definition of Phase IV would be 'studies carried out with the sole objective of aiding the marketing and selling operations directly'.

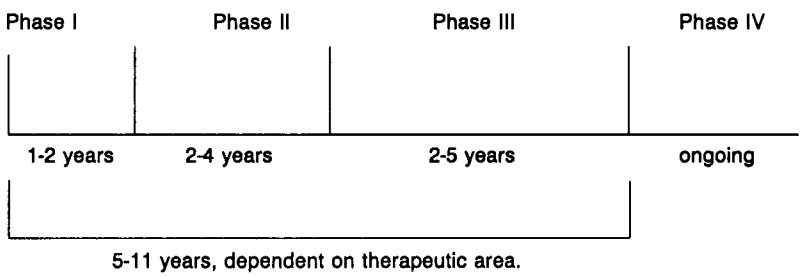


Figure 5. Time course of clinical phase of drug development.

Clinical trials and communication

The medical director and the clinical research associates who plan, implement, monitor and report on the trial programme are critical to the success of a product. They have the earliest possible contact with opinion leaders and formers, who will

carry out the initial evaluation of the compound, become trialists, and present the data from their studies at meetings. It should be remembered here that trialist is not necessarily synonymous with opinion leader, and that it is the ability to communicate which makes an opinion leader.

The first impressions of a company, and therefore of a compound, are very often formed as a result of these initial contacts, and the relationship that is built up between the investigator and the CRA may encourage trialists to provide endorsement where necessary, agree to speak at meetings, and generally support the company from the scientific standpoint. Trialists should be selected only after careful discussion between the medical, sales, marketing and communications departments, and a good rule of thumb is the 'third/third/third' approach:

- One third of the investigators should be tried and trusted trialists, with whom the medical department have worked before and on whom they can rely to produce good quality data on time.
- One third should be people with whom the company would like to work but of whom they have no experience or knowledge.
- One third should be specifically targeted people, for example those who have been negative about the compound and have not done any work with it, or an important person in an area where sales are not as high as expected.

Clinical trials can often act as door openers, and members of the medical department can often see people to whom the representatives do not have access. Thus, clinical trials not only provide the data with which compounds are registered or sold, but by close cooperation with other departments they can be a valuable and powerful communications tool.

Medical services

Pharmacists, nurses, and science graduates, including information scientists, are generally recruited to work in medical services and, as it is a service function, good interpersonal skills are an essential requirement for the job. Their responsibilities are:

1 to provide an internal and external information service on the company's products
2 to input to the legal information requirements of products, such as data sheets and patient information leaflets
3 to provide technical training on products and therapeutic areas to the company, particularly to representatives
4 to review promotional literature, in order to ensure compliance with the ABPI Code of Practice and the Medicines Act from the technical viewpoint
5 to oversee the presentation and publication of clinical trial results
6 to monitor follow-up and reporting of adverse drug reactions.

The majority of the work involves a great deal of contact with people both inside and outside the company, and departmental members must be good communicators. The role of information-provider and policeman is a difficult one to fulfil, particularly with the necessity to meet constant deadlines for promotional review, journal submissions and information provision. These functions are, however, extremely important, in that the field force are the only members of the company whom the vast majority of health professionals meet, and if inadequately trained and briefed by a poor information department they will have no knowledge base on which to build their relationships with doctors, nurses, and pharmacists. Representatives must be able to rely on a source of information which is prompt, efficient and accurate. Input and suggestions as to technical promotional items, for example slide sets, is crucial. In addition, with the responsibility for ensuring that

trial data is promptly presented and published, close cooperation and communication between different departments is essential.

Regulatory affairs

The primary functions of regulatory affairs within the medical department are:

1 to obtain product licences, including all aspects of clinical trial regulation and dossier preparation
2 to maintain product licences, including input to reviews and manufacturing practice
3 to advise on aspects of the Medicines Act, particularly as regards promotional activities
4 to provide input to the regulatory aspects of business development and licensing.

Regulatory officers are commonly science graduates and pharmacists, generally with some work experience prior to entering the pharmaceutical industry. A sizable part of the job is to review and check procedures, and thus they are in danger of being under-appreciated and thought of as policemen. However, of necessity, the job may involve contact at senior levels to obtain the most up-to-date views on practices and procedures. In the UK, many senior physicians are involved in the workings of the Medicines Control Agency, either officially or as advisers, and this potential source of contact should not be forgotten. The best way of using this resource is to ensure that those responsible for regulatory affairs understand the importance of their contacts, and inform the relevant individuals.

Focusing cooperation and communication

Managed effectively, the medical department can develop a significant role in direct support of the marketing and sales effort, rather than merely existing as a service function providing data and information. The current climate is one of restrictions on promotional spending and consumers, both healthcare professionals and patients, are becoming increasingly vociferous in their protests and accusations about the pharmaceutical industry. Part of the way to combat this criticism is to provide an 'added value' service – that is, to provide a service externally in return for sales and to be seen to be actively 'putting something back'. This can be done in many ways, but the essential similarity is the scientific basis of the activities which include:

- meetings and symposia
- regular information reviews on therapeutic areas and products
- educational training for health professionals
- educational training for patients
- sponsorship of study grants
- sponsorship of patient support groups
- provision of research grants
- provision of telephone helpline services for health professionals and patients
- sponsorship of doctors' therapeutic societies
- provision of funding for journals and publications.

The involvement of the medical department, whose staff must be experts in their therapeutic fields and their products, is

mandatory. One of the commonest reasons for the department to be under-utilized is lack of communication. The marketing and sales functions may not be aware of the use that can be made of the medical department's strengths and contacts, and this can be rectified by a combination of activities:

- making presentations to different departments, including the sales force, on services and talents available, which usually results in a flood of requests for information and help at conferences, area meetings, local doctor meetings, etc
- offering members of other departments the opportunity to spend a day in the medical area in order that they may better understand how it functions
- sending members of the medical department out to visit other departments and to see them at work.

An extremely common complaint is that nobody knows who is visiting whom and when. Medical personnel from central functions are particularly likely not to inform the local company of visits, but are by no means the only offenders. The unfortunate representative can then walk into an embarrassing situation, and be without the information he needs to handle it. This can be rectified by designing a simple form that is completed prior to any visit by head office personnel to a doctor, and circulated to the appropriate departments, usually medical, marketing and sales. It will not, of course, immediately solve all internal communication problems, but will make individuals in different departments think more carefully about their colleagues' needs.

Once internal communication has been established, external communication becomes easier. If a representative understands that he has back-up from the medical department for meetings, contact with doctors, requests for sponsorship, information etc, he can concentrate on his tasks and work more effectively. Communication does of course have a dual role, in that

representatives also feed back valuable information to the medical department.

Trialists may become opinion leaders, product champions, and speakers, who can talk with the authority of experience of the drug. This is one of the most important tools a company has, and collaboration between departments ensures that potential candidates are identified at an early stage and nurtured. Conversely, informed opinion on the suitability of potential opinion leaders comes best from those who have worked with them – usually the medical department.

Another valuable source of information and indirect marketing is through opinion leader advisory boards, whose objectives include:

- obtaining market feedback
- shaping development programmes
- a combination of both.

This board should be managed by or at least in collaboration with the medical department, so that the scientific aspects of the discussion are presented accurately and factually. Handled and managed properly, a group of six or seven senior opinion leaders can become a valuable source of information, ideas and feedback, and can also be used as product champions and spokespeople.

Communication and input to management

The medical director should be a member of the business management team. This is invaluable for regulatory input, suggestions and ideas as to strategy, market and therapeutic trends and crisis management, among others. Doctors are trained to analyse information and make decisions on limited data within short timeframes, as they do when deciding on a

clinical strategy, and this ability brings a valuable aid to the business management team, provided it is coupled with commercial awareness. Too often, unfortunately, doctors remain unaware of their commercial environment and are a hindrance rather than a help to the business. A commercially aware pharmaceutical physician is a necessity in the management team.

Summary

Clearly the primary aim of the medical department is to support the marketing and selling operations of the business. One of the commonest mistakes made by members of the department is to forget this, and to act solely in the role of 'policeman'. This is unhelpful and is not in the best interests of the company.

Internal and external communication provides many of the solutions to the problems of the industry and increases effectiveness and productivity. The first and most important lesson members of the medical department should learn is to suggest an alternative solution, rather than just to say 'no'. This applies across a spectrum of activity, from straight copy clearance issues to input to campaigns and educational programmes. If this rule is adhered to, much of the traditional enmity between the medical department and the marketing/sales operations can be easily avoided. Activities should naturally be within the framework of relevant regulations, but there is enormous scope for ingenuity in order to contribute to the final goal of all concerned – the profitability of the company.

4

The Sales Force

Alec Stewart

It has long been recognized that effective sales communication involves a two-way exchange of information, and that outgoing and incoming channels must both work effectively. This applies not only at the customer/salesperson interface, but within the marketing organization itself. A company's internal communication system must be efficient and produce the right messages for the sales force to deliver to the right people at the right time. It must also be structured to receive and process all relevant incoming information.

This is especially important in times of change, and in NHS terms these are such times, with health service managers assiduously seeking value for money. It is therefore appropriate for pharmaceutical company managements to scrutinize their own marketing operations to ensure that they communicate not just efficiently but cost-effectively.

As the function which directly affects company income, a sales force is its key communication investment.

A sales force audit

Most pharmaceutical sales forces still operate to a basic system originating from the 1950s, with mornings spent seeing GPs, periodic lunchtime meetings, afternoons spent visiting hospitals and community pharmacists, and occasional evenings taken up with a variety of meetings involving doctors, pharmacists or nurses, depending on the products and targeted audiences. To secure consultant support for products, hospital sales forces have been utilized by most companies; some have been retained, some reduced and some discarded. Many representatives now visit FHSAs (Family Health Services Authorities), but overall there has been little dramatic change in 40 years. It is therefore worth considering:

- the inevitable effects of new NHS strategies, including formularies, generics, cash limits, indicative prescribing, etc
- the cost of recruiting and training representatives
- the high turnover of representatives and the extra cost of vacant territories, retraining, etc
- the low (and often decreasing) daily medical call rate
- the limit on 'out-of-hours' working effectiveness
- new companies
- the Japanese factor
- the world economy

- the estimate that over 50% of all products reaching the market do not achieve a profit!

If one takes the average salary and expenses of a medical representative – the company car, its depreciation and running costs, the not inconsiderable matter of pension fund contributions and other compulsory outgoings such as National Insurance and maybe private medical insurances – and adds to this the cost of training, sales force management and administration, it is possible, by dividing the grand total by the number of representatives, to calculate the cost of each doctor interview! Such 'auditing' has led most managements to look for ways and means of improving the cost-effectiveness of the representative.

Improving customer contacts

Various methods have been used to improve customer awareness of companies and their products via the sales force.

Entertaining and sponsorship

In the 1960s, lunchtime meetings within practices became commonplace, whilst junior hospital doctors' tastes were regularly catered for by company-sponsored 'mess parties'. Sponsorship of postgraduate centre meetings became the main access for meeting GPs and hospital doctors *en masse.*

'Handouts'

Promotional gifts, such as pens and pads, are always welcome and probably good value for money. The more impressive give-aways usually go straight home!

The locum sales force

Hiring temporary medical representatives to carry out special 'blitzes', during a major launch for example, is one way out of a field force manpower shortage. There must however be a question mark about the quality of such calls if the level of personal representative commitment, through company or product loyalty, is considered important.

Segmentation and serendipity

Segmentation

There is merit in most of the targeting systems currently available. There are also drawbacks, and unsustainable claims about targeting techniques should not be accepted at face value.

The information obtained from what is a significant investment is available to all subscribing companies, creating the potential for processions of representatives to beat a daily pathway to the doors of targeted doctors. Unfortunately, however, this information does not include how to see those doctors, although a quotation from one segmentation system supplier is enlightening.

> 'Although physicians are becoming less accessible due to the introduction of appointment systems, they are not as inaccessible as marketeers often believe'.

GP appointment systems have however been around for over 15 years, longer than most targeting systems in the UK. It

is not easy to tell experienced representatives that doctors are really not as inaccessible as they believe!

Updating targeting systems depends on the assumption that representatives will reveal hard-won specialized knowledge of their most valued contacts. Is this a realistic expectation?

In considering how well segmentation really does work in practice, it is worth looking at a statement from one major segmentation supplier when referring to a targeting 'malfunction'. 'The problem stems from lack of management commitment rather than technical difficulty.'

Serendipity

Serendipity is defined as the faculty of finding interesting or valuable things by chance or where one least expects them; segmentation diminishes the likelihood of unexpected opportunities. Up-to-date records and intelligent representatives will always produce action plans which include high-priority calls, but doubts have been expressed about the deliberate avoidance of accessible and interested doctors, which is inevitable with segmentation systems.

Yet nobody can state categorically that Dr X will not start to use a certain product. What certainly can be stated is that Dr X does prescribe drugs and given the right information he or she might try a different one; an excluded doctor might just be newly elected to the LMC (local medical committee), or chairman of a key formulary committee. Dr X personally does not like NSAIDs, but he knows someone who does – his newly qualified daughter who is not even in the targeting company's files. That is where serendipity comes in, and if it did not exist, somebody would have to invent it!

Communication technology

The truly dazzling advance in methods of gathering, storing, processing and disseminating information has transformed the

potential for directing, controlling and motivating a sales force. Reports, sales analyses, territory and national records can all be stored and accessed at the press of a button.

Communication between management and representative, at one time mainly achieved by telephone, memos and personal visits, now depends heavily on the computer. In spite of, or maybe because of, the increasing sophistication of information technology, however, there is now a need for marketing managements to pause and consider the situation. The medium must not become more important than the message, and personal management and motivation skills cannot be left to a VDU.

> The old adage that good management is 20% about systems and 80% about people still applies in the 1990s.

High tech humans

Human beings are still the best examples of state-of-the-art communication technology! Representatives are the key to effective communication, and once trained, the aim must be to assess their and the company's real communication needs – and then to decide how best they can be motivated and supported to achieve the new objectives of the 1990s.

The future and the need for change

The new NHS

In order to assess the precise sales force role in the communication chain for the 1990s, it is essential fully to

understand the government objectives for the NHS and to appreciate the extent of the changes already made and, more importantly, to understand the changes planned for the future. The effects of these changes will be extensive.

The new NHS of the 1990s is already very different from that for which the basic structure of most pharmaceutical field forces was designed. Further NHS change will be rapid, and high on the priority list are the pharmaceutical services, the provision of which is under scrutiny as never before. Drug information sources are now highly sophisticated and accurate, and are becoming increasingly coordinated and influential.

The question which must be addressed by senior management in all companies, large, medium and small is this – 'Are we really as up-to-date as we think we are?'

The shake-up in the NHS will confront representatives and their managements with a whole new series of challenges. In the field of primary care, local formularies, PACT (prescribing, analysis and cost data), and cash limits, together with blacklists and hospital influences, all challenge the representative's skill and ingenuity. Until 1990, hardly any representatives needed to bother with FPCs (family practitioner committees), and few had ever even heard of them or knew what the initials stood for. What a different story now, with FHSA general managers having to keep special appointment books in order to cope!

'Seamless' care

How many senior marketing managers are aware of the existence of the 1991 policy statement issued by the NHS management committee? The intention is to integrate primary and secondary care to produce a programme of 'seamless' care by removing some of the arbitrary and traditional divisions in its provision, and the policy statement emphasizes the need for pharmacists to work in close collaboration with doctors, nurses and other social care professionals. Once established, practice nurse prescribing will not only remain – it will grow rapidly.

People are living longer. Residential and nursing homes and similar institutions already account for a high proportion of the population receiving medication, and it is only a matter of time before that proportion will double. Working together, GPs, pharmacists and social services staff are already seeking a rational solution to what is currently a very varied national picture. There is both obligation and opportunity for the pharmaceutical industry here. Drug information, not only for the elderly, but for carers of the elderly, is not uniformly available, and sales forces can help to communicate such information in collaboration with appropriate authorities. This is a huge problem – and a huge market.

The therapeutic partnership

In his closing remarks to the 1991 British Pharmaceutical Conference, Professor Peter Noyce (Professor of Pharmacy Practice, University of Manchester, and formerly Deputy Chief Pharmacist, Department of Health) said:

> 'Pharmacy's increasing contribution to the therapeutic partnership impinges on relationships with the pharmaceutical industry. The physician is no longer the only decision-maker on drug therapy, and the industry also needs to concentrate its efforts on pharmacists and to recognize that patients too are becoming active parties in their own treatment'.

At the same conference, Professor A Breckinridge (Department of Pharmacology, University of Liverpool) underlined the key role which accurate drug information would play in the

future, along with practice budgets, indicative prescribing, and the medical and pharmaceutical advisers to FHSAs.

Time for a change?

In view of the imminent effect of the NHS changes on the provision of pharmaceutical services, it is time for companies to make a re-evaluation of how medical representatives are recruited, trained and deployed.

The right people are probably being recruited – young, intelligent, articulate, academically well-qualified and ambitious – but is the industry providing the job satisfaction and career prospects necessary to keep the majority of them long enough to satisfy those ambitions? Are internal communication systems really working well? Current turnover rates suggest not.

The representative is the company

Unique medicines for which there are no alternatives are rare. Where a choice of drug must be made, the company reputation is of paramount importance, and to most doctors, pharmacists and other key members of the healthcare team, the representative is the only contact they ever have by which to judge.

Image is not all, but it certainly plays a key role. Senior management must ensure that representative recruitment, training and career prospects all match the new needs of the 1990s. It should be a matter of real concern to senior management and boards of directors when, their middle management having selected and trained apparently ideal young representatives and at a considerable cost, a high proportion leave the industry after a very short time. Surely the real answer is not a continuous roundabout of new recruiting campaigns and training courses?

The representative and education

An emerging and effective all-round role for a representative, apart from disseminating product information to doctors, pharmacists, and other decision-makers, is to be part of a team providing an educational service. In this respect, one of the most significant developments for a very long time has been national sponsorship of genuine education projects.

Continuing education

'Continuing education' in its literal meaning has become a permanent feature of medical and pharmaceutical professional development, including support staff, and marketing managements should bear this in mind when planning long-term strategies.

Nowadays there is a great deal more to representative educational activities than merely showing a video at a lunchtime video meeting with several GPs. Good examples of true educational involvement are companies which have underwritten the development, production and administration of nationally recognized training schemes. FHSAs have a growing role in continuing education, and appreciate firms which support professional and staff career development as opposed to non-accredited 'training' which is often a pleasant buffet supper plus a speaker or maybe a video. As well as strengthening the corporate image of their companies, there are obvious benefits for representatives involved in these training projects.

Computer assisted learning

Many companies recognize the contact benefits to be obtained from providing representatives with computers and interactive learning programs on topics having some relation to their own products. Used in the surgery, computer assisted learning

(CAL) provides an excellent link between representative and doctor/nurse/practice manager, and is perceived as a most acceptable and professional educational involvement. It is important that representatives retain the main communicating role in these situations, and do not become travelling projectionists.

Postgraduate Education Allowance

The introduction of the Postgraduate Education Allowance (PGEA) within the GP contract opened the floodgates to requests for companies to assist with educational events ranging from small in-practice sessions to medical expeditions to the Andes. Many companies are now wary of what is in fact a random sponsorship policy, and are turning more to investing in structured national training programmes of a strictly clinical nature, usually related in some way to the company's product range.

> Genuine education and training will rank high as a valuable communication investment for companies in future.

The representative as negotiator

Salesmanship is often depicted and taught as a form of negotiating. With medical representatives, the objective is to negotiate with a doctor to the point when that doctor recognizes and accepts the benefits to everyone involved of prescribing a specific branded drug. Negotiations rarely go beyond that stage, and although some representatives visit community pharmacists as a matter of courtesy, the assumption

has been that a signed prescription will ensure that pharmacies will have to get in stocks to meet such prescriptions.

The new NHS, however, will demand more of representatives than the ability to negotiate one to one. There will be a network of individuals and groups, each of whom can influence which products will be used, and when. Local variations at practice, district or regional level must first be identified, and priorities decided based on their varying degrees of influence, before individual negotiations can even begin.

If representatives have found it difficult to influence hospital formulary committees in the past, their negotiating skills are going to be severely challenged in the 1990s. The structure of primary care in 1992 for example is extremely flexible compared even with 1989. The pharmaceutical industry must match that flexibility within its own marketing approach, with representatives being skilled, trained entrepreneurial negotiators, not just articulate messengers delivering a pre-packaged set of instructions for all doctors.

The industry needs pharmaceutical communicators

We have already discussed the 'therapeutic partnership', and the NHS proposals on prescribing. The need to identify prescribing decision-makers and communicate with them effectively means that senior marketing managements must include more pharmacists in the future. The qualification MRPharmS could be as valuable to the pharmaceutical industry in the 1990s as an MBA came to be regarded in the early 1980s. The manager with both is going straight to the top!

The big problem is how to persuade pharmacists to join the pharmaceutical industry in marketing, which is not seen as an especially appropriate or attractive career for young graduates. One way could be to emulate the armed forces, who 'sponsor' selected students during their undergraduate days. With some form of commitment to ensure that on qualifying such graduates work for a minimum of, say, three years with the

sponsoring company, is this one route for the industry to consider?

At another level, the Industrial Pharmacists Group of the Royal Pharmaceutical Society works hard at maintaining links with schools of pharmacy and at encouraging pharmacy graduates to seek a career in the industry. Traditionally this initiative has revolved around the technical areas of expertise to which pharmacy graduates are well suited. However, the time is surely due for pharmaceutical companies to ensure that marketing and general management opportunities in industry receive similar attention in all contacts with schools of pharmacy. The qualities of leadership and management are as relevant as academic achievement if pharmacists really are to play the role in industry that the profession in particular, and the therapeutic partnership in general, really deserve.

Encouraging suitable pharmacy graduates into management and marketing could pave the way for significant improvements in sales force communicating in the pharmaceutical industry.

Obstacles to good sales force communications

The main challenge facing most senior marketing managers in the 1990s will be to ensure maximum sales force effectiveness. Just as representative stability and reliability is reassuring to customers, so is sensitive and knowledgeable leadership continuity a desirable reassurance to representatives. Leaders must also set the highest standards of behaviour, professional and personal, or lose credibility. The communication chain is only as strong as its weakest link.

The ratio of senior female managers compared with the proportion of female representatives in the pharmaceutical industry speaks for itself. In many sales forces there are now more women than men, so is there a chance that in the not too distant future there will be something approaching a similar proportion of successful women candidates for the top management posts? If this does not happen, it could be

assumed that their leadership potential is being deliberately overlooked.

A further obstacle to good communications is sexual harassment, which can be direct or indirect. It is seen in one-to-one situations, eg manager/representative, but also occurs at meetings or conferences where it can manifest itself in attitudes to subordinates in the use of what was once known as foul (now all too often regarded as 'macho') language in sales or product briefings. It is impossible to assess its scale, and the problem should be kept in perspective. Nevertheless, every company should have channels through which victims can take effective steps to counter harassment without putting their jobs in jeopardy.

People, not pins

The sales force is not a list of territory numbers, a pattern of coloured pins on a wall map, or a computer menu. It is a team of human beings, men and women with homes and families, usually working in isolation from their fellows and totally dependent on their leaders for information, guidance, motivation and, perhaps above all, job satisfaction. They need and deserve the very best two-way communication systems, internal and external, though they should be joint masters of those systems, not their slaves.

All this requires that not only must the right people be in the right jobs, whether at representative or manager level, but that each job has the right job description for working effectively in the new NHS environment of the 1990s.

5

Meetings, Symposia and Conferences

Peter Holden

The organization of meetings is an industry in its own right, and a flourishing one. Dozens of companies are involved and their services range from mere selection of venues through to full organization of the meeting, including travel and accommodation for speakers and delegates. Meetings are more and more frequently becoming a finely tuned marketing communications vehicle. They are a legitimate and highly effective part of the marketing mix and come in various shapes and sizes. Symposia and conferences may involve hundreds or thousands of delegates, whilst workshops, round tables and seminars involve smaller numbers, perhaps ranging from less than 10 to 30. Generically, 'meetings' covers the gamut of sizes.

Meetings versus face-to-face selling

The obvious advantage of the meeting is the size of the audience: addressing a group of customers can often be more cost effective than face-to-face selling. However, the value of a large meeting in actual hard sales terms is notoriously difficult to measure. Any meeting should be a combined effort involving sales, marketing, medical and communications functions which each contribute to its overall success. As will be discussed in more detail later in this chapter, follow-up of delegates is of crucial importance: a meeting does not stop when the last speaker has finished his presentation and the promotional effort may continue for a year after the event.

Measurement of a successful meeting

What is the objective of the meeting? Why is it being held at all? To measure the success or failure of a meeting it is necessary thoroughly to question the motives and objectives for organizing it; the more expensive the meeting, the more serious should be the questioning. These objectives should be realistic and achievable and should not just be 'to sell more product'; although justifiable, it is difficult to measure the isolated effect of a single meeting in achieving this end.

Realistic objectives for holding a meeting could be:

- image enhancement
- marketplace noise
- market preparation – prelaunch activity
- to establish an identity
- to facilitate representative activity
- to provide access to new customers

- to extend a product life cycle
- product launch
- to increase sales.

To measure definitively the degree of success of a meeting a benchmark must be established. Whilst qualitative and quantitative market research can give hard data with regard to company image, market preparation and product launch, other objectives may be more difficult to measure. When a company is set to enter a new market with a new (or not so new) drug, then establishing a benchmark of its image in that market will be simple. It is a more difficult task to establish a measurement of image – though not impossible when a company is extending its franchise in an existing market.

When the key objectives are increased sales or extension of product life cycle, it is probably unrealistic to expect to be able to measure the effect of a single event in isolation. It is more realistic to look at the total effect and justify the complete mix. If, after a meeting, representatives find it easier to gain interviews with target customers, then it is logical to suppose that they may be in a position to sell more product.

Large meetings: symposia and conferences

The larger the meeting the greater the risk, and the possibilities for disaster are multiplied and directly proportional to the complexity of the programme. Large meetings require large venues, which present an interesting challenge where logistics such as accommodation and servicing are concerned. Forward planning with adequate safety margins is the antidote to catastrophe. Planning and scheduling, with a count-back system (*see* Figure 1) will ensure maximum effectiveness and efficiency, and highlight omissions or unrealistic deadlines.

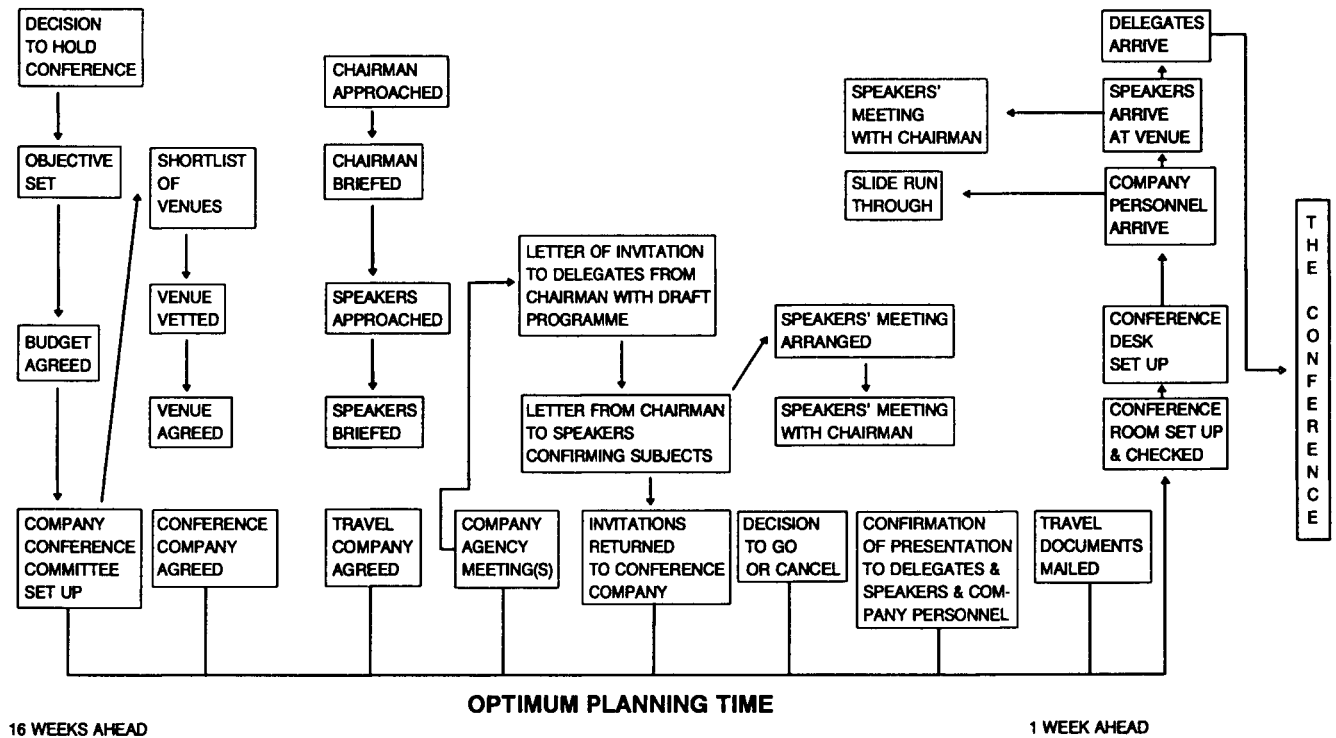


Figure 1. Conference planning.

A great deal of adrenaline and excitement may be generated for organizers and delegates by a composite programme. Holding small workshops or seminars within a large symposium is great fun, but can be a potential minefield.

Composite meetings

Meetings with composite programmes are amongst the most successful with which I have been involved.

In one instance, dividing a hundred specialists into five groups in order to discuss the same case histories was magnificent theatre with a serious end point. After the case histories had been examined and discussed, five chairmen were appointed to present the findings of their individual groups, and a cliff-hanging situation developed which was not only exciting but deadly serious.

After four chairmen had reported back we had a hung parliament, with two groups recommending one treatment protocol and two opting for a modified form of treatment. Whilst both forms of treatment were favourable to the sponsoring company, one protocol was rather more favourable to the company's product. So the scene was set. The fifth chairman gave his report from the final group. Knowing that he had in effect the deciding vote, he was not only able to tease and tantalize the audience, but he was aware of the company interest and made the most of it.

The decision came down on the side of the treatment protocol which happened to favour the sponsoring company; this was controversial and led to further heated debate. Such was the impact that a report of the conference gained coverage in the medical press and the

debate continued in the pages of one particular journal for some weeks.

The final outcome was that the representative body of this particular speciality formed a working party to discuss the treatment protocol for the condition in question which, after lengthy discussions and debates behind closed doors, came up with its own treatment protocol very similar to the majority version from the original meeting. This protocol was published in the speciality journal and became accepted as the standard treatment protocol for the condition.

This company-sponsored meeting achieved many objectives for several groups. The specialists were able to debate a controversial treatment in open forum and arrive at a majority decision, and then to put pressure on their representative body to set up the working party to make the protocol official. The sponsoring company ended up with a favourable consensus concerning their product and this consensus received the imprimatur of the specialists' representative body. On top of this the consensus was widely publicized in the pages of prestigious medical journals.

It would be difficult to argue that the meeting described was not a success, whichever benchmark is used to measure it!

Smaller meetings: workshops, seminars, consensus groups

The small decision-making meeting provides greater intimacy, and is often the ideal platform for arriving at specific treatment protocols and management plans. The selection and briefing of

speakers for such a meeting is crucial to a positive outcome and the surroundings are more important than for larger gatherings. Particular attention should be paid to the ambience of the room and seating arrangements: the configuration of delegates may be crucial and decisions need to be taken on whether this should be u-shaped, round, oval or hollow square.

Small meetings which have the objective of making a decision invariably benefit from an overnight stay by delegates. This enables them to get to know each other and discuss pertinent questions informally before the formality of the meeting proper takes over. Often potential issues which might jeopardize the meeting can be mollified by informed discussion, which can stop an issue turning into a crisis.

Recording smaller meetings often pays dividends, and if a publication is to result from the meeting then recording is essential. Because of the more intimate nature of a small meeting, the use of 'group response' technology is usually inappropriate.

Who should attend?

Who should attend this meeting? It is probably accounting for a reasonable chunk of someone's budget, and it may well be that this is part of the sales force or marketing budget. Alternatively, the spend for the meeting – it being educational – may come from a communications budget as part of a below-the-line spend. There is often enough agonizing about the budget to fill several meetings. Even more agonizing takes place over the attendance list.

The attendance should be governed by the objective of the meeting, and somewhere within the objective must come product. Medical, marketing, communications and sales personnel have an interest in product, so it can be logically argued that they should all be represented. If the meeting is to be attended by key customers then there should be enough

relevant staff to allow 'marking' of all these important contacts so that relationships are established, renewed or consolidated. Much highly relevant intelligence can be gathered and opinions heard if sufficient company people are on site.

When budgets are tight (and they always are) and only a limited number of company employees can attend, then the decision as to who goes is simple. Those people in the company responsible for opinion leader contact and development should be there, and those who will be responsible for the ongoing day-to-day contact with the majority of the delegates must be represented. It is crucial that the sales force be well represented so that they can take ownership of the meeting and to allow swift follow-up of delegates; if this means that members of medical or marketing departments give up their places in favour of the sales force then this is a good business decision.

I have been responsible for meetings where the sales force involvement has been minimal and this can be justified if the objective does not have a sales angle. For instance, a consensus meeting organized to allow a small group of specialists to arrive at an agreement which has fundamental strategic importance to the company would not be appropriate for sales force attendance. Similarly, speculative meetings where the key objective is opinion leader discovery and development would be better dealt with by communications personnel.

When the objective of the meeting is product orientated then only by major representation will the field force take ownership, become involved and take a positive attitude to the all important follow-up procedure.

Attendance hooks

Recently the qualification of a meeting for the Postgraduate Education Allowance (PGEA) has helped secure attendance and reduce the drop out or no shows for general practitioner meetings. The PGEA rules and regulations, however, are notoriously inconsistent across the regions and are in the

process of being re-evaluated.

When considering meetings for hospital doctors or multi-disciplinary groups where such PGEA considerations do not apply, then other hooks need to be found. Interest may, for example, be added by the inclusion within a clinically based meeting of topics of a non-clinical nature. Management or communications workshops have, for example, proved particularly successful in achieving high attendances of hospital doctors.

The levying of an administration fee or service charge on delegates is usually found to be acceptable and in my experience has reduced absenteeism dramatically, from 40% to 10% on average.

There is now an increasing trend to form an alliance with a publishing house in order to maximize the communications process surrounding a series of meetings. This sort of alliance can produce immense dividends with regard to publicity for the meeting and dissemination of published material after the meeting. However, one of the major drawbacks of such an alliance is that it may reduce the PR opportunities across a broad spectrum of media. The company forging such an alliance needs to be mindful of this and realize that publishing houses do not have the expertise of a specialist communications company.

Venue vetting

The importance of vetting a potential venue cannot be overstated. Nothing should be taken at face value and every recommendation and endorsement should be treated with scepticism until it has been checked out in person.

A comprehensive venue check list is essential no matter how large or small the meeting, or how far from the office, and this will vary depending on the nature of the meeting. The list shown in Figure 2 is not intended to be exhaustive, but to give a guide to the main points which should be borne in mind. It can

Transport	**Check**
Availability of public transport.	☐
Transfer time from airport or station.	☐
Accommodation	
Number of rooms.	☐
Availability of overspill accommodation.	☐
Number of suites.	☐
Number of syndicate rooms.	☐
Number of restaurants.	☐
Number of bars.	☐
Coffee and tea stations: number and location.	☐
Exhibition facilities.	☐
Standard of accommodation.	☐
Food	
Quality.	☐
Variety (very relevant if several days).	☐
Vegetarian alternatives and other dietary provisions.	☐
Wine	
Quality of house wine.	☐
Availability of alternative at house cost.	☐
Main Meeting Room	
Dimensions.	☐
Seating capacity.	☐
Power points.	☐
Black out.	☐
Acoustics.	☐
Audio-visual Equipment	
Slide projectors – do they work?	☐
Video projectors – do they work?	☐
OHPs – do they work?	☐
A/V technician on site?	☐
Leisure Facilities	
Gym.	☐
Swimming pool.	☐
Squash.	☐
Tennis.	☐
Other.	☐

Figure 2. Venue check list.

be frustrating, time consuming and costly if omissions are made from the check list which have to be followed up with innumerable faxes and telephone calls, and it is therefore important to be clear what one is looking for.

Selection and briefing of chairmen

Notwithstanding the importance of the crowd pullers and product champions, the most important person in any symposium is the chairman. Whilst not being a guarantee of success, the selection of the chairman and subsequent careful briefing are certainly major contributors.

Good speakers are not necessarily synonymous with good chairmen. Nevertheless, a good chairman requires the qualities of an orator and a Thespian. In addition, he needs to be an active listener and have the inter-round summary qualifications of a W Barrington Dalby. He needs to be able to understand and distil the essential elements of any argument, discussion or debate, and he must have the weight and experience to command the respect of his peers. Ordinarily the chairman will be a senior consultant or professor in the medical speciality pertaining to the meeting. However, if the meeting has a multidisciplinary faculty then a senior consultant or professor in a more general or a close disciplinary speciality may be required. Alternatively, a highly respected non-medical chairman may be suitable and can add an extra dimension to the meeting.

The first approach to a potential chairman may be made via a letter or telephone call. This communication should be followed up with a meeting. At this first meeting the aims and objectives of the symposium or conference should be outlined, and the objectives and the likely roadblocks to achieving the objective should be clearly and openly stated. Whilst one may have clear ideas about who should be speaking in key slots, it is always a good idea to seek the chairman's advice as to who the most suitable speakers for certain topics might be.

If the potential chairman cannot agree to the meeting's objectives and an acceptable compromise cannot be reached, then there is only one course of action open to the conference organizer: the invitation to act as chairman must be withdrawn with empathy. An understanding of the potential chairman's viewpoint may lead to a fundamental rethink of the objectives, or alternatively to a better understanding of the sensitivities involved when another is approached.

Once the chairman has agreed to become involved, his cooperation on various issues can help the meeting to move smoothly from planning to implementation. Invitations to speakers and delegates from the chairman on his own letterhead add weight and professionalism to the whole proceedings, and if a publication is to come from the meeting then a chairman's letter requesting abstracts may be more persuasive than a letter from the sponsoring company; the same applies to requests for formatting of slides and abstracts.

The chairman may also have a role after the meeting if any market research is to be undertaken. Follow-up questionnaires, bearing the chairman's name, may elicit a higher response rate than if such research is carried out by the company or its agency.

Selection and briefing of speakers

For large meetings, speakers may be divided into four groups: crowd pullers, programme fillers, funny turns, and product champions.The crowd puller ensures 'bums on seats'. He may be a renowned researcher, an eminent professor, an industry guru or just plain controversial. The funny turn may add lightness to a heavy performance, but may be able to give a subtle covert message. The product champion is the man with the key message – the evangelist or 'hot gospeller'. Often companies are reluctant to put up a product champion because they fear this lacks credibility; however, credibility can be stretched even further if there is no company message.

In 1988 around 200 specialists were taken abroad for a medical symposium. The meeting was sponsored by a single pharmaceutical company and spanned three days with plenary sessions interspersed with free time. Nowhere on the programme was the 'product puff'. There was great debate in the bars about when the 'promotional bit' would come, who would deliver the message and what it would be. A book was even opened as to when the selling would start and many bets were laid.

The meeting came to a conclusion without a product champion climbing on the platform or promotional message being communicated. This led to a good deal of disquiet and the main question asked was 'Why have we been brought here?' The question was never answered, and the company lost credibility and was distrusted for a considerable period after the meeting.

Once the selection of speakers has been made comes the delicate task of briefing them and then trying to ensure that the brief is adhered to. I know of numerous cases where companies have alienated opinion leaders by making unreasonable demands. A product champion loses all credibility if he goes over the top and appears bought, and this can lead to an undermining of the image and reputation of the product and the company.

A face-to-face meeting is the only way to brief a key speaker, and a briefing should never be carried out on the telephone or by letter. The speaker needs to have a clear understanding of what is expected of him, and any doubts must be clarified, negotiated and agreed during the meeting. If an agreement cannot be arrived at then a substitute needs to be found. Obviously, if the speaker in question is the only one who fits the brief then a negotiated compromise must be the way forward.

Like any other form of opinion leader work, briefing speakers needs to be regarded as a business deal. Senior members of the medical profession are not naïve. They have integrity and personal reputations to consider and protect. Knowing that the sponsoring company requires a certain message to be put across clears the air and allows for open discussion. If an opinion leader declines to speak to a given brief because of a point of contention, then this needs to be explored. A negotiated compromise is often more valuable than a hole in the programme because of a missing star.

If a publication is to come out of a meeting then it is reasonable to request a manuscript or a synopsis of a speaker's talk. This is often a good monitor of whether or not the brief is being adhered to or any misinterpretation has crept in to the talk. Preparing slides and having a slide run-through prior to the actual meeting are other useful ways of assessing adherence to the brief.

I have never ceased to be surprised at how lax companies are about speaker briefings. Often only the product champion is briefed and all the other speakers are left to do their own thing. Whilst one can appreciate that marketeers may be justifiably blinkered in only considering their product message, unbriefed speakers lead to sloppy performances and an overall poor symposium. All speakers should be given a clear understanding of the overall aims of the meeting and how each presentation links with the others.

Presentation training

In the main, most speakers will have a track record of speaking on 'the circuit', so will have been observed in action. Nevertheless, nobody is perfect and everyone can benefit from training if necessary.

Recently the person I had invited to deliver a key talk in a large and very important symposium expressed a reticence about his capabilities as a speaker. He was a senior man who had given many presentations, lectures and talks; however, he had never presented to such a large group and never in such exalted company. We talked about his misgivings and discussed various possibilities for training. Finally we arrived at what turned out to be the ideal solution. A single half-day was booked with two professional presentation trainers, who took the doctor through basic presentation techniques, such as breathing, voice, projection and relaxation. The key point, however, was the distilling of the doctor's presentation into one key message. This was given as a 'dramatic opening' and the doctor never looked back. He gave an assured, confident performance, got his message across with a deal of assertion, and has remained eternally grateful for the training opportunity!

High-tech conferencing

Meetings of any size can benefit immensely from one of the 'group response' systems introduced several years ago. Such systems enable delegates actively to participate in the meeting, and provide valuable feedback for the organizers and the sponsoring company. The 'group response' system can be used as a teaching aid, as well as a means to achieve some sort of agreement or consensus. It also enables the speaker to get near instant feedback on how well his points are being put across.

Satellite technology is advancing at a pace, and it is now quite feasible to link groups of delegates in several geographic centres throughout the UK. The main faculty of speakers may

be in one centre and debate is beamed to delegates in the regions.

Such is the sophistication of the new technology that it is also perfectly feasible and practicable to conduct a video conference involving various countries around the globe. Care obviously needs to be taken about the timing of such conferences, but time differences can be accommodated and successful video conferences are becoming more and more frequent. Given the optimum conditions and judicious stage management, such conferences can prove very cost-efficient: they negate the need for overseas travel by delegates and can be fully interactive. The most recent arrival on the video conferencing scene is a system costing less than £20,000. The advantage of this system is that it can be wheeled from room to room, and plugged into any of the integrated services' digital network provided by most of Europe's telephone companies.

Interactive technology is also becoming part of the conference business. Such technology again allows increased participation and greater involvement in the learning process.

Recording and transcription

Unless it is absolutely necessary, recording of meetings should be avoided. However, if it is intended to publish the proceedings then there is no real alternative. It is important to seek the agreement of the chairman who will, if necessary, seek the consent of the speakers.

Recording can only be successful if the quality is high and it should therefore never be done on the cheap. The use of multi-directional microphones and broadcast-quality audio tape will give the best results. A seating plan of the speakers will make the always difficult job of transcribing a great deal easier, and the chairman can be of immense help by asking speakers to identify themselves. This is particularly helpful during a discussion, when numerous interjections can make the transcriber's job a nightmare.

If a prestigious meeting warrants a video recording, or if a video film is being made during a meeting, then the same ground rules apply as for audio recording. It is important never to cut corners, and to use broadcast-quality equipment.

An external company should always be used for recording – in-house facilities, unless exceptional, are usually a compromise.

Follow-up

It is absolutely crucial to the marketing and sales effort that delegates to a major meeting be followed up quickly after the event. This follow-up may take the form of a postal questionnaire or market research telephone survey, both of which are valid methods. Nevertheless, the most effective approach is a personal call from a company representative who is known by the delegate in question. A suitable follow-up item to facilitate the representative's visit should be provided and the representative may indeed form part of the market research activity.

Follow-up should ideally take place within two or three weeks of the meeting and sales management should make this a key priority. The cost of the meeting will undoubtedly have come from a product budget somewhere along the line, and sight should not be lost of the cost argument. The spend from this product budget needs to be recouped and demonstrated to be a good return on investment.

I have been responsible for one meeting where the field force did not take ownership. They did not consider themselves to be involved and there was an outbreak of anarchy. Over half the delegates had not been followed up

even six months after the event. Impetus from what had been a very successful meeting was lost and the investment of close to half a million pounds was not capitalized upon.

The best way to ensure ownership and involvement in a meeting which has a clearly defined business objective is to form a steering committee. This committee should comprise sales, marketing, communications and medical personnel who will play a key role in the planning and implementation. Only when ownership and involvement from the inside can be translated into follow-up after the event can a meeting involving high numbers and high costs be justified.

Objectives

Have the objectives been defined and agreed? ☐

Costs

Has a budget been agreed? ☐
Have all hidden costs been considered, eg company and agency personnel? ☐
Has a 15% contingency been added to the budget? ☐

Administration

Has a timetable been established? ☐
Have check lists been drawn up? ☐
Have responsibilities been assigned to company personnel? ☐
Have agencies been booked? ☐

Venue

Is the meeting to be held in the UK/overseas? ☐
If overseas, have flight and transfer times been considered? ☐
Has a visit been made to the venue? ☐
Can the venue cater for the number of delegates expected to attend? ☐
Is the conference room suitable – size, acoustics etc? ☐
Is lighting/air conditioning/heating/ventilation suitable? ☐
Are there sufficient syndicate rooms? ☐
Are there adequate cloakroom facilities? ☐
Has the quality of catering been sampled? ☐
Are vegetarian/other dietary options available? ☐
Can the venue provide social facilities? ☐
Is overnight accommodation available? ☐

Chairman and speakers

Have the chairman/speakers been chosen/approached? ☐
Have the chairman/speakers been fully briefed? ☐
Has a rehearsal been scheduled? ☐
Have speakers' technical requirements been established, eg slide projector, OHP etc? ☐

Technical equipment

Has the need for/availability of/serviceability of technical equipment been established? ☐
Has the format of slides etc been agreed? ☐
Will the meeting be recorded? ☐
Is a group response system required? ☐
Is the PA system acceptable? ☐
Has an AV company been retained? ☐
Will an AV technician be in attendance? ☐

Materials

Have name badges, pens, folders, signs been arranged? ☐
Has the use of a logo been considered? ☐
Has the need for exhibition material been established? ☐

Publicity

Will the full proceedings/highlight report be published? ☐
Will a daily bulletin/newspaper be published during the meeting? ☐
Has a medical writer/PR company been retained? ☐

Figure 3. Conference check list.

6

The Role of Advertising in Communications

Phil Welch

What is advertising?

Everyone knows what advertising is and what it is not. In the health industry the word is frequently used to describe more than just press advertising: it is either a broad well-defined area, or a vast subject encompassing many communication facets. Certainly every agency, client (marketeer), publisher and doctor knows what advertising is, and everyone has their own opinion on whether it works or not, how it works, why and when it works. It is a subject about which agencies and their clients become very protective – almost as if the advertisement is the essence of their brand, assuming monumental importance and taking on an emotional mantle all of its own.

It is remarkable to think that advertising can even have the power to make one believe in products that do not exist. The consumer advertising industry once ran awareness campaigns using an Australian perfume called Sheila. The product never

existed but chemists and cosmetic counters could have sold it many times over!

Definition without definition

Why is advertising in the pharmaceutical industry 'definition without definition'? At its most literal level pharmaceutical advertising is the paid for images, usually in colour, which appear in the medical journals. Clients, via their agents – advertising agencies, pay for the space, and agencies and clients agree upon a design and the arrangement of words and images to appear in that space. It seems so simple. If, however, that were all there was to pharmaceutical advertising I would be able to employ less people in the agency, and we would all be able to work a three-day week.

In the drug industry, advertising frequently encompasses much more than advertisements per se, and the majority of agencies offer the following services:

- media planning and buying
- writing/designing detail aids
- planning direct mail campaigns: concept, design, writing, targeting
- writing/designing technical monographs
- providing ideas for/sourcing brand reminders
- supplying materials and support for exhibitions
- writing computer programs
- public relations
- writing/designing training programmes
- providing audio visual aids: films, slides, tape
- organizing conferences

- producing educational packages
- devising sales force incentive schemes
- marketing
- premarketing
- new product development.

As the industry has prospered, so companies and agencies have developed and evolved to service niche or discreet areas of the advertising business; the other major established disciplines are PR, training, conference organization and education.

To come back to the definition, advertising can frequently be just an advertisement, but invariably it encompasses considerably more. An American colleague of mine describes it as 'soup to nuts' to indicate the campaigning out of an idea or theme, often expressed at its simplest as a picture with a headline, appearing on a paid-for page in a medical journal, through to the film of the book of the advertisement.

Vertical integration

Having spent the majority of my career working for healthcare agencies (née pharmaceutical agencies) with large advertising corporations, I have frequently been called upon to present to my management the work I do for my clients, and the disciplines/communications tools employed. The audience would often include the heads of consumer advertising, PR, sales promotion, direct marketing, design, new product development, and conference services agencies.

Whereas each of the above disciplines tend to be fairly discreet and have a client base which may range from banks to the producers of baked beans or bicycles, the client – for example, a bank – may employ several agencies to do what the average pharmaceutical agency performs for its own clients. Pharmaceutical agencies are, therefore, what I term 'vertically

integrated' in health, as opposed to being specialists in one discipline only. Other phrases used to describe services other than advertising are 'btl' (below the line) or 'atl' (above/across the line). Pharmaceutical advertising agencies are often specialists in all of the disciplines listed in Figure 1, but only in relation to drugs/healthcare brands. What advertising is, therefore, depends on how broad one wishes to be in one's description.

Figure 1. Vertical integration.

Does advertising work, does it sell?

'Next time somebody tells you "I don't believe advertising works" ask them "Then how come so many people want to control it?"' This is the headline and proposition for a house advertisement run by the US healthcare agency Dorland Sweeney Jones which appears in the US pharmaceutical

marketing/advertising press. Has everybody got it all wrong? If advertising does not work then why do so many people want to be associated with failure?

The far-sighted reader will already have seen the paradox. The previous section outlined some of the other communication disciplines which are loosely called advertising. The problem is that most pharmaceutical companies are involved to a greater or lesser degree with these other disciplines. When it comes to answering the question 'Does advertising sell?', therefore, the overwhelming answer has to be 'I don't know'. This is because it is impossible to tell whether it was the advertisement which sold the product to the doctor, or whether it was the representative, the mailshot, the exhibition or the PR; it is possible that they all did, as an amalgam, or that some did and others did not. With the exception of a few specific cases, most of the time we do not know. We believe that the advertisement has worked, but quantification of its absolute selling power in the absence of other stimuli is usually left to 'gut feeling' and deduction.

Telemed, a UK monthly video magazine for the medical profession, has proved the effectiveness of television advertising in the absence of other media, but there are too few catalogued instances of advertising effectiveness in isolation. In the pharmaceutical marketplace it is rare to use advertising in the absence of other methods. This is because:

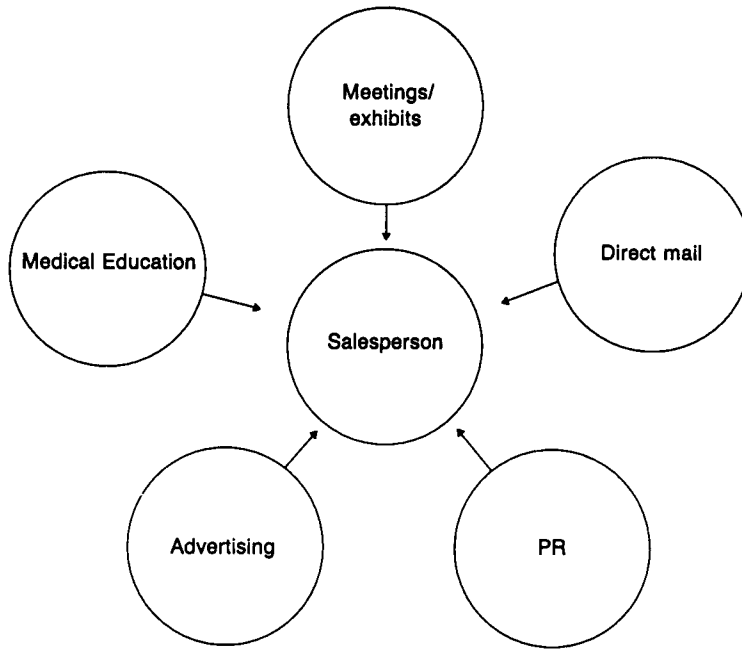
- it is accepted practice to use a full marketing mix
- it is not considered prudent to 'experiment with just one element'
- it is not possible to separate journals by geographic regions, which is a classical test marketing method
- it is not possible to separate PR by region
- a full mix will usually work better
- there is a strong belief within the industry in the need for sales force support for a given brand.

The simple answer to the question 'Does advertising work?' is 'Yes'. This is partly why so many people, ie clients, agencies and publishers, want ownership of it. The only people who would not agree are the customers, ie the doctors. I have never heard of a doctor who freely and openly admits that advertising works in the pharmaceutical marketplace; the reasons for their lack of conviction include the following:

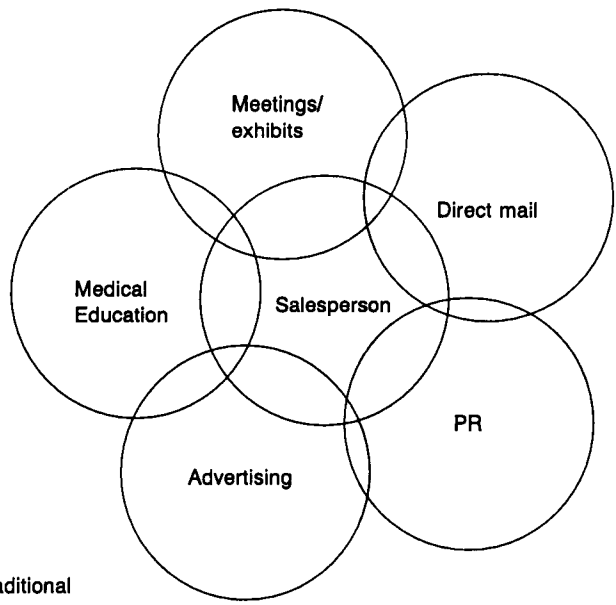
- doctors do not like admitting to being sold something
- it is impossible to separate advertising alone from the 'mix' and thereby to attribute the sale to the advertisement
- prescribing actualities and prescribers' perceptions often vary; doctors may be prescribing something in a way or with a frequency of which they are not conscious or which they will not admit
- much advertising is crude and muddled, and does not have a strong call to action; if it does, this may not be to write more prescriptions for the drug.

The last point bears further examination. Frequently the role of the advertisement is to sell more product, either directly or indirectly, but it can be to change a perception, modify an attitude or rethink a clinical situation. The product message can then often be secondary, and the close of the sale is left to the salesperson, the mailshot or other parts of the campaign, or even to subsequent campaigns.

As mentioned earlier, the advertising agency has the luxury of several tools at its disposal. Yet too often each tool is used for the same purpose. One would not dream of having a tool kit consisting only of hammers, so why should the same functions be expected of the range of communication tools the agency has at its disposal? Traditionally these were designed to support the salesperson (*see* Figure 2a). Advertising can, however, often work at a far more significant level than this, and for it only to



(a) Traditional



(b) Non-traditional

Figure 2. Traditional and non-traditional roles of pharmaceutical marketing.

support the salesman is to waste its full capabilities. The non-traditional role as shown in Figure 2b takes recognition of the fact that each element of the mix can do certain things better than others.

The roles for the elements given in Table 1 are not exhaustive, and in certain circumstances they will definitely change; for new campaigns, for example, I would suggest attributing specific communication tasks to each tool at the briefing stage. Instead of trying to get each element to accomplish everything, for example an advertisement which is also a detail aid, each medium should be used to its best advantage, whilst ensuring that the degree of overlap is not so great that the effect of what each element can achieve is spoilt.

Advertising	• Impact • Immediacy • News • Emotion	**Meetings/ exhibits**	• Information • Sharing • News/data
Direct mail	• Interaction • News • Detail • Comprehension	**Medical education**	• Learning • Information • Comprehension • Sharing
Salesperson	• Comprehension • Commitment • Comparison	**PR**	• New angles • Building/dispelling myths • 'They say so' as opposed to 'We say so' • 'News'

Table 1. Roles for elements of the marketing mix.

Advertising is conceived, nurtured and brought to its consumers by a team of people; it is then consumed by the audience in isolation, and subsequently discussed and analysed ad nauseam by an enlarged team of people in public: this is the market research advertisement feedback session. It is all too easy to forget that print, and to a large extent broadcast advertising, is consumed on a personal level far from the open forum of a large gathering of the advertising agency, client marketing and market research functions. Private emotive feelings can often get drowned out by the reality and actuality of such gatherings.

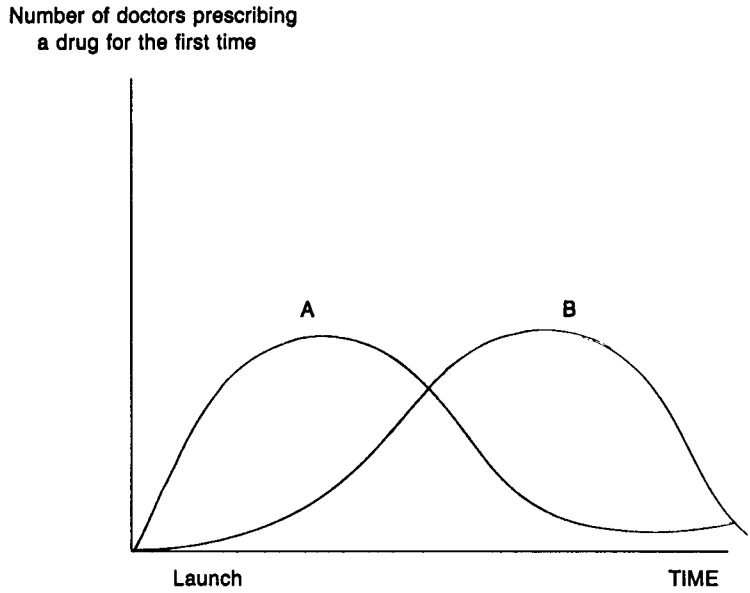
Advertising new and old brands

New for a year

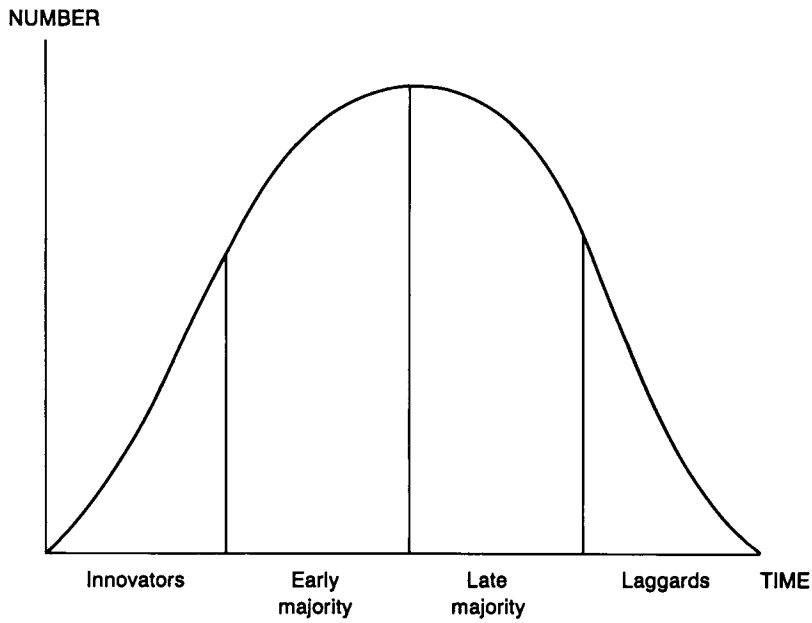
As the word 'new' can only be used for a finite period then do all brands become old after the first anniversary of their introduction into the marketplace? In the motor industry tired models are given facelifts with new fabrics and colours, and are presented to the consumer as the latest model. Somewhere between these two extremes lies reality in the use of the label 'new'. Today, new pharmaceuticals are able to use this preface and rightly so. In most markets the word has been proved to be one of the most powerful in advertising and communications.

Communication requirements of new drugs

In order to gain acceptance of any new drug in any field, there will firstly be the bold and brave who try it, the 'innovators'; later, as time passes and confidence develops, the 'middle majority' will adopt the product; and in time the drug will find its level with the population of users. The role of advertising and communications is to endeavour to move the adoption curve shown in Figure 3a to the left, ie to get curve A to occur



(a)



(b)

Figure 3. The adoption curve.

rather than curve B, thereby effectively compressing the time factor, and resulting in greater usage of the product by a larger number of doctors at an earlier stage. This adoption curve represents a normal distribution within the population of doctors, both GPs and those working in hospitals, who can be ascribed the characteristics outlined above (*see* Figure 3b).

It is, however, vitally important to remember:

- that different doctors may well be in different places in the adoption curve for different therapeutic products
- that some doctors will be worse than 'laggards': they may never adopt a particular drug
- that practice formularies can and will affect particular adoption curves; for instance, a particular drug might well have been adopted by a practice member prior to the existence of the formulary, but nowadays he may be forced into being a 'late majority' due to practice resistance to take on a new drug.

When advertising a new drug, therefore, these factors must be borne in mind in addition to the communication requirements hammered out by client and agency. New brands are in general more likely to appeal to the innovators for that particular therapeutic sector, but frequently brand and marketing management are involved in bringing to the market line extensions or derivatives of existing brands. In this case the parentage and heritage of the brand must be taken into account when developing advertising and communications. Table 2 pairs together some of the major classes of consideration that need to be examined prior to writing the advertising strategy and developing creative work.

Advertising older brands

Frequent product management changes can result in frequent agency changes, and the inevitable change of advertisement. As a result many major, significant, solid, well-performing brands have a chequered advertising history. A doctor's recall is all too often of the past advertised imagery rather than that of the current advertising. This is not necessarily the fault of the current agency; the new advertisement has to compete with previous perceptions of the brand as well as to support current promotion.

By virtue of the fact that they are better known, older brands should be able to rely upon advertising which communicates largely with imagery, in other words with the visual components rather than with words. This is because much of the rational argument for brand usage will already have been delivered by other means. Also, as a generalization, old(er) brands are not usually expected to offer new facets/new information to the doctor, and the advertising role can therefore be different from that for new brands. This does, however, have a fatal flaw: the market does not stand still, and to show good old 'Brand X' in the same light as before may not be sufficient for it to earn its share of prescriptions.

The issue of how to communicate old and new brand imagery via creativity is beyond the scope of this chapter, but it is worth noting that old/ageing brands can wear 'new clothes' in terms of advertising livery and image. Consumer examples abound of the forever contemporary brands such as Coca Cola, Levi and Marlboro: these products are almost neolithic in age by pharmaceutical standards, yet in each case the essence of the brand is eternally relevant. How is this achieved? Through advertising.

CHARACTERISTIC	CLASSIFICATION
• New therapeutic class/category • Existing therapeutic class/category	I
• Real breakthrough • Marginal improvement • No real advance*	II
• Line extension • Reformulation • New mode of delivery (eg slow release, syrup, injectable)	III
• No 'product' change, just new data • Please look again at this class/this drug	IV
• 'Good old' • Don't forget • Still the best	V

*clinically speaking

Table 2. Advertising considerations for old, new and not-so-new brands.

The difference between pharmaceutical and consumer advertising

It is my firm belief that the message and detail will, of necessity, require that prescription drug advertising is different from consumer advertising, but that the creativity should be on a par with, if not exceed, that of consumer advertising. Why is this so? Firstly, our products are not dog foods, banks or bicycles, and the information content of the message must therefore be different; no-one in their right mind would want a doctor to believe that he was being sold a tin of dog food instead of a pharmaceutical product. Table 3 shows the similarities and differences between advertising prescription drugs and consumer products. Pharmaceutical marketeers do, however, have the luxury of sales forces, direct mail/marketing and all the other promotional avenues and these should surely make it possible to unload the advertising of non-essential tasks. If an advertisement is not laden with too many objectives for communication it can, therefore, excel at one; and to excel at one will allow the creativity to shine through.

Pharmaceutical advertising rarely wins awards for creativity as judged by the consumer industry. There are several reasons for creativity coming a poor third in the pharmaceutical marketeer's requirements for advertising, some possible suggestions for which are:

1 The pharmaceutical marketplace is largely conservative; this applies to both clients and their agencies.
2 The ABPI Code of Practice imposes restrictions.
3 Clients do not demand spectacular creativity.
4 The creative teams in the agency are told that doctors will never buy the product.
5 Good creativity is not always logical or fully explainable.
6 Market research can frequently kill good creativity and fosters safe mediocrity.
7 There is a multi-layered approval process: legal/medical/registration/marketing.

Prescription drug	Consumer product
Customer (doctor) is not user	Consumer generally user
Customer does not pay directly – this is now changing in actuality	Consumer pays
Customer trained to be rational/logical/sequential in decision-making process	Consumer uses variety of decision-making processes
Products rarely sold to customer through humour	Products often sold to consumer through entertaining advertising
Majority of the advertising is press	Huge mix of advertising media (broadcast TV most powerful)
Customer sometimes does not see success of 'purchase' (a well patient may not return)	Purchase usually tangible
Rational base/basis often needed for prescribing – trigger may well be emotional	Trigger often emotional – post-rationalization is frequent

Table 3. Prescription drug and consumer product advertising.

8 Advertising has too many objectives, ie more than one.
9 The detail aid is more important than the advertisement, therefore the 'aid wags the ad'.

The agency role

I always tell clients and prospective clients that an agency should be treated as an extension of the marketing department and it is paramount for clients to furnish full information about the product – market, budgets, corporate climate – in order for the agency to be able to put forward the best advice. Feeding agencies information piecemeal will lead to incomplete solutions to marketing communication problems and an ultimate souring of the relationship.

The role of the agency is ultimately to come up with ideas which build, grow or sustain business – ideas for direct marketing/direct mail, for promotions, incentives and product reminders – and the best situation for nurturing ideas is one of openness and encouragement, when information is shared and common goals and objectives are identified.

I do not believe that advertising agencies and their clients should consider the relationship as short-term just to overcome an immediate market problem. The learning curve in understanding a brand and the client company is vitally important. Agencies perform better for their clients if they have worked with the field force, attended the training courses, met the medical directors and copy signatories, and are as steeped in the product as the marketeer himself.

The specific roles of the agency are as follows:

1 Strategy and positioning assessment: to establish whether the brand is positioned correctly and that the strategy is realistic.
2 Account planning: to be aware of what customers and consumers, ie doctors and patients, really think and feel

about the brand, and whether the client has a true perception of the realities.

3 Budget planning: to decide whether the marketing mix is cut correctly and if not, why; whether more or less funds should be applied for; whether the phasing of spend is correct; whether the client is getting value for money; and to measure the effectiveness of the spend.

4 Campaign origination and development: to come up with good ideas and to develop, nurture and merchandise them; to continue with a good idea for a long time, and to know when to introduce a new one.

5 Market research liaison: to work with client research departments to do the best and most useful field work, and to interpret this correctly; to make sure that objectives are simple, realistic and measurable, and that market research does not kill a good idea.

6 Quick response: to be able to think on its feet and react decisively to urgent situations, such as competitor activity or product drama – this should not mean, however, that agencies should be deprived of time to prepare good work.

7 Media evaluation, planning and purchasing: to look for fresh media avenues and ideas, assess new spaces/sizes and mixes; to get good value for the product and its marketing requirements.

Client/agency relationships

Client/agency relationships often unfortunately seem to mirror the rapid turnover of marketing personnel within pharmaceutical marketing departments. It is a brave marketeer who will leave the advertising and agency roster alone upon taking up a new position. The advertising and communications may well need some change, but is wholesale reorganization necessary? Our products are fairly long term, unlike consumer fads such as Rubik's cube or heat sensitive T-shirts. The short-term view,

and sales promotion techniques which cannot be sustained, are unlikely significantly to influence the long-term performance of a given brand. Each new product manager or marketeer, however, wants – justifiably – to demonstrate his effect on the product, and use this input as a springboard to further his career within the company or to move higher up the seniority ladder within another organization. Whilst agencies will happily address the short-term sales approach, which will be highly profitable for them, the long-term franchise should not be neglected by either party.

Trust, above everything else, is the most important ingredient for a successful and long-lasting relationship to the benefit of everyone, and not least to that of the brand. If a client trusts the agency's advice, and champions strong initiatives with the agency, and if the agency believes that the client has tried their hardest to fight the viewpoint, then a tremendous esprit de corps will develop. If on the other hand a client reneges on promises, or vice versa, then a slow rot may set in. As with personal relationships, client/agency relationships require work on the part of both parties, as well as understanding. Humour too, is a good ingredient that helps oil the wheels of working together and brings out better creativity from all concerned.

The best response from a client to an idea is a firm 'yes', the next best is 'no'. The worst response is a weak 'yes' or a 'maybe'. Both sides should feel free to speak their minds, and the real way forward will inevitably emerge from frankness or confrontation.

Conclusion

There are hundreds of rules about advertising and many exceptions to all of them. Success and creativity for ideas to promote drugs is more of an art than a science; we need to understand the medicine and the emotional forces at play, but an agency should never lose sight of the fact that their clients

and their clients' customers are human beings, who respond to communication techniques. Here are a few crystal ball predictions for the 1990s:

- Pan-European medical television will emerge carrying pharmaceutical advertising.
- The need for prescribing information to be carried on UK drug advertisements will and should be challenged.
- Consumer-standard creativity will become an 'in-vogue' requirement of pharmaceutical marketeers.
- A non-sales force, direct-marketing led pharmaceutical company will emerge.
- Euro-branding will become an issue, both positively and negatively: positively from an economy and continuity viewpoint, and negatively with respect to the differentials for pricing, positioning and distribution.
- DTC (direct-to-consumer) advertising will be legitimized for certain categories of Rx (prescription) drugs.
- 'Cosmequeticals' will increasingly attract consumer agencies and creative talents to enter the pharmaceutical agency business.
- In pursuit of their careers, marketeers will cross Rx to OTC (over-the-counter) and consumer boundaries more frequently than today, to the benefit of all concerned.

7

The PR Consultancy

Neil Kendle

Over the past decade public relations has emerged as a major weapon in the marketing armoury. This reflects not just a coming of age for this relatively new discipline but also fundamental changes within the pharmaceutical industry and the medical profession, which have led to a reappraisal of the marketing mix: increasing medical specialization; increasing costs of field forces and direct promotional costs; tighter mandatory limits in the UK on direct promotional spend; decreasing effective patent life during which to amortize development costs; and the increasing involvement of patients in the treatment process. The pharmaceutical industry is recognizing the power of PR in all stages of the product lifecycle, but particularly prelaunch and at launch.

With the boom in medical PR has come the inevitable proliferation of PR consultancies. There are currently something like 40 PR healthcare consultancies in the UK; these range from the large multinationals down to the one-man-band so it is important to assess one's needs and choose carefully.

Most important is the need to identify the good rather than the merely plausible.

For simplicity this chapter has been addressed to pharmaceutical company executives and refers specifically to product PR. However, it should be of value to anyone with an interest in medical and healthcare PR.

What is PR?

What is meant by public relations, or at least what do *I* mean, there being almost as many definitions as there are PR practitioners? Consider this.

> If a person who is thinking of buying a GTi car sees an advertisement in a magazine for the Golf GTi he will probably read it. But he will be sceptical. This is Volkswagen talking and he knows that they are only going to highlight the car's better features. If he then turns the page and there is a review of GTi cars in which the reviewer concludes that the Golf is definitely the one to go for, the reader is much more likely to be influenced. Better yet, if he knows or meets someone face-to-face who is clearly knowledgeable about cars and who recommends the Golf, he will already be halfway persuaded, when he comes to test drive it, that this is the car for him.

So, the key to PR is *third party endorsement*: for example, getting opinion leaders to endorse a pharmaceutical company's messages to other doctors or a well respected GP to endorse their message to his peers. It follows that PR is not necessarily concerned with generating media coverage. The press is just one of the vehicles for getting that message from the sender to

the receiver, although obviously it is one of the most potent and widespread. Where people get confused is that editorial coverage in the press, the review of the GTi cars for example, is, unlike an advertisement in the same publication, itself seen as third party endorsement regardless of the original sender. Thus the journalist also becomes an opinion leader.

PR is much more than press coverage although this does tend to be the most visible aspect. Other PR techniques are very important. These include symposia and conferences, opinion leader development, working with formal bodies, consensus groups, publications, videos etc. Those involved in pharmaceutical marketing are probably saying here 'We already do most of those'. I agree. The point is not that the decision is taken to hold a symposium but whether a symposium is the right vehicle for communicating third party endorsement about a particular product. If it is, how does it interact with one's other activities? These should not be carried out just because 'things have always been done that way'. They should be carefully thought out, designed to achieve one's communications strategy, and they should be *consistent.*

Why one needs PR

Even though the use of PR for pharmaceutical promotion has increased in recent years, I feel that of all the elements of the marketing mix it is still underused. Where and when could it be valuable? Where does PR fit into the marketing mix?

	Prelaunch	Intro	Growth	Maturity	Decline
Sales force	2	1	1	2	–
Journal advertising	4	3	2	3	–
Mailings	3	4	3	1	1
Conferences and symposia	1	2	4	4	–

Table 1. Communication at each stage of the product life cycle.

Marcel Corstjens[1] has described at what point in a product life cycle the various elements of the marketing mix are the most important (*see* Table 1). He does not look specifically at PR but he does have a category of conferences and seminars which we can take as a model of third party endorsement. Corstjens assigns the highest relative value to PR at the prelaunch phase, and I would probably agree; but I get the impression that this is based on the fact that the other elements of the marketing mix – the field force, advertising and direct mail – are largely prohibited. This implication that PR has its main place only because other activities are not applicable undervalues its importance as a means of changing attitudes in preparation for the introduction of a new product.

Since the early 1980s the percentage of prescriptions for new products in the UK, that is for products less than five years old, has virtually halved. This suggests that the pharmaceutical market is becoming more conservative, that it is much more difficult for new products to succeed; whether they will do so is often already determined at launch by whether the marketplace is receptive, by whether the need has been created or not. Prelaunch PR is vital.

In the introduction and growth phases of a product life cycle, Corstjens rates the field force as most important. I would not necessarily disagree with this either, but the balance of influence is shifting. It is getting more and more difficult for representatives to hit their call rates. Companies are thus left with a choice of seeing the same number of doctors less often or, more likely, of seeing fewer doctors more often. In other words targeting. In these circumstances PR can be a useful adjunct both to get to the doctors not seen by representatives and, by preparing the ground, to make doctor/representative visits more productive.

Later in the life cycle, direct promotion – mailings and advertising – are rated as important, and PR as relatively unimportant. Few marketing executives would agree with this. In a recent survey of UK pharmaceutical executives[2], 74% considered PR to be useful/extremely useful in the maturity stages of a product's life. The problem with Corstjens' analysis

is that it takes no account of product or market differences which can dramatically affect the relative importance of PR and advertising.

PR and advertising

Many seasoned pharmaceutical industry executives are coming to the view that too much faith is often placed in mailings and advertising, particularly at the mature stage of a product's life cycle, with advertising being used too widely and uncritically. At its simplest PR gives credibility to a message and advertising raises awareness. However, many people expect advertising to do much more.

> A few years ago we had a brief fling with the UK subsidiary of a multinational pharmaceutical company. This company had an ageing product which, although it was still one of the top twenty UK drugs, was going out of fashion. Moreover it had been pushed off the company's detail schedule by newer products. The product still retained a great deal of support from specialists however. We were briefed to come up with a PR support programme which could counter the lack of exposure from the loss of detail time and make the product fashionable again. The PR budget was only £35,000 but £300,000 had been allocated to journal advertising and mailings. They were obviously looking mainly for advertising to turn around their mature, declining product. This was expecting too much from advertising.

I sometimes think that advertising spend is like the cliché 'Nobody ever got sacked for buying IBM'. A product manager

will probably inherit a pattern of promotional spend and he is unlikely to run into trouble if he continues this. It takes a brave man to cut the advertising spend to invest in PR. However, when promotional spend is tight and companies are forced to reconsider the whole promotional strategy, rather than cutting PR, which might be the expected course of action, they often conclude that they are spending too much on advertising and too little on PR. Thus, whilst overall spend goes down, the PR budget may well increase.

The FCB product grid

I have argued that in simple terms advertising is at its best when it is generating awareness and reinforcing existing beliefs. PR is more effective at persuasion. But the nature of the product and the market must affect the job to be done. Vaughn[3] has developed a useful analysis, the Foote, Cone & Belding or FCB Grid (named after the advertising agency in which he worked), which takes into account differences between types of products and the environment in which they are marketed (*see* Figure 1). Corstjens has adapted this to a medical environment[ibid].

I have long been aware that doctors have a mental spectrum of risk to which they assign products. There are those products where the risk of prescribing that product, say in terms of side effects, or the risk of therapy failure, is low. These include cough and cold remedies, simple respiratory infections etc. In these cases doctors will, for example, try new products without recourse to hospital endorsement. At the other end of the spectrum for high-risk products, such as anti-cancers, GPs will only prescribe on the advice of the specialist. Most products fall in between at various points on the risk spectrum.

Corstjens has plotted a matrix of doctor involvement which represents prescribing risk, uncertainty about the innovation and the doctor's clinical interest, against the latter's mental process in deciding on a prescription. He argues that for some product categories the decision is based on rational arguments,

whereas for others less rational factors – company loyalty, impact of the product on the patient's self-image – are more important. Although this is written from the perception of an advertising man it does give us some guidance about communication messages and media. For example, in the category *High involvement/Low rationality* there is a need to reassure and legitimize the decision process. He recommends symposia and group presentations to provide peer group support and personal assurance for the prescriber, with journal advertising to provide more emotional support.

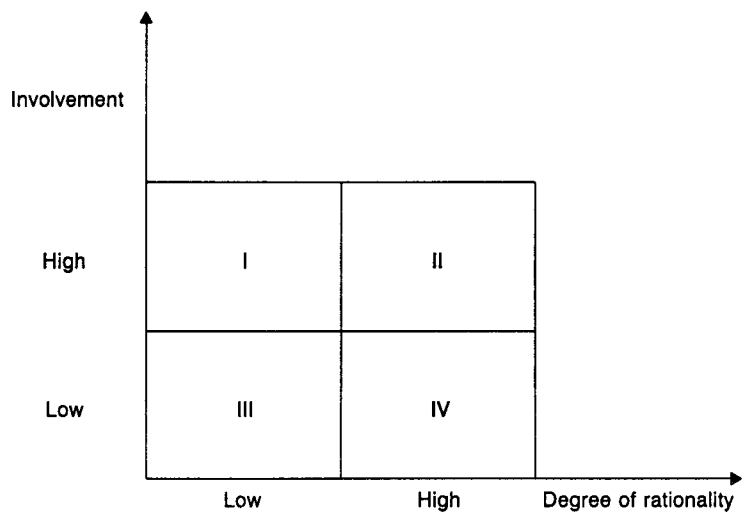


Figure 1. The FCB Grid.

Reaching a wider audience

The difficulty and increased cost of reaching prescribers is encouraging many pharmaceutical companies to look for other marketing strategies. This often results in consumer-oriented campaigns. In the US a great deal of effort has gone into consumer advertising programmes for disease area awareness on subjects such as vaccination, diabetes, ulcers and high

cholesterol. In the UK these disease programmes are also being taken up with enthusiasm but the emphasis here is on PR as a medium.

The latest edition of the ABPI guidelines endorses the increasing recognition that patients have a right to be informed about products as well as the disease states. This is a qualified go-ahead on giving information to the lay public however. One major manufacturer appears to have misinterpreted the meaning of this and has had a severe rap over the knuckles for its prelaunch campaign for a new product.

The need for a strategic approach

Good public relations needs thought, planning and organization; it needs as much thought, attention and professional skill as the marketing or financial planning of a company. Like the marketing plan, the communications programme should start with a consideration of the marketing *objectives*, the *strategy* for achieving these, and only then with the *methods* by which they will most effectively be achieved.

In preparing a PR programme many people grab at methods, but it is the strategy which is the backbone of any campaign. It is too easy to rationalize an ill-conceived or inappropriate idea in retrospect, all too easy to be seduced by the buzz of getting a lot of press coverage without really analysing whether the messages conveyed are those one wishes to communicate. We constantly need to ask ourselves 'What are we trying to say?' in the same way that those devising a marketing strategy should ask 'Why should a doctor prescribe our product?'

This is less of a problem in consumer PR where the old adage 'all publicity is good publicity' is more accurate, and this is, incidentally, the reason why journalists so rarely make good medical PR practitioners. Their training teaches them to see the 'best' story, and whilst this may generate a lot of coverage it may also do nothing to meet the strategy; there may be another

story or a twist which, though it gets less coverage, achieves more in fulfilling this.

One campaign which did not go according to plan, where the strategy was incorrect, was the Zantac versus Losec issue. Glaxo's strategy was to generate adverse publicity about Astra's drug Losec, comparing it unfavourably to their own Zantac. However, the result was to raise Losec awareness amongst prescribers to a level which Astra would not have been able to generate on their own. Glaxo won the battle but lost the war.

Another Glaxo division, Allen & Hanbury's, however, got it spot on with *Action Asthma*. This was a campaign designed to get undiagnosed and undertreated sufferers into the surgery. Little attempt was made to get any particular product or group of products mentioned. There was no need to. When one picks up something approaching 80% of all prescriptions for asthma one cannot lose – a classic market leader strategy.

Many companies fall into the trap of adopting a strategy of increasing the size of the market, or interrupting the repeat prescription cycle, when they are not market leaders. Thus most of their work is to someone else's benefit. Of course one must not be blinkered about which market one is competing in. The product may have only, say, a 10% share of the market but a 40% share of new prescriptions.

How to choose a consultancy

The cliché about choosing an agency – advertising, PR or whatever – is that consultancy work is a 'people business' with

the most important item being the people with whom one specifically deals. There is some truth in this, but it is remarkable that some agencies are consistently good over the years despite changes in personnel. This comes from the corporate culture: a commitment to excellence that starts at the top and permeates the whole company. Good executives moving from excellent companies to lesser ones all too frequently move down to the standard of their new consultancy, rather than bringing that consultancy up to the standard of work they were producing elsewhere.

Finding good people is, however, hard. We have had some very good people from other consultancies but in general we tend to recruit from the pharmaceutical industry and the medical and allied professions, and teach those executives PR skills, rather than to recruit from the PR world and teach the sensitivities of working in healthcare. The problem is that PR people are great at, for example, getting press coverage but they frequently have no brakes. They cannot see the potential pitfalls of any of their activities.

A story is told about one of the big UK consultancies, which held a press conference to launch an artificial sweetener. A well-known health correspondent from one of the national dailies had been campaigning about the health risks of this substance. At the press conference, to which this particular journalist was invited and which he duly attended, the consultancy served a particularly nice fruit punch, only to announce at the end of the conference that the punch had in fact been sweetened by the product which was being launched. They certainly demonstrated to the journalists that the product was palatable, but the health correspondent never forgave them. And quite rightly. They had tricked him into taking a substance which he felt, rightly or wrongly, to be dangerous.

Can the consultancy deliver?

There are two elements to a successful PR campaign: good ideas and successful implementation.

A potential client, in selecting an agency, will have looked at what they have achieved for other clients, and their work may appear to be impressive. But extravagant claims about what they will achieve on his behalf should be treated with the scepticism they deserve. If the agency has presented well, the possibilities offered will be exciting – and a good PR campaign is exciting – but it is important to be realistic. I remember reading in a PR proposal which a client showed me the claim 'We will put pressure on the editor of the *BMJ* to commission an editorial on Product X' or words to that effect. Once or twice in my career I could honestly say that we were instrumental in getting *BMJ* or *Lancet* editorials. But never by putting pressure on the editors.

Can one agency undertake all of the activities involved in healthcare PR – organizing conferences and dealing with opinion leaders, as well as achieving press coverage? Does this not smack of their being jacks of all trades? Not at all. What makes a successful press conference is what makes a successful symposium or a successful video. It is the decision that that particular activity is the correct one in the first place to achieve the strategic aims of the programme; an understanding of the communications process and the messages to be communicated; organization and commitment to excellence. There are companies, it is true, whose specific function is to organize a conference, produce a newsletter etc, and sometimes going direct to them will be the preferred route.

How important are good press contacts?

Does it matter whether the consultancy has good press contacts? Knowing journalists and being trusted by them certainly helps, but they are not the key to good press relations.

Much more important is an understanding of the editorial process: how the various media work; what makes a good story; when journalists would like to attend a press briefing and when they want an exclusive; what makes a journalist tick. It is tempting to look at a story from one's own viewpoint. We are so involved with it, it is difficult to understand why the press have not used it or why they have not used it in the way it was intended.

A medical weekly newspaper will get hundreds of press releases each week and the vast majority of these will go straight into the bin. They are useless – in fact they are worse than useless because they may prejudice the recipient against any further communications from the sender. The role of the PR consultant is to act as a broker, ensuring that both sides get what they need out of the relationship; thus the consultant takes the client's messages and tailors them into something which the journalist regards as newsworthy.

This might appear to be obvious but in my experience it is difficult for someone close to a product to learn to appreciate this, to understand that journalists are not as fascinated by the details of the product as they themselves are. For this reason, unlike most consultancies we do not jealously guard our journalistic contacts; we encourage our clients to take an active part in editorial meetings and to get to know the journalists. We even offer a training course which looks at this journalistic process from the journalist's viewpoint in order to help our clients understand what it is like to be on the receiving end.

Trust

Once a consultancy has been selected they should be briefed thoroughly and provided with as much information and background material as possible so that they have a total view. The consultancy must be trusted with confidential information if they are to do an effective job. If they cannot be trusted, a consultancy should be found which can. An honest,

balanced approach is important. A client may believe that his product is the greatest thing since beans came in tins but when the consultancy starts talking to other people they will also hear any negative aspects. It is better for a trusting working relationship that they should hear of these from the client.

Fees

How do PR consultancies make their money? Mostly consultancies make their money by selling hours. That is, for every hour spent the client pays the consultancy an agreed rate. At the time of writing this can vary from anywhere between £35 and £50 per hour for a junior member of staff, and £85 and £150 per hour for a board member. On the face of it that may seem an awful lot of money but it has to cover much more than just the executive's salary: the offices, the support staff, non-billable time etc. A consultancy which is making a pre-tax profit of 15% on its fees is doing pretty well.

Fees are, however, frequently a bone of contention between PR consultancies and their clients. The main problem is that pharmaceutical executives are on the whole more used to dealing with advertising agencies than with PR consultancies, and it can come as a shock to find oneself paying for time spent.

Should consultancies be expected to do a free pitch for a client's business? The ground rules are changing. Increasingly companies are asking for this and increasingly consultancies are agreeing to do it. In the past we have only agreed to do so in exceptional circumstances. Firstly there is the time involved in researching and writing up a good programme. Writing a PR programme is not like pitching for advertising business in terms of the work needed: whilst one good creative idea can make an advertising campaign, a PR programme will need extensive research and development of ideas. On average it may cost between £10,000 and £20,000 in man hours. A potential client would not necessarily be expected to pick up the whole of this but he would be expected to make a contribution. If we were to

get involved in a number of free pitches, however, some important decisions would have to be made about the economics. Should we do less thorough, less well-researched programmes? If the prospective client is not paying for the programme do we need to put up our rates to cover the costs, in which case our existing clients are paying for all our new business pitches? The same questions should be asked about those companies who will willingly pitch for free.

One way round the problem is to ask a number of consultancies to come and give a capabilities presentation. They will all be delighted to show what they can achieve and the client can then pick the one he feels would be best to develop a programme for his product.

The client/consultancy relationship

Having decided to use a PR consultancy, the client must be prepared to commit a great deal of time. A consultancy cannot merely be briefed and sent off to do their work; they cannot work in this sort of vacuum, especially at the beginning of the project. Not making one's time and knowledge available will result in the consultancy, and maybe the client, having to do a disproportionate amount of work later on. Among the things the client brings to the relationship is, of course, a detailed understanding of his product and the market in which it competes. But he will also have essential knowledge about the culture and values of his company, which the consultancy needs in order to recommend programmes which will work.

I have often heard consultancies say 'We see ourselves as part of the marketing team'. Well, as I have said there certainly needs to be a very close working relationship. But the very fact that they are not part of the client's organization and its day-to-day pressures is one of the reasons for employing an outside consultancy: they bring complementary skills and knowledge; they will have a less biased perspective of the client's communication needs which will help them fulfil their role as

broker; and the fact that they work for several companies gives them a breadth of experience in devising and implementing communication programmes.

Perhaps one unexpected benefit, if the client is not threatened by having his strategic thinking challenged, is that this outsider's viewpoint can be a great benefit in refining his thoughts. He should therefore see this relationship as a partnership where each party contributes different skills and fulfils different tasks. PR, used in the right way, and conducted by skilled and experienced practitioners, is a potent marketing tool. Used badly or inappropriately it is at best useless, at worst damaging. The key to success is a considered and well-executed programme which is an integral part of the marketing plan. A consultancy should be chosen with care, both for their ideas and experience, and for their enthusiasm and ability to deliver what they promise.

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8

Opinion Leaders

Peter Holden

Who are opinion leaders?

Opinion leaders are simply experts in a particular speciality whose views are valued by their peers. They can thus influence and, more importantly, change opinions by means of the written or spoken word. They are the crucial element in marketing communications activities and provide expert third party endorsement, which is far more valuable and potent than even the most creative advertising.

Elegant subdivisions into opinion makers, educationalists etc have been tried (*see* Figure 1), but the definition above is adequate for all groups; all are influencers and changers of opinion. Classically the opinion leader operates from the top of a pyramid (*see* Figure 2) and the opinion is cascaded down.

CATEGORIZATION

A Influence is International/National
B Influence is Regional
C Influence is Local

1. Opinion Maker
- Capable of bringing about change and new thinking.
- Capable of having a real influence on prescribing habits.
- 'Crowd puller' at a symposium, nationally.
- Chairman and/or keynote lecturer at symposium.
- Would always be categorized A1.

2. Opinion Leader
- Would echo views of the opinion maker.
- Capable of having a real influence on prescribing habits.
- May be a 'crowd puller' at a symposium.
- Would be categorized A2 or B2 or C2.

3. Educationalist
- Teacher of aetiology and/or treatment.
- May have an influence on prescribing habits.
- May be a 'crowd puller' (because of technique or subject).
- Usually a symposium programme filler.
- Would be categorized A3 or B3 or C3.

4. Esoteric Expert
- Renowned and respected for their work.
- Little or no influence on prescribing habits.
- Useful as programme filler.
- Might be a 'crowd puller' if topical.
- Would be categorized A4 or B4 or C4.

Figure 1. Opinion leader categorization.

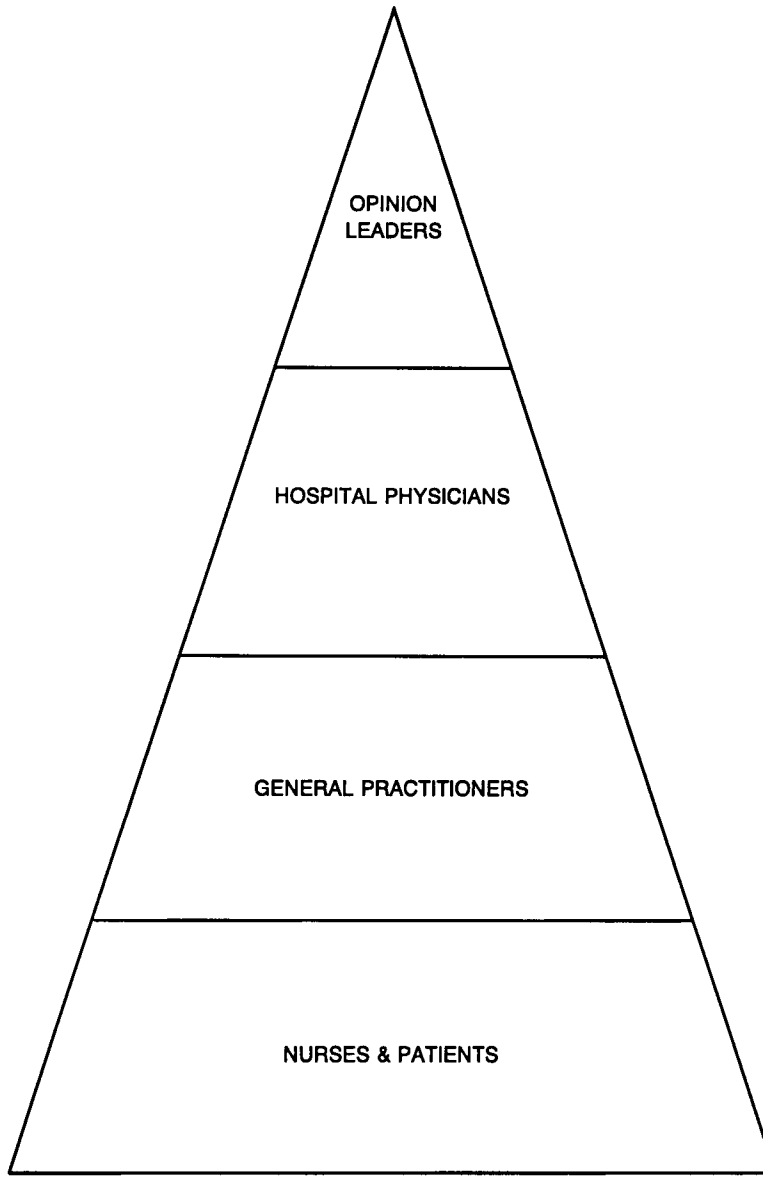

Figure 2. The opinion leader pyramid.

The perceived wisdom is that opinion leaders are necessarily senior consultants or professors and this is generally the case. Nevertheless, there are numerous examples at senior registrar level and within general practice. Often original research, strength of conviction or a wish to 'take on the establishment' can lead to the creation of an opinion leader. Once potential talent is identified by the communications expert it needs to be developed and its 'warmth factor' – a measure of the doctor's attitudes, feeling and involvement with the company – increased.

Recent market research (*see* Figure 3) tells us that one of the most significant factors which influences a GP's attendance at a medical/pharmaceutical meeting is the presence of an expert or opinion leader on the programme. Speak to any professional symposium and conference organizer and they will extol the virtues of 'crowd pullers' in the programme who guarantee 'bums on seats'. This phenomenon is true not just for the pharmaceutical industry, but for just about every other thriving area of business.

Opinion leaders are independent clinicians or scientists, who are men or women of integrity, and there is a danger that companies can become obsessive and regard them as company property. This attitude is self-defeating for both the company and the clinician. If an opinion leader appears to be bought or biased towards a particular company then credibility is lost, opinions become worthless and a valuable asset is devalued. There is nothing wrong with positive opinion leaders being regarded as prime assets and guarded with some jealousy. However, it must be remembered that whilst guarding is one thing, possession is quite another.

The major pitfall open and stepped into by many companies is that trialist is synonymous with opinion leader. Ideally this should be the case, but unfortunately many an excellent study carried out by a first-rate trialist has not been given the publicity it deserves because the presentation of the data was distinctly lacking. Presentation skills courses for key clinical trialists may facilitate the progress from trialist to opinion leader.

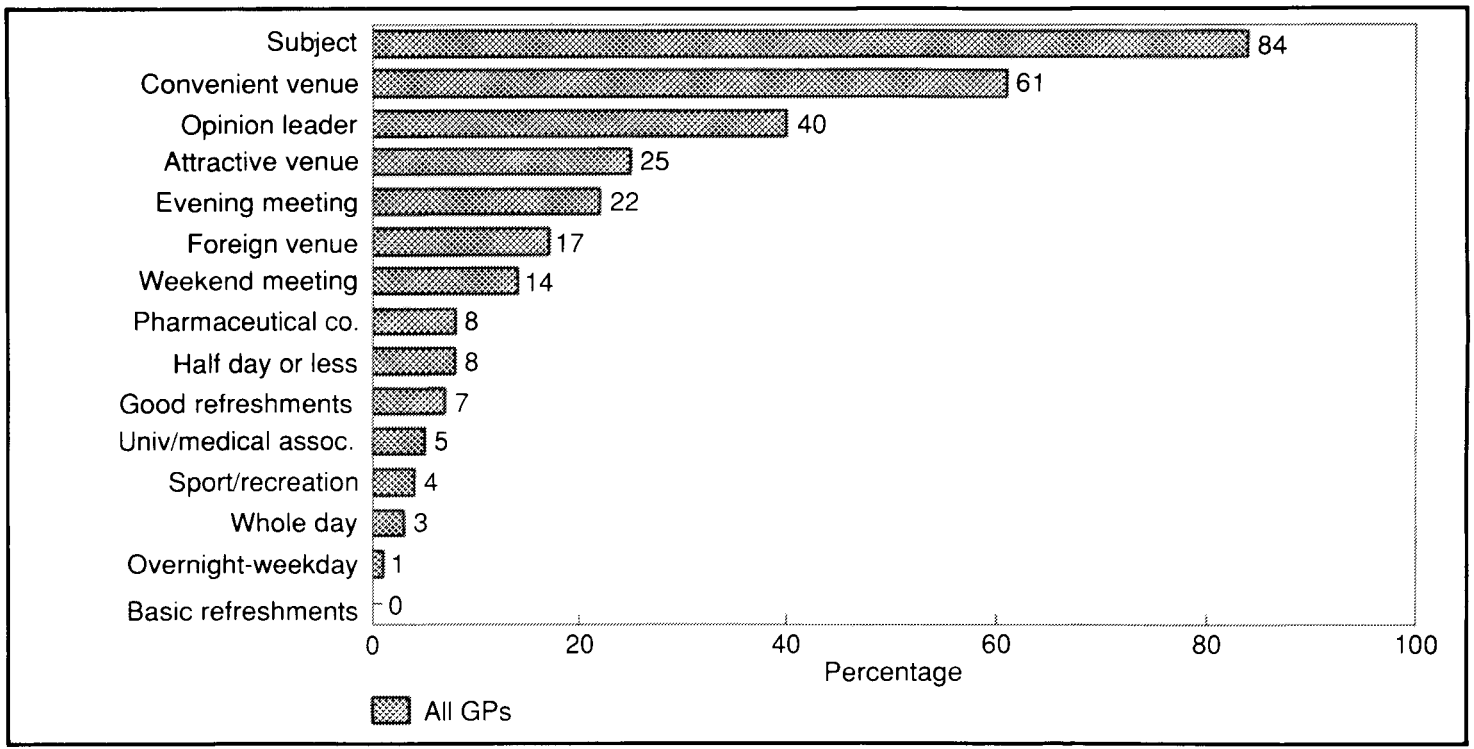

Figure 3. Factors affecting GP attendance at medical/pharmaceutical meetings. (Meditex, 19-24 September 1989).

Another frequent area of confusion is between opinion leader and product champion. Such confusion is dangerous and may lead to an opinion leader becoming compromised. It is important to be aware that opinion leaders are clinicians or scientists with respected opinions, which are heeded and valued by their peers. They may be supportive and helpful to the company and give valuable advice on a product recommending, for example, its use alongside other therapies – but presenting a balanced view. The product champion, on the other hand, will get off the fence and recommend a drug before or above other therapies. Product champions are rare, and should be used sparingly. Overused at too many symposia or by too many supportive articles, they become devalued and develop a credibility problem.

Opinion leader assessment

When a company enters a new field of medicine part of the premarketing activities will be to discover and develop opinion leaders. As the medical speciality is new to the company the question inevitably arises 'How do we discover who they are?' Intelligence gathering is necessary (*see* Figure 4) and, as in most business enterprises, planning is essential and timesaving in the long run. Just because a company has developed a 'state-of-the-art' diuretic for congestive heart failure does not mean that the opinion leaders will be cardiologists. Similarly, a drug that reduces the size of the prostate gland in benign prostatic hypertrophy will not necessarily be welcomed by urologists with long waiting lists and thriving private practice.

This is why it is crucial that the marketing and communications functions work closely together. Many is the occasion when hard market research data can be confirmed or refuted by 'on-the-ground' intelligence from the communications experts talking to the medical experts. The role of the company's field force in gathering such intelligence should never be underestimated.

1 Sales force contacts
2 R & D trialists
3 R & D personal contacts
4 Marketing personal contacts
5 Medical department personal contacts
6 Own personal contacts
7 Publications
8 Cross referral 1 – 7
9 Isolate 'common denominators' (CDs)
10 Re-reference CDs with personal contacts
11 Visit CDs
12 Intelligence gather from CDs
13 Categorize CDs
14 Obtain further contacts from CDs

Figure 4. Opinion leader intelligence gathering.

Existing opinion leaders in a speciality can soon be discovered by perusal of journals and symposia proceedings and, if sponsored, the latter may also give an insight into the allegiances of the experts. So continued exposition by individuals in a field of medicine identifies them as opinion leaders. This is the first important step in the intelligence gathering operation. The next step is to visit these experts and actually ask them about their own and their colleagues' opinions. This will inevitably lead to the discovery of further leaders and the confirmation of the group discovered in step one.

The validation of an opinion leader group may be taken several stages further by utilization of the expertise of the field force and medical department. This process is particularly relevant to a company extending its franchise within a field of medicine in which it is already well established. Once a core group of opinion leaders has been identified the company will need to demonstrate its commitment by bringing the elite group closer and developing links.

Obviously with prime assets it is valuable to monitor and evaluate the investment, and a progress and commitment file should be kept and regularly updated (*see* Figure 5). The system

NAME AGE
TITLE AND QUALIFICATIONS

DOCTOR NUMBER CATEGORY
SPECIALITY
TEACHES
HOSPITAL ADDRESS

TEL NO
RELEVANT PUBLICATIONS

HOME ADDRESS

TEL NO
MARITAL STATUS SPOUSE'S NAME
CHILDREN
INTERESTS (SPORT, MUSIC ETC)
ADDITIONAL INFORMATION

INVOLVEMENT WITH COMPANY
[ ] TRIALIST
[ ] LECTURER/CHAIRMAN QUALITY

INPUT FROM COMPANY
FINANCE YTD
INFORMATION
TRAVEL
EQUIPMENT
COURSES
DETAILS OF INVOLVEMENT WITH OTHER COMPANIES

OTHER RELEVANT INFORMATION

WARMTH FACTOR

DATE OF LAST VISIT
DATE OF NEXT VISIT

Figure 5. Opinion leader file.

may be manual or alternatively the file may be kept on computer.

Two levels of leaders are worth considering: the established and the potential.

Established opinion leaders

These will be senior consultants, professors or senior GPs, and occasionally less senior clinicians or scientists who have done original research or are particularly vociferous about a point of view.

> Recently there has been much controversy regarding the use and abuse of B_2 agonists in asthma therapy. It is interesting that the temperature of controversy was turned up by an 'hypothesis article' in *The Lancet* [1]. Whilst the hypothesis was elegantly argued, it was nothing more or less than that. As the author was a respected pharmacologist his piece was picked up by the medical and lay press and widely publicized, leading to further correspondence with the editor. Additionally, the companies manufacturing B_2 agonists became involved, resulting in a meeting of experts who issued a statement. This in turn was picked up by the press.

The main role of any opinion leader is third party endorsement, either by the written or spoken word. Thus, depending on whether he is to perform in writing or orally, a development programme will have a particular end point. The doctor or scientist will be giving third party endorsement in writing either in a published clinical trial or a review article,

and he will be putting forward opinion or clinical data as a speaker at a symposium or meeting.

Development programmes for established opinion leaders are standard practice in most major pharmaceutical companies and may include the following:

- sponsored attendance at international symposia
- payment as adviser or consultant to the company
- sponsorship of research or researcher
- provision of slide/lecture notes equipment.

Recently, bearing in mind the importance of third party endorsement, several companies have taken a more enlightened and broader approach. They have realized that clinicians and scientists have to be managers within the new NHS structure. Accordingly they have taken the far-sighted approach of running management courses of various types. In this way the industry shares its expertise and skills in management with colleagues in the medical profession, which in turn leads to closer links between the medical profession and the pharmaceutical industry.

Putting established opinion leaders on various types of presentation courses often proves worthwhile for both the leader and the sponsoring company. The leaders improve their skills, and are thus of greater benefit to the company, which itself benefits from the closer links and improved 'warmth factor'. My own experience of organizing training courses for senior physicians has led to the development of long-lasting business relationships which have proved invaluable in times when issue or crisis management have required a third party reference. Additionally, during the planning stages of a major meeting or initiative these close business relationships have provided objective opinions on very many important issues.

Potential opinion leaders

Opinion leaders of the future are obviously important to every major pharmaceutical company. To identify these rising stars, several approaches may be adopted. Simple talent spotting at major meetings and symposia is quite valid, whilst a relatively junior clinician or scientist may 'arrive' as an opinion leader through the publication of a simple piece of clinical research in a reputable journal. The publication of review articles by younger doctors also enables them to become 'known', and this is often a route to becoming an opinion leader without seniority or unique research.

Potential opinion leaders may be developed by the establishment of competitive fellowships and scholarships, such initiatives allowing future opinion leaders to rise to the surface. Once identified, close relationships may be built and established relatively quickly by accompanying the scholarship recipients to a prestigious meeting. Involvement of the official representative body of a particular medical speciality creates closer links and bestows greater respectability on any scholarship or fellowship initiative.

Another well tried way of developing opinion leaders and consolidating existing relationships is to involve them in clinical trial work. These trials may be at any stage of a drug's development and early involvement of key clinicians is often beneficial in developing important relationships.

Advisory groups

Bringing together a group of 'specialists' to act as paid advisers to a company can produce substantial dividends. Such an advisory group may consist of consultants only, but it may be better balanced if a specialist GP is included when the product is being targeted at this audience. The group can be seen to best effect when used as part of a pre-launch strategy, and the

utilization of advisers in issue or crisis management is obviously beneficial.

The role of an advisory group must be clearly defined, and members must be apprised of their duties and remit. A formal secrecy agreement is usually necessary, as advisers will be privy to information deemed as confidential or sensitive.

A key function of an advisory group is the development of a positioning statement, and this is particularly relevant when a product has conflicting data. Independent advisers can act as arbiters: they enable the company to look outside its narrow corridors and see beyond the marketing platform. They must therefore be able to resist the steamroller of marketing pressure and give considered independent advice.

The advice of a group chosen post launch to look at future strategy or particular tactics can be invaluable. The post-launch viewpoint is particularly relevant when a competitor drug enters the marketplace or new clinical data alters the marketing perspective.

The chairing and handling of an advisers' meeting requires a delicate touch. Whilst advisers are free agents, the meeting will and should have marketing, communications and medical input from the company; thus forces will be at play which might compromise certain interests. The marketeers might be trying to outflank the medics; similarly, the medics may be guilty of intransigence over the interpretation of data vital to a particular marketing platform. The external advisers may initially feel uncomfortable in such an environment, and the chairman of the meeting must be alive to the various sensitivities and guide those involved towards constructive conclusions.

The presence within the meeting of a representative from the company's communications agency offers an extra dimension which can benefit both the company and its advisers. Such a person may play the role of 'honest broker', putting advisers at ease and interceding between any internal warring factions.

A meeting which can have such fundamental repercussions on the direction and outcome of the company's business should

be fully minuted and can often benefit from recording and transcription.

Media opinion leaders

Journalists, reporters and editors are just as much opinion leaders in the medical media as doctors are within the medical profession. For some inexplicable reason companies often jealously guard their medical opinion leaders yet are quite willing to let an agency be the focus of attention for those within the media. Whilst this is understandable in a small dedicated communications function it is never justifiable and once the focus of attention for any opinion leader becomes an agency then a valuable asset is being mishandled. Nevertheless, it is sometimes useful for the agency to provide an introduction to, or a buffer between, a company and an opinion leader. The latter are relatively easy to identify in the medical journals and in the health pages of the lay press, as are editors and journalists/presenters in radio and television.

A similar process of development as described in the case of medical opinion leaders can be embarked upon, though there is one cardinal difference between developing relationships with media professionals and the medical profession: whilst it is quite acceptable to group physicians, surgeons, professors or GPs together this is seldom the case with media people. Essentially the reason for this is simple. Generally, the medical profession have a commonality of purpose and expertise, and except in exceptional circumstances have no particular competitiveness, nor any axe to grind. Media professionals, on the other hand, are forever looking for a story, or a different angle on the same story, so a separateness is inevitable and frequently, though not always, essential.

Often the best way to establish close links with the media is by regular lunch meetings when information can be provided about events within the company which might be considered newsworthy. Seminars on a particular medical topic using an

opinion leader can be a viable way of contacting journalists, though this does not give an exclusive single contact which, as already mentioned, is the ideal.

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9

The NHS and its Managers

Chris Ham

In recent years the NHS has been through a series of reforms designed to strengthen management and achieve better value for money. Many of these reforms have been initiated because of a concern to ensure that the large sums of public money allocated to health services are used efficiently. Established methods of providing services have come under question, and few areas of expenditure have escaped scrutiny. The amount of money spent on drugs, especially in general practice, has resulted in a number of initiatives to control expenditure and promote cost-effective prescribing.

Health services managers have come to play a more prominent part in the running of the NHS as a result of the reforms which have been undertaken. This process started in 1983 with the Griffiths Report. As a result of Griffiths, the position of managers was strengthened considerably, and they were expected to take on a leading role in implementing government policies at a local level.

Partly as a consequence of these changes, the traditional autonomy of doctors has come under challenge. Doctors themselves have taken more responsibility for the management of resources in many places, but they have also found managers taking a closer interest in clinical decisions. This has impacted on both GPs and hospital doctors and the effect has been to make doctors more accountable for their performance than has often been the case in the past. The medical profession retains a good deal of influence over the use of resources but clinical freedom operates within more closely defined limits.

Despite the rhetoric of political debate, patients continue to have a weak voice within the NHS. Both the Citizens' Charter and the Patients' Charter aspire to increase patient choice and make the NHS more responsive to the wishes of patients and the public, but much remains to be done to make this a reality. Decision-making is dominated by politicians, managers and healthcare professionals, and patients and the organizations representing their interests have limited influence.

How then is the NHS organized and run? And where do managers fit in to the structure? These are the questions addressed in this chapter, which also considers the financing of health services and the way in which priorities are set.

The organization of the NHS

The organization of the NHS in England is illustrated in Figure 1.

The Secretary of State for Health is responsible to Parliament for the provision of health services and discharges his responsibility through Regional Health Authorities, Family Health Services Authorities, Special Health Authorities, District Health Authorities and NHS Trusts. Community Health Councils are statutory bodies established at a local level to represent the interests of their communities in the NHS, but lie outside the managerial chain.

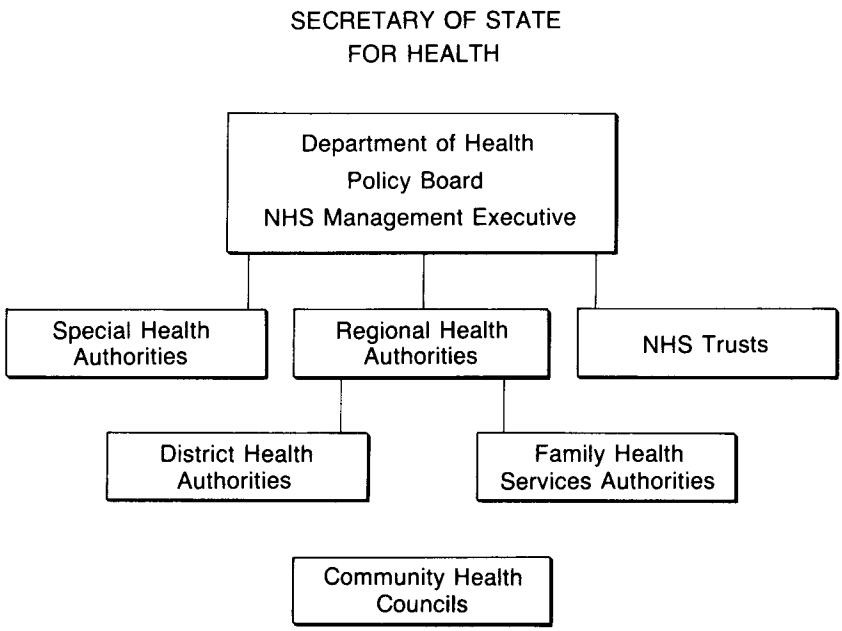

Figure1. The organization of the NHS in England.

The Department of Health

The Department of Health is responsible at a national level for the NHS and also for setting the policy and legislative framework for the personal social services and other health issues. The Secretary of State for Health sits at the head of the department and he is supported by a Minister of State for Health and by a number of junior ministers. Some 5,200 civil servants work in the department. The most senior of these civil servants are the Permanent Secretary, the Chief Medical Officer and the Chief Executive of the NHS Management Executive.

The Secretary of State is assisted within the department on NHS matters by the Policy Board and Management Executive. The Policy Board sets the broad strategic direction for the NHS, and the Management Executive deals with all operational matters within the strategy and objectives established by the Policy Board. The Policy Board is chaired by the Secretary of State and its members include a number of

businessmen, people drawn from the NHS, officials (including the Permanent Secretary and Chief Executive) and health ministers. The Management Executive is chaired by the Chief Executive of the NHS and its members comprise civil servants and people from business and the NHS. In effect, the Management Executive acts as the 'head office' for the NHS, although it operates within the policies set by ministers.

Regional Health Authorities

Regional Health Authorities (RHAs) are the intermediate tier between the Department of Health on the one hand and District Health Authorities and Family Health Services Authorities on the other. There are 14 Regional Health Authorities in England serving populations ranging from two million to over five million (*see* Figure 2). The revenue budget for Regional Health Authorities varies from £558 million to £1,458 million.

Each authority comprises a chairman and five non-executive members appointed by the Secretary of State, together with up to five executive members. Two of the executives, the General Manager and the Chief Finance Officer, are ex-officio members. The remainder are appointed by the chairman and non-executive members together with the general manager. The Regional Health Authority works as a corporate body and is accountable to the Secretary of State.

Regional Health Authorities perform a number of functions in the NHS which are mainly concerned with planning, resource allocation, and monitoring performance. They also have a significant part to play in implementing the Government's reforms of the NHS. This includes guiding the introduction of NHS Trusts, overseeing implementation of new funding systems for GPs and NHS authorities, leading the development of contracting, and ensuring that the reforms are introduced on time and in a managed way.

Figure 2. Regional Health Authorities.

District Health Authorities

District Health Authorities (DHAs) are the bodies responsible for purchasing hospital and community health services for their residents. There are around 190 District Health Authorities in England with populations ranging from 89,000 to 860,000. The revenue budget varies from £13 million to £183 million.

Each Authority comprises a chairman appointed by the Secretary of State, five non-executive members appointed by the Regional Health Authority and up to five executive members. Two of the executives, the general manager and the chief finance officer, are ex-officio members. The remainder are appointed by the chairman and non-executive members together with the general manager. The District Health Authority works as a corporate body and is accountable to the Regional Health Authority.

District Health Authorities perform a number of functions in the NHS. These include purchasing healthcare for their residents and managing the services provided in directly managed units. District Health Authorities also have a number of traditional public health responsibilities.

Family Health Services Authorities

Family Health Services Authorities (FHSAs) manage the services provided by GPs, general dental practitioners, retail pharmacists and opticians. These family practitioners are independent contractors and are not employees of the NHS. The terms and conditions under which family practitioners work in the NHS are negotiated nationally. Family Health Services Authorities are responsible for implementing the national contracts in their areas.

There are 90 Family Health Services Authorities in England serving populations ranging from about 130,000 to 1,600,000. Each conforms to a major local authority area and generally follows the geographical boundaries of District Health Authorities. Family Health Services Authorities comprise a chairman appointed by the Secretary of State, five lay non-executive members and four professional non-executives appointed by the Regional Health Authority. The Authority also includes a general manager appointed by the chairman and non-executive members. The Family Health Services

Authority works as a corporate body and is accountable to the Regional Health Authority.

Family Health Services Authorities perform a number of functions. These include managing the contracts of family practitioners, paying practitioners in accordance with contracts, providing information to the public and dealing with complaints made by patients. They have also been given a number of new functions, including setting up and monitoring indicative prescribing amounts and working with Regional Health Authorities on the introduction of GP fundholding.

NHS Trusts

Under the NHS reforms, hospitals and other units providing patient care may volunteer to become NHS Trusts (NHSTs). These are self-governing units within the NHS. They are run by boards of directors and are accountable to the Secretary of State without any intervention from Regional or District Health Authorities. 57 Trusts came into operation in April 1991 and a further 95 in April 1992.

Trusts have a range of freedoms not available to directly managed units. In particular, they are able to determine their own management structures, employ their own staff and set their own terms and conditions of service, acquire and sell their own assets, retain surpluses, and borrow money subject to annual limits. Each trust is required to prepare an annual business plan outlining its proposals for service development and capital investment. Like other units, trusts receive their income from contracts with health authorities, GP fundholders and other purchasers.

Special Health Authorities

Some NHS services are administered by Special Health Authorities (SHAs) responsible for specific areas of activity.

Examples are the eight authorities covering London's post-graduate teaching hospitals, the Health Education Authority, the Mental Health Act Commission and the Special Hospitals Services Authorities. The Special Health Authorities are not part of the NHS structure but are directly accountable to the Secretary of State.

Community Health Councils

Community Health Councils (CHCs) are statutory bodies established by Regional Health Authorities to represent the public's interest in the local provision of health services and to be the channel for consumer concerns. As a general rule, there is one Community Health Council for every District Health Authority. Community Health Councils normally have 18 or 24 members nominated by voluntary organizations, local authorities and the Regional Health Authority. The secretary is a paid employee of the Regional Health Authority. Most Community Health Councils operate on an annual budget of around £40,000 provided by the Regional Health Authority.

The role of managers

The management of the NHS has undergone a series of changes in the last decade. In 1983 a team led by Sir Roy Griffiths, Managing Director and Deputy Chairman of the retailers, Sainsbury's, produced a report on health services management which was highly critical of management at all levels in the NHS. In particular, it argued that consensus management through multidisciplinary teams failed to provide the drive and leadership needed in the NHS. The Government accepted the findings of the Griffiths Report and announced that its recommendations would be implemented.

As a consequence, general managers (now often referred to

as chief executives) were introduced at regional, district and unit levels, accountable for the total performance of their organization. Management systems were refined and developed, including the introduction of performance-related pay and individual performance review, which were later extended to other management levels. The employment package for general managers also included short-term (usually three-year) rolling contracts. The intention of these changes was to place a high premium on achieving improvements in services and to break away from the inertia that was sometimes a feature of consensus management.

The introduction of general management had a number of other effects. In place of management teams which had the same membership everywhere, a variety of management arrangements emerged to suit local circumstances. This included the appointment of senior managers to take responsibility for quality assurance as part of the move to make services more responsive to patients. These managers initiated a series of policies designed to make the NHS user friendly. Examples included surveys of patient satisfaction, staff training in customer relations, and initiatives designed to produce clearer information for patients. Despite these efforts, the NHS agenda in the 1980s was dominated by financial issues, in particular the concern to balance the books and achieve higher levels of efficiency. As a consequence, patient concerns remained marginal, despite a genuine commitment on the part of many health authorities to raise the quality of care delivered to their communities.

Another effect was to devolve decision-making powers from District Health Authorities to units of management (that is hospitals and other services). Devolution did not occur universally, but where it did units were given more responsibility to manage services within parameters and objectives set by the District Health Authority.

In parallel with these changes, the Department of Health pioneered the introduction of resource management. In broad terms, resource management seeks to improve patient care by:

- devolving budgetary responsibility to clinical teams within hospitals
- enabling managers to negotiate workload agreements with these clinical teams
- improving information systems to provide staff with better data about their services.

Initially resource management was developed at six acute hospital sites where medical and nursing staff were known to support the principles involved. Following promising progress reports from the six sites, and the ministerial review of the NHS, the Government decided to extend resource management rapidly to other hospitals. Central funds were set aside to support implementation and a heavy emphasis was placed on training and organizational development.

Resource management is important in signalling a move away from an NHS in which doctors have had considerable freedom to practise without taking into account the effect of their decisions on their colleagues or on the use of resources. Of course, clinical freedom has never been absolute, but as a result of the Griffiths reforms it operates within more closely defined limits. This involves greater cooperation between doctors in setting clinical policies (eg in relation to the use of expensive drugs) and closer involvement on the part of general managers in clinical matters. Hospital doctors retain a significant amount of influence in determining the direction in which services develop, but managers have moved from the position of being administrators to take on a more active role in the running of the NHS.

The general management revolution initially bypassed the family practitioner services. However, following the ministerial review of the NHS, Family Health Services Authorities were asked to appoint general managers. Also, the membership of Family Health Services Authorities was changed to make them more businesslike.

In parallel, GPs and other members of the primary care

team have been expected to take on a bigger role in the management of services. This has included measures to tighten up on prescribing, including the introduction of a limited list of drugs for GPs and the use of the prescribing, analysis and cost (PACT) system. More recently, Family Health Services Authorities have appointed independent professional advisers to work with GPs in reviewing prescribing and referral patterns. As in the case of resource management in hospitals, these changes imply greater accountability on the part of doctors and closer managerial involvement in medical decisions.

Financing health services

Expenditure on the NHS in the UK amounted to over £32 billion in 1991/2 and important changes have been introduced into the way in which this money is allocated. In the case of District Health Authorities, the aim is to allocate resources to authorities to enable them to purchase services for the population they serve. Health authorities are responsible for negotiating contracts with providers for the delivery of services and these contracts set out the standards of care that should be achieved. Over time, the basis on which health authorities are allocated resources will move to a weighted capitation formula in which budgets are determined by the size of the population adjusted for age, sex and other relevant factors. This will mean a significant change in the amount of money available to some authorities.

GP fundholders also act as purchasers of some services for their patients. The funds that GPs have available to spend are determined in discussion with Family Health Services Authorities and the Regional Health Authority. The scheme covers a defined range of services, comprising outpatient services, diagnostic tests, and in-patient and day-care treatments for which there is some choice over the time and place of treatment. The cost of these services is deducted from the allocation of the relevant District Health Authority. The

allocation of the relevant District Health Authority. The resources made available to GPs in the fundholding scheme also include an amount to cover the cost of prescribing. This is the largest single element in the fund which is controlled by GPs.

GPs who are not in fundholding practices have indicative prescribing amounts (formerly known as budgets). The introduction of indicative prescribing as part of the NHS reforms is a continuation of the policy of seeking to improve the efficiency, quality and value for money of drug prescribing. Family Health Services Authorities set and monitor prescribing amounts and work with GPs in reviewing changes in prescribing patterns. The cost of the drugs bill in general practice has forced the Government to take a closer interest in expenditure in this area. Much the same applies to expenditure on drugs in the hospital service where doctors and managers have increasingly made use of formularies as a way of achieving better value for money.

The pressures on health service spending are certain to increase in the 1990s. Whichever party is in government, the amount of money available for growth is likely to be limited. Advances in medicine will open up new possibilities for diagnosis and treatment and it may not be possible to provide funds for all of these developments. The rationing of healthcare will become more difficult and both health authorities and GPs will be faced with some tough choices.

Rationing has always been part of the NHS as the existence of waiting lists for some operations demonstrates. The NHS reforms make rationing more explicit because the introduction of contracts to link the purchasers and providers of services has the effect of forcing purchasers to determine what they wish to buy with their resources. The consequence is that they have to be much clearer about what services they are not purchasing, either because there is insufficient money or because those services do not have high priority.

In this context the NHS is in a similar position to the State of Oregon, USA, which has been through a public exercise in determining what services should be provided as part of the

Medicaid programme. A list of over 70 treatments was identified following a period of public consultation, and following a review of the evidence on the cost and effectiveness of these treatments a set of priorities was drawn up. Within the budget available, it was only possible to provide funding for 587 treatments. However, as a result of the process, the State legislature agreed to find additional resources for the Medicaid programme, and it may well be that politicians in the UK will also find that the pressure to increase spending on the NHS will increase as a result of the NHS reforms.

It is also clear that those who are seeking funding for the development of new services will have to be able to demonstrate the benefits that will result. Health authorities and GPs will want to be sure that they are spending their resources to best effect. It will no longer be possible to guarantee funding for new developments as they come on stream and difficult decisions will have to be made about the use of available funds. The purchasers of care will increasingly require evidence of the cost effectiveness of medical technologies (whether drugs, equipment or new techniques) before allocating resources.

As a consequence, managers may make increasing use of information on cost per Quality Adjusted Life Years (QALYs). The Quality Adjusted Life Year is a technique which seeks to summarize in one measure the benefits of medical intervention in terms of the number of years of life they save and the quality of life saved. Information about costs can then be added and the cost per Quality Adjusted Life Year can be calculated. If this procedure is carried out for a range of treatments, it is possible to draw up a league table for the cost per Quality Adjusted Life Year for different treatments. When this is done, it can be shown that hospital dialysis is less cost beneficial than renal transplants, while hip replacements or pacemaker implants are even better buys. It should be noted, though, that the use of Quality Adjusted Life Years remains controversial, and there is far from universal acceptance that they are a useful tool for determining priorities.

Conclusion

The impact of recent reforms to the NHS can be summarized as follows. Hospital doctors and GPs have become more closely involved in the management of the NHS and the position of managers has been strengthened. The resources available for growth have been tightly constrained and this has forced health authorities to examine more closely the cost effectiveness of their decisions. Various policies have been pursued to promote the better use of resources, and these are certain to continue in the 1990s with attention being focused on the PACT system, indicative prescribing and GP fundholding. In this situation, the rationing of healthcare will become increasingly difficult, and tough choices will have to be made about the use of available funds. The pharmaceutical industry, like other suppliers to the NHS, will have to persuade managers that its products offer benefits over traditional methods of providing care, and will need to support its claims with evidence and information drawn from research.

10

Marketing Communications – the Future

Peter Holden

Whilst hardly catchy or slick, the title of this book – *Marketing Communications in the Pharmaceutical Industry* – is at least descriptive. We have covered the principal marketing communications vehicles which surround the 'pure' marketing activities, and it is hoped that the book will fill a gap in the marketplace and provide a definitive text on the subject. Careful thought was given to the selection of contributors, and it should be noted that whilst the Association of the British Pharmaceutical Industry (ABPI) was approached they declined our invitation to contribute. This I think is a pity because it could be argued that they should play a central role in marketing communications.

It was never the intention that the book should be read from cover to cover, but if it is, then areas of contention and disagreement will become apparent. There is inevitably a certain degree of overlap of activities. On the agency side you would not necessarily expect those involved in advertising and PR always to be in agreement; they are, after all, often

competing for a piece of the same marketing budget, and it is not uncommon for advertising agencies to consider that they are good at PR. With apologies to the editor of the chapter on advertising, I have never yet come across an advertising agency which is good at both. The two disciplines are different, and there are some very sound reasons for keeping them separate. Advertising requires creative skills which are very different from the kind of creativity required in PR. Put simply, advertising tells whilst PR sells.

The marketing communications vehicles discussed – internal communications, the medical department, the sales force, meetings, symposia, conferences, advertising, PR and opinion leader development – are all there, and the customer, in the guise of the NHS, is strongly featured. So what of the weighting of these various vehicles, and what of the future?

A failure to view marketing communications in totality leads, in my view, to a waste of a valuable resource. How many companies actually share marketing or business strategy with their agencies? How many companies bring together all those responsible for the many facets of marketing communications? When a company appoints an advertising and a PR agency, does this facilitate regular meetings between all interested parties? In my experience, the answer to all these questions is 'Not very often, if ever', and this is the very crux of the problem. Senior managers do not see marketing communications as a complete picture, or as a series of complementary activities; instead, they tend to see these as separate entities in compartments with no connecting doors.

The weighting of various activities will vary according to the product and the stage of its lifecycle. Opinion leader development, whilst crucial during prelaunch and immediate launch phases, may be less important for a mature product. Classic PR can similarly do much for a product in its infancy, and should be the main vehicle for prelaunch and launch phases. Advertising creates awareness when a product is launched, and may maintain the awareness of a mature product. At the sharp end, the sales force should be implementing the marketing communications strategy; this can, however, only

be achieved effectively and efficiently if there is a common understanding of the important goals.

Just as it is important that the company shares strategies and plans externally with its agencies, so internally the communications process is crucial. Business units and project teams which cross boundaries are an essential part of the marketing success. A project team for a new product launch should therefore include members of the medical, marketing, communications and sales departments. As the launch date approaches, the support agencies will become more and more involved.

At least once a year, marketing communications people from within the company should sit down with their counterparts from outside the company and seek answers to the following questions:

1 Where are we now?
2 Where do we want to be in the future?
3 How are we going to get there?

Advertising and PR agencies will have much to say about question 3, but in order to make a really meaningful and valuable contribution they need to know the answers to the first two questions, and the background and data which helps to yield the answers. This sharing of background information and strategic thinking will facilitate the implementation of sound plans and tactics.

To return to the actual mix of activities, many have sounded the death knell of the medical representative in the past, yet there are probably more representatives and larger field forces now than at any time. Targeting of key doctors has developed into something of a science, and its merits and demerits are hotly debated. The targeting of fundholding practices seems a logical step forward.

Medical television was once seen as a major competitor to journal advertising, but has yet to materialize as a major force. However if, as seems likely, the proposals to use television down time come to fruition then advertising revenues could be

diverted away from journals. A television channel for GPs based on the ethos of the primary healthcare team could have a certain cachet. With PGEA (Postgraduate Education Allowance) approval, it could become a major player in GP education and training. Pharmaceutical companies and indeed many other companies with goods to sell will then wish to channel advertising revenue its way.

The Pharmaceutical Price Regulation Scheme (PPRS) and the organizational changes in the NHS will certainly make companies think more about educational and communications activities which do not attract tax penalties – and indeed they already have. Meetings, symposia, educational videos and distance learning programmes will become more common. Those companies which, by virtue of their very size, fall outside the PPRS penalties may continue to make major use of above-the-line promotional techniques. However, they will supplement these activities with others which do not attract PPRS. Those companies, on the other hand, which fall within the PPRS net will more and more resort to activities which are exempt. As a result, financial considerations rather than strategy may determine the make-up of the marketing mix. Funds may be diverted into below-the-line activities and the promotional message strengthened through serendipity.

As mentioned in the chapters on the medical department and on the NHS managers, cost benefit and quality of life studies will play a major part in promotion. In fact, it will become the norm for formularies to demand 'economic' and quality of life studies before drugs are sanctioned for use. Such studies will tend to be undertaken during the premarketing phase and may become part of product licence applications.

The future of marketing, then, seems set for change – change not in the actual vehicle used, but in the mix. The NHS changes and government intervention will cause marketeers to be more innovative and examine below-the-line activities more closely. Communications activities in their broadest sense will be seen for the powerful marketing influence they can exert. The number of communications/PR agencies will inevitably decrease from the 40 or so that exist today. However, the

activities which they undertake will increase and diversify, and take a greater share of the marketing budget.

Abbreviations

ABPI	Association of the British Pharmaceutical Industry
CHC	Community Health Council
CRA	Clinical Research Associate
DHA	District Health Authority
DTC	Direct to Consumer
FHSA	Family Health Services Authority
FPC	Family Practitioner Committee
GP	General Practitioner
LMC	Local Medical Committee
MBA	Master of Business Administration
MRPharmS	Member of the Royal Pharmaceutical Society
NHS	National Health Service
NHST	National Health Service Trust
NSAID	Non-Steroidal Anti-Inflammatory Drug
OTC	Over the Counter
PACT	Prescribing, Analysis and Cost Data
PGEA	Postgraduate Education Allowance
PRO	Public Relations Officer
QALY	Quality Adjusted Life Year
RHA	Regional Health Authority
Rx	Prescription
SHA	Special Health Authority

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