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## Contents



## Up Front

### The Price of Drugs

A recent AARP study indicates that manufacturers' prices for prescription drugs rose nearly 3 times the rate of inflation. PhRMA counters that prescription drug prices increased at a lower rate than other health services. Besides, chides PhRMA, AARP should spend more effort signing up as many seniors as possible for the Medicare-endorsed discount cards. So there!

Another argument often heard from industry supporters on the issue of drug prices is: "If we cut drug profits [by lowering drug prices], research will slow down and breakthroughs won't be there when we (or our children or grandchildren) need them." [See recent PHARMA-MKTING thread.]

People should be thankful that they have effective drugs, say supporters, and they should keep that in mind when they complain about drug prices. In other words, stop complaining about drug prices and be thankful we do this for you!

These and other typical pharma industry responses to criticism about rising drug prices may make economic sense, but they do not resonant with consumers' perceptions and emotions. In fact, sometimes it seems more like a slap in the face than a consoling pat on the back.

I think pharma is being caught off-guard by consumerism—in general, pharma doesn't seem to understand consumers and how to deal with consumer issues although they spend lots of money advertising to consumers and thus are partly responsible for creating the problem.

As more and more consumers pay higher co-payments for drugs (or don't have any Rx coverage at all—the Census Bureau found last year that almost 44 million Americans had gone without health insurance for the previous year. That number has been increasing by roughly 2 million a year.), more and more consumers will be complaining about drug prices and demanding action from their representatives in Congress.

Pharma needs to realize that it just can't "win the argument."

The industry should stop arguing about drug prices, especially trying to make the price of drugs seem insignificant compared to other healthcare costs, and actually do more to lower prices while maintaining the profits they need.

Is it possible? A few members of the PHARMA-MKTING online discussion group think so. See the recent thread on this topic.

There is a 500-lb gorilla lurking here—the executive order by the president calling for the widespread deployment of health information technology within 10 years.

At a recent National Health Information Infrastructure conference I attended in Washington, DC, Dr. Mark McClellan, administrator of CMS, said that the new Medicare Law gives the government "new authority to move forward" with the rapid deployment of ePrescribing and other technologies that will reduce costs by allowing Medicare to pay for results.

The pharma industry, in other words, will need to guarantee results worth the higher price of their products and the government will be able to use technology to accurately measure outcomes and hold drug companies accountable.

IMHO,

**John Mack**, Publisher & Editor
**Pharma Marketing News**

## Feature Article

### California's Physician Prescribing Act: A History of Twists and Turns

By **John Mack**

California Assembly Bill 262 (AB 262) was introduced in February, 2003, just a few months before the Health Information Portability and Accountability Act (HIPAA) Privacy Rule became effective in April, 2003. Back then the bill was aimed at preventing the disclosure by healthcare providers of patients' medical information for marketing purposes without prior patient authorization.

AB 262, as well as other state bills backed by the AMA and its state affiliates (AB 262 is sponsored by the California Medical Association), intended to "fix" the marketing provision of the HIPAA Privacy Rule. Under HIPAA, the fact that a covered entity (e.g., physician) receives payment for a non-oral communication to a patient does not automatically qualify the communication as "marketing." AB 262 as introduced, on the other hand, defined such communications as marketing requiring prior patient authorization.

#### Twists and Turns

Reading the history of this bill as it wends its way through the legislative process is like viewing the layers of an onion being peeled away. AB 262 started out as another attempt to prevent "patient information" from being used for marketing purposes under the guise of protecting patient privacy. Under intense lobbying by various interest groups, the authors dumped the patient privacy language and added provisions to protect physicians from being profiled by pharmaceutical marketers. Incredibly, the authors attempted to enlist the right of "physician privacy" as an argument!

The story of AB 262 is a cautionary tale about how certain healthcare stakeholders use privacy issues as a weapon to protect their own proprietary interests.

In July, 2003, the act was amended to add provisions about prescription data. The revised AB 262 would require modification to the California Business and Professions Code specifically relating to pharmacists, making it unlawful for pharmacists to directly or indirectly sell or otherwise transfer prescription data to any person.

In August, 2003, the act took a more physician-oriented approach and focused on "prescribing data of a physician" and specified that the release of such data by pharmacists is prohibited if a physician has placed his or her name on a certain list to be created by the Medical Board of California, with specified exceptions.

Then, in January and June, 2004, the HIPAA-like marketing provisions were struck from AB 262, leaving only the provisions regulating release of prescribing data by pharmacists. The bill was now focused on "Doctor Prescribing Data" and officially became known as the "Physician Prescribing Practices Act."

#### Where It Stands Today

Today, AB 262 seeks to regulate the use of prescribing data for marketing purposes and to protect the privacy interests of doctors by regulating the activities of pharmacists and "data vendors" like IMS Health (see box).

**Data Vendors**

A "Data Vendor," as defined by AB 262, is any entity that acquires physician prescribing data and sells or transfers that data for any commercial purpose and whose primary business is the collection of this data.

The bill originally required data vendors to register with the Attorney General and the Medical Board of California in order to lawfully receive prescribing physician data. Pharmacists would have been responsible for verifying that a data vendor is registered before releasing data to the vendor. The registration requirement, however, was struck from the bill on July 7, 2004.

**Who are the data vendors?**
The industry leader among the pharmaceutical data vendors is Connecticut-based IMS Health. IMS Health is a publicly traded corporation (ticker: RX) with annual revenues of approximately $1.3 billion and market capitalization of nearly $6 billion. Other major companies in the field include NDCHealth (annual revenue of approx. $450 million), Dendrite (annual revenue of approx. $320 million), and Verispan (annual revenue of approx. $100 million in 2002).

Specifically, AB 262 establishes a "Do Not Use" list at the California Medical Board where doctors could register to prohibit their information from

being sold by data vendors. Pharmacists would be able to sell or release physician prescribing data to a data vendor only if the data vendor agrees to comply with the "Do Not Use" list maintained by the Medical Board.

**California Medical Board**

The Medical Board of California is the State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Medical Board members are appointed by the Governor (12 physicians and 7 public members), the Speaker of the Assembly (1 public member), and the Senate Rules Committee (1 public member).

## Uses of Prescriber Data

In order to understand how prescriber information is used, the California Senate Judiciary Committee sent questionnaires to six major pharmaceutical manufacturers: Eli Lilly, GlaxoSmithKline, Johnson & Johnson, Merck, Pfizer, and Schering-Plough. Schering-Plough declined to respond to the Committee's inquiry. Eli Lilly, GlaxoSmithKiline, Johnson & Johnson, Merck, and Pfizer voluntarily provided responses to the questionnaire.

The responses received indicated that pharmaceutical manufacturers purchase information from data vendors for use in a wide range of activities, including marketing. For example, GlaxoSmithKline writes that prescription data is used by their company for a wide variety of purposes, including:

- research trial design,
- research and development purposes such as analysis of drug candidates to determine patient needs,
- recruitment of physicians for clinical trials,
- market research,
- market analysis,
- sales reporting,
- routine pharmaco-epidemiology and pharmaco-vigilance activities, including risk-benefit assessment of the public health significance of adverse events and other potential safety issues, and
- monitoring utilization patterns for drugs that are involved in FDA mandated risk-management programs.

All the other companies emphasized that the data played a significant role in their research and public health purposes. For example, Pfizer wrote that they use the data to notify prescribers in the event of significant regulatory events (e.g., a product warning or recall). The timeliness of such communications has enormous patient safety implications, a fact that was confirmed recently in connection with a recall involving counterfeit Lipitor, Pfizer's cholesterol-lowering medication. Because of the availability of prescriber data, they are able to timely alert providers who might have distributed the counterfeit product unwittingly.

GlaxoSmithKline wrote that with respect to research prescription data is often used to find physicians who treat the illnesses in question. Contacting doctors directly to help find patients is a highly efficient way to help lower R&D costs. In contrast, broad media advertising for patients is not only very costly to purchase, but also carries high administration costs and yields a small number of patients per dollar spent.

All the companies confirmed that the data is used for marketing purposes. Merck wrote that this information helps them to effectively target medically relevant resources such as samples and patient education materials to physicians. Lilly wrote that it used the information to ensure that sales territories are of appropriate and efficient size and also that sales representative compensation is drawn, in part, from this information.

## Arguments in Favor

Organizations registering in favor of the bill included:

- AIDS Healthcare Foundation
- California Academy of Family Physicians
- California Alliance for Retired Americans
- California Medical Association (Sponsor)
- California Public Interest Research Group
- Consumer Federation of California
- Senior Action Network

The Judiciary Committee held several hearings on the collection and use of doctor prescribing data by data vendors. At these hearings, the California Medical Association (CMA), the AIDS Healthcare Foundation (AHF), and the California Alliance for Retired Americans (CARA) raised a number of concerns about the activities of the data vendors.

*Continues on next page…* ☞

Witnesses from CMA objected to the marketing practices of manufacturers that obtained data from data vendors, particularly when sales representatives made sales pitches that revealed how much the representatives knew about the doctor's prescribing patterns. More generally, CMA argued that the collection and sharing of physician-identified prescribing data raises privacy and public health issues that should be addressed by the Legislature..

According to CMA, AB 262 will restrict drug companies' access to physician information and regulate the multi-million dollar practice of lobbying physicians to prescribe high-priced drugs. The CMA indicates that currently drug companies pay retail pharmacies to obtain a list of physicians and the brands of drugs they prescribe. By gathering data on the more than 260 million prescriptions filled annually in California, drug companies are able to develop profiles of individual doctors indicating how often they prescribe a competitor's drug. This information is gathered without the knowledge or consent of either the physician or patient.

As explained by CMA, individual companies rely on this data to identify which physicians are most likely to be influenced, based on statistical analysis, by sales representative. As one data collection company reported, “Research has shown that winning just one more prescription per week from each prescriber yields an annual gain of $52 million in sales.”

The AIDS Healthcare Foundation (AHF), the largest AIDS organization in the United States, indicates they have witnessed over the years the inappropriate tactics drug-marketing representatives have used to influence health care providers to use their products. Drug reps, according to AHF, rely on prescribing data to target physicians they believe can be convinced to switch to their products.

As indicated by AHF, studies have found that drug manufacturers spend approximately 16% of their budget on marketing and more than 4/5 of that money is spent on marketing directly to physicians. The use of prescribing data helps the drug rep to get the biggest bang for his or her buck, a bang that translates into huge costs for consumers and third party payors, including the State of California. As argued by AHF, this situation can lead to inappropriate and unnecessary prescriptions that impact the care of the patient. Often, claims AHF, drugs are prescribed that are not necessary, are not the best treatment and may come at a higher price than other therapeutically equivalent drugs.

## Arguments in Opposition

Organizations registering in opposition to the bill included:

- Amgen, Inc.
- Aventis Pharmaceuticals, Inc.
- California Healthcare Institute
- California Pharmacists Association
- Endo Pharmaceuticals
- IMS Health Incorporated
- Quintiles Transnational
- Verispan
- Wyeth Pharmaceuticals

The data vendors and pharmaceutical industry responded with several arguments.

First, they argued that doctors should not have a privacy interest in their professional conduct. Privacy, they argued, is a right that has been afforded only to individuals in their personal capacity; an extension of the privacy right to professional conduct would be unusual and set a bad precedent for oversight of commercial conduct.

The data vendors also argued that doctors’ primary concern appears to be the marketing practices of sales representatives, and that regulation of data collection or sharing would be unjustified and detrimental to the many public health uses of the data.

The California Pharmacists Association (CPhA) is opposed to this measure for several reasons. As argued by CPhA, the recent amendments to this bill have placed language into the Pharmacy Act and requires pharmacists to monitor and regulate information flows between the pharmacies and the various entities with which the pharmacy comes in contact, and ensure certain information about physicians’ prescribing information is not released except for various permitted purposes. Failure to do so could subject pharmacists to criminal prosecution, civil liability and potential loss of license. CPhA also argues that physicians will be given a private right of action to enforce the legislation. Presumably, this right of action could be initiated against a pharmacist that has not properly monitored information flows or adequately restricted the use of the information.

While CPhA is certainly supportive of retaining patient confidentiality, CPhA stated, pharmacists’ time should be spent on the practice of pharmacy

for patient's benefits, not on monitoring physician level data to protect professional interests of physicians.

IMS Health Incorporated, a "data vendor," is opposed to the creation of a "Do Not Use" list and restrictions on use of prescription information proposed by CMA. IMS argues that this bill will create HIPAA-type requirements for changes to computer systems, processes, documentation and training in order to avoid improper release of physician prescribing information. These requirements will add significant cost to the health care system, and deprive everyone of valuable health care resources directed at these efforts.

Other concerns raised by IMS include:

- increased costs relating to the collection of health care information, and adverse impact on the quality of such information, resulting in loss of important health care benefits;
- the many beneficial uses of physician prescribing data for research and economic analysis will be disrupted;
- will establish a costly regulatory scheme that will result in increased health care costs;
- efforts to provide information to physicians that's relevant to their practice will become less efficient, leading to more visits, telephone calls and materials to physicians to ensure important information reaches these physicians;
- creates a privacy right for physicians which is inconsistent with both state and federal laws; and
- there is no evidence that existing guidelines regarding physician information use and disclosure sponsored by the AMA do not work.

Other opponents indicate that the restrictions imposed by this measure will disrupt established practices utilized by drug manufactures, physician organization and medical plans in acquiring prescriber data. It will drive up the cost of certain medicines to consumers and result in a substantial increase in California health care costs.

Pharmaceutical manufacturers' and biotechnology companies' marketing costs will substantially increase because marketing programs will become less efficient, according to the industry. Access to healthcare information on prescriptions may become unavailable to public health officials and other agencies and research centers and this would curtail studies that greatly benefit patients, by allowing pharmaceutical manufacturers to educate physicians on new drug combination therapy.

## What Next?

The current version of the bill does not seek to add provisions to the California Business and Professions Code, which would have held pharmacists responsible for compliance with the law. It also does NOT require data vendors to register with the Attorney General and the Medical Board of California in order to lawfully receive prescribing physician data.

The act will become operative only if, on or after January 1, 2006, there is an appropriation from the Contingent Fund of the Medical Board of California to fund the activities required of the board by the act, and sufficient hiring authority, as determined by the board, is granted to the board to provide staffing to implement the act, in which event the act shall cease to be operative five years after its operative date.

The bill was last amended on July 7, 2004 and sent to the Senate Committee on Appropriations, which will meet on August 8, 2004. From there it should go back to the Assembly for agreement on the amendments made in the Senate before a final vote in both houses.

Given the long history of this bill and its many twists and turns, there may be further surprises before it ever becomes law.

**Pharma Marketing News**

**SURVEY**

**ePrescribing:**
**Threat or Opportunity?**

What's you opinion? Please let us know.
Click here and take the survey now!

## Conference Highlight

# A Crisis in Professional Detailing

By **John Mack**

Although many people argue that physician detailing is inefficient, is often unproductive, and is difficult to do effectively, it is still "the best way for a doctor to find out about a product," according to Richard A. Bavasso, EVP/COO, Pharmedica Communications, LLC. He was speaking at a recent eyeforpharma conference on Sales Force Effectiveness, where he also moderated a panel of physicians who gave frank insights into what physicians want from pharmaceutical sales reps.

At least $15 billion annually is spent on physician marketing activities – including:

- Sales rep details
- Samples
- Patient education materials
- Brand awareness items
- Peer selling
- Medical meetings
- Market research/consulting
- Medical journal articles
- Medical journal advertising
- Call centers/support

Twenty-five percent of the annual $27 billion spent on pharmaceutical marketing is on the field force. "It's a significant investment," says Bavasso.

### Not Just Donuts, Coffee, and Pizza

While medical practice has changed dramatically in the past 30 years, professional detailing has not. It still relies on a colorful piece of cardboard with some charts and graphs and claims and benefits. The representative still tries to convince the doc that his or her company's product is better than the competitor's product.

After warning the audience that the series of referenced declaratives he was about to share with the audience were not going to be pleasant to their ears, Bavasso began to describe the physician perception that the value of the representative as a resource has declined over time. Instead of an educator, their perceived value has denigrated to a the most negative connotation of "sales person" and, in worst case scenarios, just a delivery person dropping off samples and pizzas! "The receptionist gets more excited about seeing the sales rep than the doc," quips Bavasso with tongue in cheek, "because of the donuts, coffee, and pizza."

> *"The time has come to extirpate the word 'detail' from the vocabulary of the pharmaceutical industry. ...there is no disputing the fact that it has degenerated into a stereotyped, memorized, endlessly repeated, unmemorable, stupefyingly dull monologue that generally anaesthetizes the listener's sensibilities: it often sounds as if it were deliberately designed to render him catatonic."*
>
> Source: James Pancras, "The New Medical Representative," Masterman

### Trends Impacting Effectiveness

It's a very crowded and noisy marketplace with lots of fighting for share of voice. An average physician is called upon by 20 reps per day according to Bavasso who cited research by Ernst and Young and Hambrecht & Co. as sources. A high-volume prescriber may have 50 reps knocking on the door each day. Is it any wonder that reps are turned away 43% of the time or that some physicians are even considering charging for access?

The increase in the number of sales calls is not proportionate to the increase in number of sales reps. Although the sales force has doubled between 1995 and 2000, the number of audited calls has only increased by 10%. Realistically, reps average only 2 quality details per day (quality details includes discussion of features, benefits, and data). The reps have less time per call, are only able to deliver incomplete messages, and aren't able to really differentiate their product from the competition's. "The pharmaceutical sales representative has one of the most difficult jobs in the country," remarked Bavasso.

### What Do Doctors Want?

The physicians on the panel were: Peter Alagona, MD, FACC, a clinical intervention cardiologist from Florida, a specialist who writes about 60 prescriptions per day ("a million dollar customer," says Bavasso) and Robert Green, DO, FAOA, a primary care physician from Connecticut.

Dr. Alagona has always viewed healthcare in the US as a cooperative venture that includes third-party payors, the government, insurers, hospitals, medical centers, physicians, and the drug

and medical device industries. At the risk of sounding "politically incorrect" Dr. Alagona emphasized that the pharmaceutical industry has been an indispensable partner. "I look at the industry as a resource, not just a partner,' said Dr. Alagona. "That's why I try to interact with as many company representatives as I can."

Dr. Green has also enjoyed interacting with representatives. "Unfortunately," says Dr. Green, "not every representative has the ability to teach and some just push the sales aid. Only 10% to 20% have remarkable abilities, the rest can communicate, but tend to push the same message all the time. Towards the end of the day I've had enough." Dr, Green especially welcomed reps that could bring to him concise results from clinical studies about new indications for products. "It's an indispensable form of education for me."

## Good Rep vs. Bad Rep

Although Dr. Alagona praised reps who could engage in informative interactions and provide supporting evidence from the literature, he also was adamant the inadequacy of current detailing practices has less to do with sales reps than a failure of leadership and lack of vision. "Sales reps," said Dr. Alagona, "have been hog-tied and gagged to the point where they are of very little value." Dr. Alagona specifically cited PhRMA guidelines and other restrictions imposed on sales reps by their companies. The problem is made worse because companies interpret the guidelines differently.

"The most valuable representatives I've interacted with," said Dr. Green, "were those that brought the education that I need, not the exact same message they give other docs over and over again."

"It is much better to have one rep who is valuable, who has a relationship with the office staff, and knows when it's a good day or not a good day to see me," suggested Dr. Alagona, "than to have 'storm trooper' representatives coming to the door."

"Successful representatives," said Dr. Green, "can build upon the relationship and remember what they talked about a week ago and now talk about a different point rather than come in with the same information over and over again."

## Samples & Patient Education

Both doctors agree that pharmaceutical samples are a great benefit to their patients and pharma companies should talk more about their sample programs in their public relations activities. "You are talking about billions of dollars worth of free medicine given out by the industry," said Dr. Alagona, "but I have never seen this mentioned anywhere in the lay press. Doctors don't appreciate and patients don't appreciate it. To me this is a typical pharmaceutical PR faux pas." He also suggested that by dropping off samples without getting any commitment from the doctor is rewarding bad behavior.

Dr. Green pointed out that he and many other doctors have had patients that were kept alive by samples due to their inability to pay for pre-scriptions. "Samples are indispensable," said Dr. Green, "I would never start a patient on a new prescription without a trial run with samples first."

"Patient educational information materials are extremely important,' suggested Dr. Alagona. "The problem I have is getting copies of scientific articles from reps. They just can't do it even though the articles may be available on Web sites or are otherwise in the public domain."

## Sales Rep Preparedness

Sales reps don't seem to know much about the relationships physicians may already have with their company. Dr. Alagona, for example, was a speaker at a product launch meeting, yet the rep inquired if he knew about the product! "There's not enough education of the reps about the docs they are visiting," say Dr. Alagona. Reps need to understand better the people they are trying to sell to.

Dr. Green would also like to see a progression in the information that reps deliver. "Each time I see a patient," Dr. Green mentioned as an analogy, "I don't go through their whole medical record with them starting from the beginning. A lot of times reps come in and start at the beginning with the same message. It would be much better if they built upon what they covered a few weeks ago."

## Local Dinner Meetings

An audience member asked about the worth of dinner meetings and what factors influence whether or not physicians decide to participate?

"A restaurant is nice to go to," suggested Dr. Green, "but what's important is who is presenting. Although the information is important, the presenter may not be a great communicator. You end up bored and wondering why you went! These types of meetings have real value for physicians who want to keep up to date in their practice."

"Dinner meetings also take up a lot of my time," says Dr. Green. "The future," suggested Dr. Alagona, "will include more electronic education.

But the reality today is that most doctors still want education where they can see their colleagues and ask them questions."

## Closing Remarks and Demonstration

Dr. Alagona asked "how come I've never seen anyone from the main office, the marketing VP in charge of cardiovascular drugs, etc., down here? How come they don't spend any time in the field? How can they know what the problems are if they don't go and see what the problems are?"

In closing, Dr. Green demonstrated a new tool being tested by some drug companies to help the rep better educate the physician. This tool, a new tablet PC, stores all of the materials formerly held in the sales representative's bag and allows the rep to focus discussions and/or rapidly answer questions posed by the doctor. It allows access to any piece of educational material, be it paper, multimedia, or video, at the touch of a pen. Physician reaction, says Green, has been very positive.

"This is the future of professional detailing and this is adding value to the sales rep's ability to educate clinicians," remarked Dr. Green.

**Pharma Marketing News**

## Conference Highlight

### The Targeted Model: The Future of Pharmaceutical Marketing?

By **John Mack**

Remember the good days of pharmaceutical marketing? When pharmaceutical reps and doctors had personal relationships? When the sales rep was the dominant influencer of physician prescribing behavior? When reps were knowledgeable and provided the physician with useful information that couldn't be gotten anywhere else?

Well, the days of the traditional marketing/sales model are over according to Rick Blockinger, Senior product Director, Gastroenterology, Janssen Pharmaceutica. Speaking at a recent DMA Pharmaceutical Marketing Conference in Princeton, NJ, Blockinger highlighted well-known survey data documenting the decline in effectiveness of the typical pharmaceutical sales rep. Some of the data cited:

- Physicians have less time: 43% of sales calls result in the representative not even seeing the physician
- More reps are trying to see the same doctors: data from the Bergen County (NJ) Record indicate that between 1996 and 2001 the number of pharma sales reps grew by 110% while the number of physicians grew by only 12.5%. The result is that there is now 1 sales rep for every 10 physicians.
- The role of the representative as information provider has diminished: New technology—the Internet, PDAs, text messaging—has created new information sources. "We have not done a good job using these tools," say Blockinger. Reps have learned to use 15-second sound bites to get one main point across. As a result, Doctors find only 35% of meetings with reps helpful.

Other changes have influenced the physician-rep relationship as well. These include the influence of managed care's multi-tiered formularies, DTC advertising, and consumers armed with information from the Internet.

#### Rethinking the Brand Plan

According to Blockinger, the pharma industry has not adapted to the changing influences and has lost sight of the customer. The easiest thing for a product manager to do is to take last year's business plan and repeat it for the upcoming year. As a consequence, year after year the marketing plan stays essentially the same while the environment has changed drastically.

"Single-focused, 'approved' brand messages show no regard for differences among physicians." Targeted marketing is the future. Whether your Rx brand message is delivered via a sales rep, direct mail, website, in-store display or TV ad, it must be applicable to each segment of your target audience.

It's time to rethink the national brand plan and leverage our wealth of data on a market-by-market, audience-by-audience basis. Direct marketing principles lie at the core of this model and will help forward-thinking pharmaceutical marketers adopt a multi-faceted strategy to optimize each market opportunity and maximize ROI.

| Sales detail aids | Non-personal promotion |
|---|---|
| No regional differences | Customizable media |
| Little difference by specialty | • Direct mail |
| No ability to customize by physician "mindset" | • E-detailing |
| | One-size-fits-all messaging |

#### What We Need on the Physician Side

"We have created this problem and now its time to do something about it claims Blockinger, ""What we need is a flexible professional promotion model to customize messages to meet individual physician needs similar to how a skilled representative would communicate. Today's pharmaceutical marketing and sales model must be opportunistic and flexible enough to allow customization to the influences of different sales territories, physician types, managed care formularies, reimbursement landscapes and consumer attitudes.

We also need the ability to deliver customized messaging to physicians in a variety of formats (in person, at meetings/symposia, via direct mail, on the Internet, via email, via other electronic devices).

## What We Need on the Consumer Side

Print and TV direct-to-consumer (DTC) advertising can raise awareness, but awareness should not be equated with action. "There is no guarantee," says Blockinger, "that a consumer will come out a doctor's office with the drug that he or she requested." According to an FDA survey, when patients ask for a prescription for a specific drug, the doctor obliged 57% of the time, which is only slightly better than even odds (See "Results from FDA Physician Survey on DTC Advertising").

Consumers at different stages need different information and marketers need to develop flexible consumer promotion models to customize messages to individual prospects and patients according to their needs. The new model must differentiate among consumers who:

| | | |
|---|---|---|
| • Have little knowledge of disease state or brands | vs. | • Are already informed |
| • Are still complacent and need encouragement | vs. | • Are ready to talk with doctor |
| • Are not on therapy and need incentives for trial | vs. | • Are already on therapy and need compliance messages |

Not only that, but patients need different information from prospects and marketing messages need to change as prospects go through the behavioral progression starting at **Awareness** (just finding out about the condition and whether it pertains to them), moving to **Acceptance** (the potential risk has been personalized and the prospect is considering seeking information and/or evaluation), and finally arriving at **Action** (ready to talk with physician about treatment or is already on therapy).

## Challenges

Blockinger believes that direct marketing can provide the customization pharmaceutical marketers need, but warns that several challenges need to be overcome.

The challenges for direct marketing **to physicians** are:

- Good, honest clinical data, which is what physicians want and need for their practice.
- Strict segmentation criteria. Blockinger suggests that today's segmentation criteria based for the most part on prescribing volume is not focused enough.
- Relevant messaging. Blockinger points out that brands are reluctant to customize messages for fear of "corrupting" the brand.
- Media flexibility

The challenges for direct marketing to **consumers** are:

- Privacy issues, including HIPAA (Health Insurance Portability and Accountability Act) and evolving state medical privacy laws aimed at putting limits on access to consumer and prescribing data by pharmaceutical marketers.
- Good data for segmentation (typing tools)
- Careful message construction
- ROI measurement

Blockinger ended his presentation by challenging direct marketing vendors to help solve these issues within the highly regulated environment of the pharmaceutical industry and to lead the industry into the future of customized marketing.

**Pharma Marketing News**

## Conference Calendar

### September 2004

**Technology Supported Physician Detailing**
September 13-14, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M004mtg101.htm

**The 3rd Annual Off-Label Usage Conference**
September 20-21, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M006cmtg077.htm

**Rx to MD: Optimizing the Sponsor to Prescriber Interface**
September 21-22, 2004 • Princeton, NJ
http://www.pharma-mkting.com/meetings/M029Amtg084.htm

**3rd Annual Pharmaceutical Marketing Congress**
September 27-29, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M007Bmtg078.htm

**Direct to Consumer Strategies for Medical Devices**
September 30 - October 1, 2004 • Chicago, IL
http://www.pharma-mkting.com/meetings/M004Amtg080.htm

### October 2004

**BioNetwork 2004**
October 4-6, 2004 • Ritz Carlton Laguna Niguel, Laguna Beach, CA
http://www.pharma-mkting.com/meetings/M140mtg075.htm

**6th Annual Guidelines for Disseminating Off-Label Information**
October 18-19, 2004 • Washington, DC
http://www.pharma-mkting.com/meetings/M04Amtg083.htm

**Patient Adherence, Compliance and Education**
October 19-20, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M039Bmtg086.htm

**Executive Forum: Maximizing the Effectiveness of Medical Liaison Team Capabilities**
October 20-22, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M006Cmtg087.htm

**Customer Relationship Management (CRM) for the Pharmaceutical Industry**
October 27-28, 2004 • New York, NY
http://www.pharma-mkting.com/meetings/M004mtg085.htm

### November 2004

**Decision Support and Analysis Summit**
November 8-9, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M004Amtg076.htm

**Maximising Marketing Effectiveness to Increase ROI from your Promotional Spend**
November 8-9, 2004 • Amsterdam, NL
http://www.pharma-mkting.com/meetings/M039Amtg098.htm

**Achieving DTC Success**
November 10-11, 2004 • Princeton, NJ
http://www.pharma-mkting.com/meetings/M044mtg082.htm

**Thought Leaders and Key Opinion Leaders (KOLs)**
November 15-16, 2004 • Philadelphia, PA
http://www.pharma-mkting.com/meetings/M004Amtg090.htm

**4th Annual Forum on Generic Drugs**
November 17-18, 2004 • Washington, DC
http://www.pharma-mkting.com/meetings/M044mtg082.htm

**Patient Compliance and Persistency**
November 18-19, 2004 • London, UK
http://www.pharma-mkting.com/meetings/M004mtg094.htm

## Experts Consulted and/or Cited In Articles

The following experts were mentioned or consulted in the preparation of articles for this issue.

- **Richard A. Bavasso**, EVP/COO, Pharmedica Communications, LLC, rbavasso@pharmedica.com.
- **Richard A. Blockinger**, Senior Product Director, Gastroenterology, Janssen Pharmaceutica, 609 730-2105, rblocki1@janus.jnj.com.

## Resource List

The following resources were consulted in the preparation of this issue or cited within this issue.


- Physician Prescribing Practices Act, California AB 262, http://www.leginfo.ca.gov/pub/bill/asm/ab_0251-0300/ab_262_bill_20040707_amended_sen.pdf (accessed 27 July 2004).
- "AARP Study Finds Brand Name Drug Price Increases Accelerate in First Quarter," AARP Press Release, 6/30/2004. AARP finds manufacturers' wholesale prices for the 197 brand name prescription drugs most frequently used by older Americans continued an upward climb. Prices rose 3.4 percent during the three-month period ending March 31, 2004 compared to a 1.2 percent rate of general inflation for the same period. The average annual rate of increase rose from 6.9 percent for the 12 months ending December 2003 to 7.2 percent for the 12 months ending March 2004. http://www.aarp.org/research/press/presscurrentnews/Articles/a2004-06-30-drugpriceincrease.html
- Statement by Richard I. Smith, Senior Vice-President of Policy, Research and Strategic Planning, Pharmaceutical Research and Manufacturers of America (PhRMA), on AARP's Rx Watchdog Report, PhRMA Press Release and Backgrounder, 6/30/2004. Prescription drug prices increased at a lower rate than other health services in 2003. A study recently published in Health Affairs by analysts at the Center for Studying Health System Change includes information on hospital price trends and prescription drug price trends in 2003. According to this study, hospital prices grew by 8.0 percent in 2003. In contrast, the same study notes that prescription drug inflation "declined to 3.1 percent in 2003." http://www.phrma.org/mediaroom/press/releases/30.06.2004.1037.cfm

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