Pharma's brands are stressed and under duress. In order to survive, they need to

STEP IT UP

By Joanna Breitstein, Executive Editor
Photographs by Bill Bernstein

FROM TOP TO BOTTOM: Michael Guarini, Ogilvy Healthword; Wes Wilkes, Interbrand Wood Healthcare; Angela Moskow, Sanofi-Aventis; Mike Boken, Shire Pharmaceuticals

You can't blame brand teams for their existential dilemma. After all, the very purpose of a brand is to build customer loyalty and charge a premium for it. (Right?) But all the money, time, and effort spent building blockbuster brands made little difference last year, when $23 billion worth of patented drugs lost exclusivity—and the bulk of their value. Despite the branding, these drugs literally went from boom to bust.

Does it have to be this way? To find out, Pharm Exec gathered the industry's brightest stars for an Executive Roundtable. These execs debated and discussed a new vision for brand leadership—one in which brands work not only harder, but also smarter. An edited version of the discussion follows.

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Carole Huntsman
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"As therapies become more targeted, it really is going to be about personalizing the patient experience and providing exactly what patients need to get the best experience of the product overall."

BRANDING A NEW MODEL

JOANNA BREITSTEIN (executive editor, *Pharm Exec*): The pipeline is full of specialty drugs that have, for the most part, quite complex science. How does this translate to the branding model?

JEFF CONKLIN (VP, marketing practices and innovation, Wyeth): Your question is backwards. The model of branding is going to be driven by the complexity of consumers rather than the complexity of brands. If you're not putting customers first in driving that model, the complexity of the brand makes no difference.

ANGELA MOSKOW (senior director, diabetes marketing, Sanofi Aventis): You're right. We need to take a page out of the consumer-package industry. Because brands are there to establish the connection with the patient.

CAROLE HUNTSMAN (VP, marketing, neurology, EMD Serono): As therapies become more targeted, it really is going to be about personalizing the patient experience and providing exactly what that patient needs to get the best experience of the product overall.

BOB MASON (SVP, director of brand strategy, Palio): Think of the overall branding model like the mass customization of drugs.

MIKE BOKEN (senior director of marketing, ADHD, Shire): We will increasingly see the industry moving more toward the specialty model. With a $300 to $500 million product, you can't afford to have reminder calls four times a week. The specialty model is about understanding how to take micro products and apply the branding model to a micro space with smaller sales forces, less reliance on broad DTC, more one-on-one communication with consumers, and more focus on finding the right patients and keeping them over the long-term.

MAUREEN REGAN (managing partner, McCann Erickson Healthcare Worldwide): The model of branding remains the same even in niche markets. Specialty marketing is more about the strategic delivery of the medium or the tactical mix, which shifts from more broad-based to more online activity—things like social networking hold a tremendous amount of potential.

Jeff Conklin
Wyeth Pharmaceuticals

"Patent expiration is the most honest moment in branding. For me, the test is when you bring price into the picture. If somebody is not willing to pay, you didn't have a brand in the first place."

PATRICK CLINTON (editor-in-chief, *Pharm Exec*): Where can we see this model of branding at work today?

VINCE PARRY (president, Y Brand): A recent example is the cervical cancer vaccine, Gardasil, from Merck. There was a lot of controversy around the vaccine—in particular, social and religious issues about vaccinating girls before they come of age sexually.

Pharma companies usually are built to launch product brands, but Merck actually budgeted and planned for talking about the condition itself. It did an excellent job in driving the vocabulary and ideas about vaccinating for cervical cancer with the "Tell Someone" campaign. As a nonbranded campaign, it sort of got taken up by society and became more of a grassroots entity.

REGAN: Lunesta has taken a consumer-like approach and has done a beautiful job. In particular, they have created surround sound in terms of making sure that there are synergies between the professional and consumer markets. Although consumers have a tendency to call it a butterfly when it is actually a lunar moth, it is one of the most recognized symbols in medical advertising.

CLINTON: Why do these work so well?

PARRY: The whole way that a pharmaceutical company is structured is to sell, whereas branding is about helping people buy. And what are they buying when they buy this drug? A brand has to create an experience, a situation where people see a reflection of themselves and their values. So the whole act of putting a nurse educator into a physician's office is imparting a value to that brand. The brand becomes helpful, nurturing.

Probably the main brand experience for doctors is still the sales forces. Yet there is no training whatsoever on how sales reps should represent the brand they sell. They are not representing a nurturing, helpful, caring brand if they are coming into the office and saying, "Doc, I need your next 10 patients."

SAFETY MARKETING

BREITSTEIN: The issue of drug safety has taken over headlines for the industry. How are companies responding to this issue in terms of branding?

PARRY: Safety has always been part of the pharmaceutical brand. But now you see companies putting more insurance policies in their trials. They are beginning to address some of the public's demand for greater accountability, like conducting longer trials with broader patient populations.

Safety for mass-marketed drugs for chronic conditions, often asymptomatic, is going to be a big concern. For other drugs, there are black box warnings. But a lot of people are on Remicade, which has a black box. It just celebrated its millionth patient. Biogen Idec gives warning after warning about Tysabri, and people respond by saying, "Hey, you're holding me back."

MICHAEL GUARINI (regional president, North America, Ogilvy Healthworld): There is an element of risk acceptance. We even saw that right after the withdrawal of Vioxx—people were somewhat resilient about it.

HUNTSMAN: Patients are always going to believe that they are not that one in a million. Right now, there is a lot of pharmacovigilance, but we don't yet have the pharmacogenomics that will give us the direction as to who is going to experience the problem. So risk-management plans will be very important for the drugs that are coming.

What's interesting, though, is that companies are putting the liability for the risk-management program on physicians completely. This is a new dynamic where basically doctors are signing away their lives if they want to treat certain patients. Maybe they just don't want to go there.

CLINTON: With the new focus on pharmacovigilance and the availability of huge databases of insured patients, how can marketers create a strong brand as safety signals continually emerge?

MOSKOW: Safety is not a bad thing to talk about. We want to make sure that our patients are having a good experience. We're in a better place if they know what to expect and, even better, how to avoid it. It is important for the physician to think about patient selection, about who is the right patient and who is not the right patient.

MARK NOLAN (senior VP, group creative director, Digitas Health): One of the first things patients will look at on a Web site is the side effects page. So we advise our clients to consider a more radical level of transparency. Don't underestimate the power of patient, caregiver, and physician bloggers. The second a safety concern arises, your brand's Web site is going to be knocked down on search engines by them, or by lawyers looking to sue.

Michael Guarini
Ogilvy Healthworld

"Johnson & Johnson has the best reputation in healthcare. But no Rx product carries the J&J logo—only Band-Aids and first aid and baby care."

PERSISTANCE AND COMPLIANCE

BREITSTEIN: Pharma has long been talking about the missed opportunities of compliance. Are there any new efforts in the space that are truly promising?

BOKEN: You really create that brand equity if you can get into the hard work of figuring out what to say to the patients and delivering the right information about adverse events in their language.

There are significant adverse events that come with taking any ADHD drug. It used to be, "Don't tell parents about it, because the kids are going to go off treatment." But the bottom line was, we were having this huge drop-off, because parents were seeing the adverse event and no one was talking them through it. We made the change to holding their hands, where we send them a mailing every week once they initiate treatment, and then after two or three months on treatment, they get a reminder.

As a result, our product is the leader in compliance in the category. That's a sign that we're doing something right.

REGAN: What's new is that we're going to see more research conducted on the underlying mechanisms of noncompliance. We'll find out that there is no such thing as the typical noncompliant patient. There are many different motivations that lead to noncompliance, and, hopefully, we will be able to model different communications based on these triggers and identify which patients would benefit from more tailored communications. The financial services industry does a particularly good job of this in terms of tailoring the messages to small niches. There is potential to do that in our business, but it is in its infancy.

NOLAN: When you talk about patient compliance, you're really talking about segment compliance, because you're going to have those proactive patients that are going to be compliant even without a program. But we see using the Internet as a way to supplement what the physician tells the patient as a key driver. More and more, patients can go online and choose a mentor they can identify with—someone with the same experience, who has been there, done that, and can connect with them. Those things work.

As we become more commoditized, every market becomes more crowded. You'll to need more depth to differentiate yourself—and that is content, whether it be clinical or service content. It should be immediate and personally relevant. That may mean mobile media reaching out to patients at mealtime and saying, for example, "Crestor is reminding you to take your medication," and then recommending a heart-healthy diner nearby.

HUNTSMAN: With some biotech products, the value of each patient is substantial. Out of necessity, we really had to be ahead of Big Pharma in terms of tactics to create the patient experience.

Our product is an injectable, and patients can be needle-phobic, or they can get needle fatigue. So it really does take a hands-on approach. In our case, by employing nurse educators, we saw a 40 percent improvement in adherence. We also have a new needleless device that is in development that will actually record the adherence and compliance and provide feedback to the physician.

CLINTON: What is the most pressing challenge for brands today?

MOSKOW: The brand has to work harder to bridge that gap between when the patient leaves the physician's office with the scrip and then needs to know exactly what to do with that.

Education is a big part of it. How do you get that into patients' hands? Especially with HIPPA regulations. But they need more information than they are getting in the average five-minute call.

HUNTSMAN: Let's face it, physicians are physicians and, not only do they not have a lot of time, but they are often not the best in communicating with patients about the disease or the product.

WES WILKES (managing director, Interbrand Wood Healthcare): Chantix is putting more resources into the cessation programs than into straight product ad-

Vince Parry
Y Brand

"A lot of people are on Remicade, which has a black box. It just celebrated its millionth patient. Biogen Idec gives warning after warning about Tysabri, and patients respond by saying, 'Hey, you're holding me back.'"

vertising. It's doing an amazing job, and the company will start to see that it's going to have a relationship with these folks like no other by shifting the model away from the traditional product branding.

CONKLIN: We need to put more time into understanding how drugs fit into patients' lives in terms of maintenance. Our industry puts a lot of emphasis on getting patients started on medicine, but we also need to help patients continue their treatment. Many illnesses are chronic, yet patients stop taking their medicines when they shouldn't. When you see compliance issues in rheumatoid arthritis, hemophilia, and even transplantation, you know there's more we need to undestand about our patients and more we need to do.

BREITSTEIN: Do you think companies can improve persistence?

WILKES: Not until they start to realize that it is much cheaper to maintain that patient base even after a patent expires. That will be the biggest shift—when pharma companies start seeing patients as patients for life, and treating them as such. Even in periods where they are investing money and losing money post–loss of exclusivity (LOE) and prelaunch.

PARRY: Like with Merck. It's not out of the cholesterol business. It is waiting to get back in big time.

CONKLIN: It will get better, but on a category-by-category basis. But you can't change society. Still, quite frankly, it's our responsibility to improve compliance. It's the right thing to do to educate a patient, to talk to a physician.

BOKEN: But sometimes that responsibility is disheartening. Because you're improving compliance literally one patient at a time, one day at a time, and that requires some commitment. It is like if you had to approach your marriage this way, you would just be so grateful to have made it another day. But the point is, while there never is going to be 100 percent compliance, it is reasonable to expect that we can improve it, and in the process, patients' lives.

CORPORATE BRAND

CLINTON: Using the corporate brand in pharma marketing has both its benefits and its drawbacks. How do they stack up against one another?

GUARINI: There was never any corporate branding in this industry for two reasons. One—let's admit it—it was a very smug, insulated industry. It didn't need to do it. The other thing is if a product fell, and others were too closely aligned with the company name, the company would also take a hit. Even now, look at the marketplace. Johnson & Johnson has the best reputation in healthcare. But no Rx product carries the J&J logo—only Band-Aids and first aid and baby care.

Half the time, the brand manager doesn't want to use the corporate logo on the ad, because he feels it is distracting and doesn't sell the product. Also, though a lot of people feel that it is really great that you are giving free HIV drugs out in Africa, they want to know why their drug here is so expensive. It always comes down to access and cost.

WILKES: Whether we are talking about safety or marketing, drugs are trying to do things that are bigger than them. People expect a product to answer the bigger questions, like pricing. But drugs can't answer those questions—that's where there is a huge disconnect.

The role of the corporate brand is going to—has to—change drastically over the next 10 years. Patients are going to know who makes their drugs, and it will drive preference because these big issues, like trust, can be handled only at the corporate level. It's the most underleveraged business asset of pharma companies.

BREITSTEIN: We are also seeing more franchise brands. But there seem to be many execution issues there.

PARRY: These are self-imposed obstacles. The problem is that no one is getting paid to think about it. Whenever I get a call saying, Hey, we would like to do a diabetes franchise, my first questions are, "Is someone in charge of that initiative?" The answer? "I am." I ask, "Who is your staff?" They respond, "I am." "What is your budget?" They typically say they borrow, or maybe tax, their brands 5 percent each. Well, those teams are going to love you. So companies simply are not organized to do it.

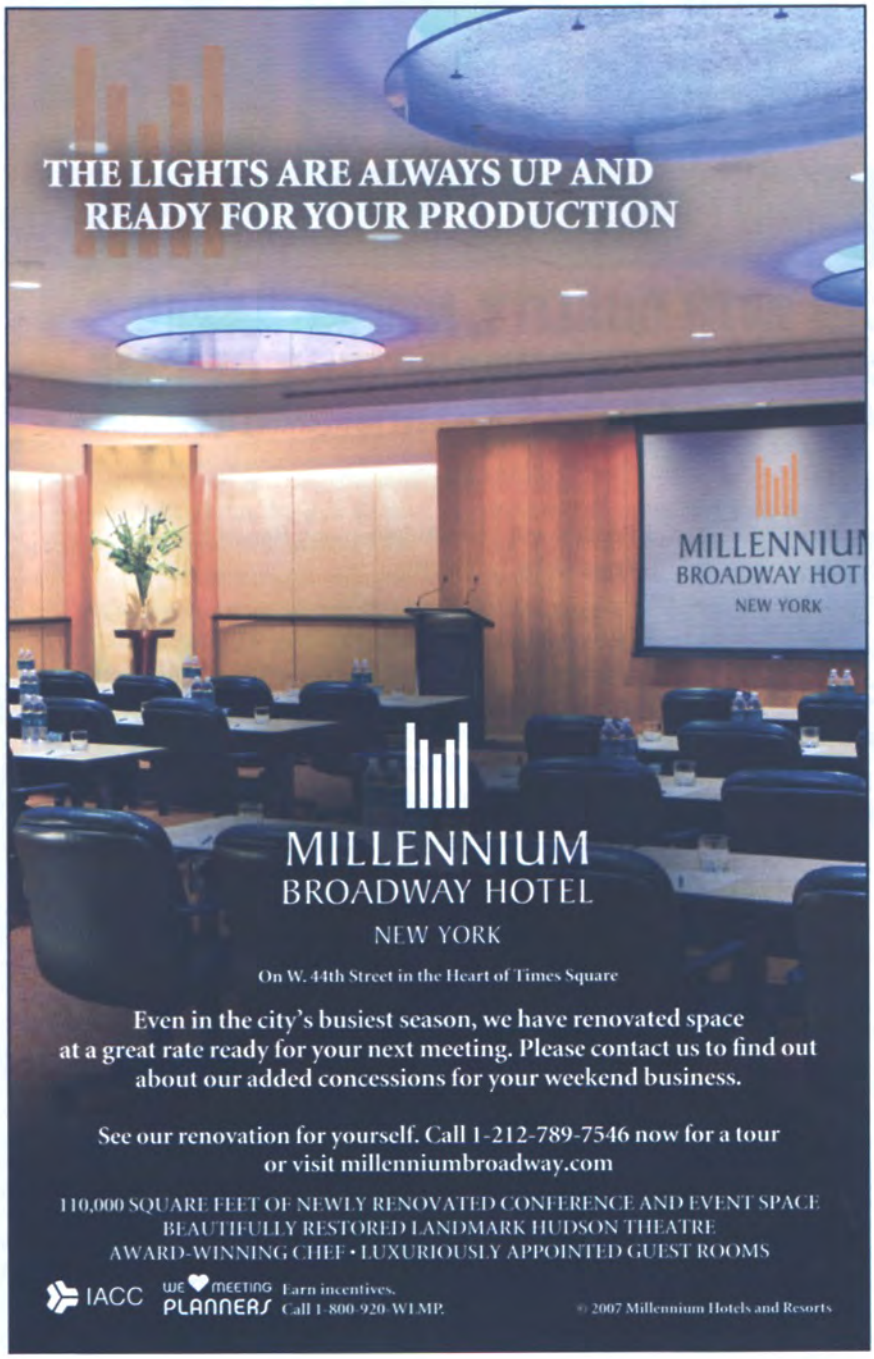
WILKES: Things are starting to change. Pfizer Oncology, for example, which had very little presence or credibility in the oncology space, allowed the company to link its services to the

oncology space.

HUNTSMAN: Everybody in the multiple sclerosis category is already doing this. Their patient services are under one umbrella, which is treated like a separate brand. Everything—whether it be access programs, reimbursement, nursing, relationship marketing, all of that—is done under the umbrella of patient ambassadors, all under the umbrella of MS Life Line.

IS THIS THE END?

CLINTON: With the barrage of blockbuster expirations, are companies rethinking how to keep the brands alive?



FROM TOP TO BOTTOM: Mark Nolan, Digitas Health; Maureen Regan, Regan Campbell Ward; Bob Mason, Palio Communications; Vince Parry, Y Brand

NOLAN: Two words, Hatch-Waxman. You will see a decline with any strategy after the patent expires.

BREITSTEIN: That's true. But look at how Zocor dropped its price and secured favorable formulary status. Do you expect to see similar strategies to ward off generic competition?

GUARINI: An emotional connection to the user is the top of the hierarchy. If you have that, then you buttress yourself to the competition and the erosion of the franchise.

MASON: But we shouldn't talk about emotion for the sake of semantics. People are always trying to throw emotion into branding. But it has to be baked into the legitimacy of the drug—the fusion of emotion and functionality together.

CONKLIN: It is the most honest moment in branding. For me, the test of the brand is when you bring price into the picture. If somebody is not willing to pay a little bit more for your brand, you did not have a brand in the first place.

WILKES: We just did a study for a client who wanted to see the demand for a post-LOE blockbuster. We found that people are willing to pay a premium over generic to stay with the same drug that has been in their body for years, just by adding some services and bringing the price down a bit. We now see two major manufacturers looking at post-LOE promotions. They are asking, Why flip the lights off after investing billions?

GUARINI: But could it boomerang back on the companies? Will I resent that if I had been taking Zocor for the last 10 years, and it was $180 a month, that I am now paying $40?

WILKES: It depends if your relationship is with simvastatin or with Merck. If it's with Merck, the company has to tell the patient what is coming, and why there is a price disparity. Right now, that information comes from the pharmacist.

BOKEN: The biggest opportunity is with life-saving drugs. If I get a cancer treatment that literally brings me back to life, then I would be willing to continue to buy from the original manufacturer.

HUNTSMAN: If there is more pharmacovigilance, what will be required of generic companies? Will they have to take on the costs of expensive risk-management programs? That may be a barrier to entry for some generic companies.

BREITSTEIN: And certainly an opportunity. Thank you all for participating.

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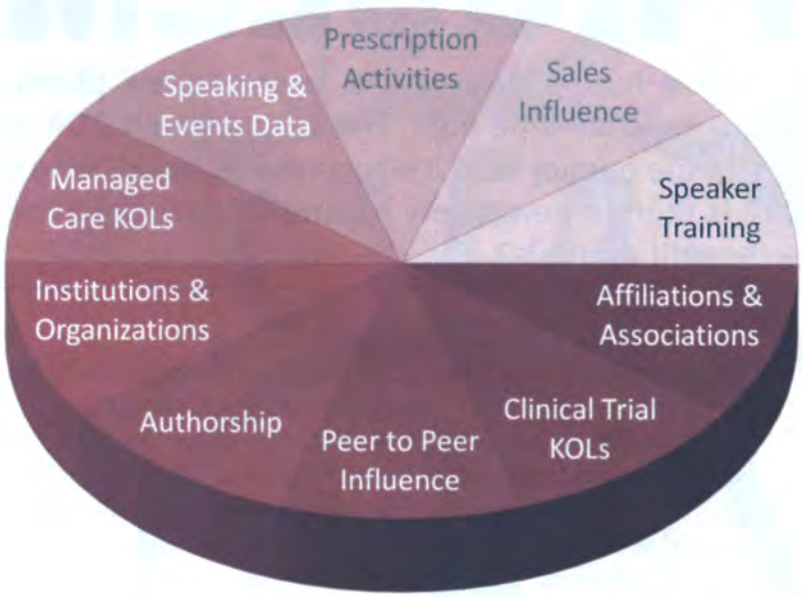

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