GALBRAITH WIGHT Re:thinking Market Access

Helping healthcare companies enable patients & their carers gain rapid & maintained access to life saving & enhancing healthcare, through **innovative** Market Access **solutions** globally.

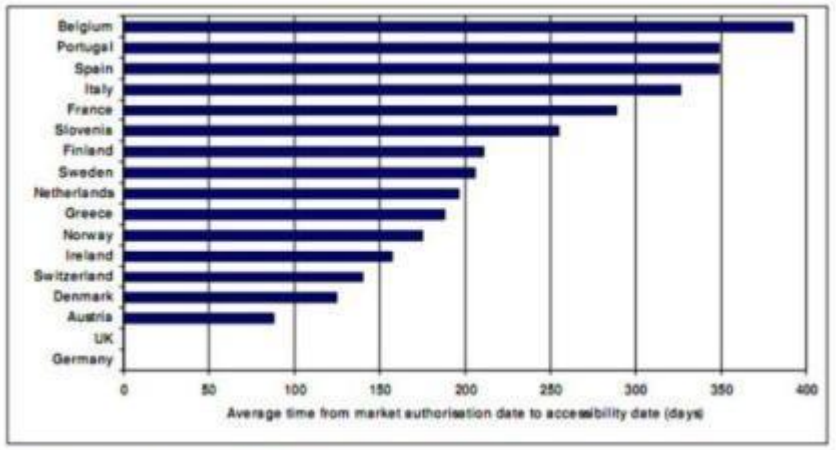
7 unforced errors in the implementation of market access & how to avoid them

Colin Wight: Chief Executive GalbraithWight

Pharma industry now takes Market Access seriously

We actively **measure** it

Figure 9: Average time from EU market authorisation to accessibility date for medicines with first EU marketing authorisation in the period 2007-09



Source: Patients WAIT Indicator 2010, EFPIA

We talk & **listen to Payer** customers

"Perception of value drives the willingness to pay, and those perceptions vary from country to country," "We need to do a much better job communicating value to payers" *Adam Woodrow, Vice President , Specialty Business Unit, Pfizer September 2011*

We've created **Market Access teams** & hired HEOR experts – in house & agencies

There are good examples of **best practice**

Herceptin trastuzumab

GARDASIL Humaan Papillomavirusvaccin typen 6,11,16,18

HUMIRA adalimumab

YERVOY (ipilimumab)

GALBRAITH WIGHT Re:thinking Market Access

Unforced errors in Pharma Market Access

1. Market access work starts **much too late** as many Senior Managers do not fully appreciate the timing and investment needs

One reason market access starts too late is a poor & inconsistent understanding of Market Access among senior management – Senior Executive research 2010*

"Every phase in the whole development process requires a different involvement from third parties – patient groups, payers"

"The process has to start when you put the molecule together, asking what the molecule should be able to deliver compared to what's out there right now"

"It has to start when you develop the TPP"

"(Market access) should not start too early, when it is not really known what the product can do"

"I would like to see this discussed – our evaluation is when we have decided on the final indication"

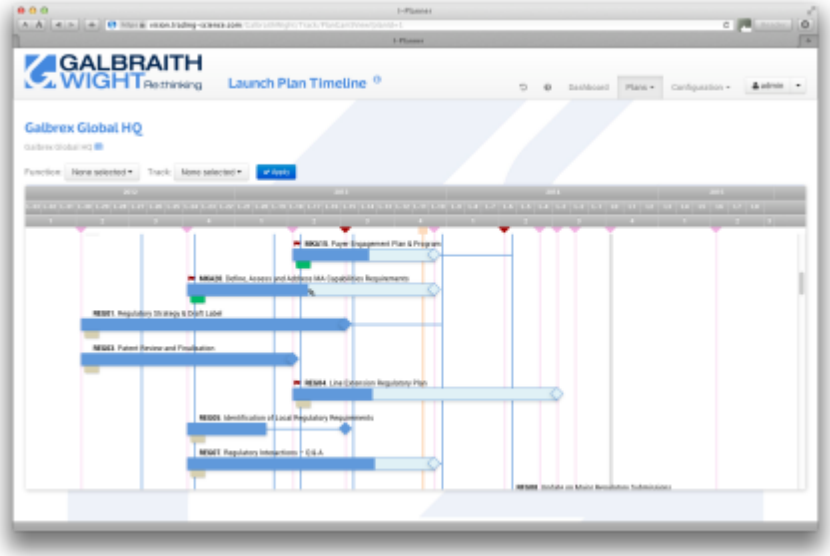
"These are discussions that have to happen before you go into Phase III"

"I'd like to see market access being considered at Phase IIb, from a labelling/indication standpoint"

** Research conducted among global heads of commercial, market access, discovery research, clinical development, regulatory, production, plus regional heads of Europe, US & Asia Pacific*

GALBRAITH WIGHT Re:thinking Market Access

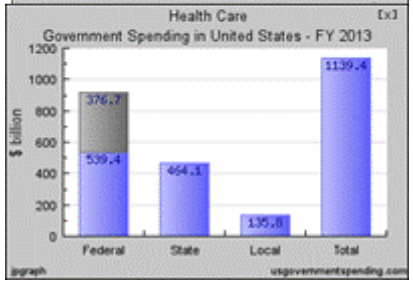
Working out what to do when for Market Access & Launch Excellence has been well established



GALBRAITH WIGHT Re:thinking
Market Access

Market Access is different in America – causing inappropriate lateness in market access planning for some US-based Pharma companies

- No national pricing & reimbursement agency or process
- 'Expensive' innovative new medicines always get covered
- Culturally opposed to rationing of healthcare ("death panels")
- Affordable Care Act prevents attaching economics to decision making
- Even CMS delivered through competing private MCOs

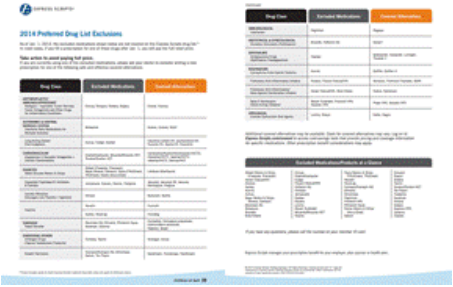


GALBRAITH WIGHT Re:thinking Market Access

But…America is changing – slowly

- CER ‘on the agenda’?
- MCOs, Care Pathway companies & Beacon Communities want cost & cost-effectiveness data, are making better use of IT, & are willing to make decisions based on this type of analysis

- CMS now represents more than 50% of medicines cost for America, and wants to find savings



- Plans increasingly restrictive on access to ‘expensive’ medicines – higher tier, high co-pay, prior authorisations, bigger rebates – e.g. Express Scripts new exclusion list
- International exchange of cost effectiveness information & methodologies – inter-governmental, ISPOR, HTAi, INAHTA

GALBRAITH WIGHT Re:thinking Market Access

Achieving national pricing & reimbursement approval are just two steps in the process & are no guarantee of success

abpi
Bringing medicines to life

Posted in category News Release by Press Office on 16/10/2013

Innovation Scorecard fails to measure up for patients' access to medicines

The ABPI has welcomed the publication of the third update of 'NICE Technology Appraisals in the NHS in England - Innovation Scorecard' by the NHS Health and Social Care Information Centre (HSCIC), on behalf of NHS England. There is however concern that this falls short of providing patients with the clear information they need to make decisions about their treatment. Read more

hscic Health & Social Care Information Centre

NICE Technology Appraisals in the NHS in England (Innovation Scorecard):
to June 2013, Experimental Statistics

Published 16 October 2013

The New York Times

Sanofi Halves Price of Cancer Drug Zaltrap After Sloan-Kettering Rejection

In an unusual move, a big drug company said on Thursday that it would effectively cut in half the price of a new cancer drug after a leading cancer center said it would not use the drug because it was too expensive.

Add to Portfolio

The move — announced by Sanofi for the colon cancer drug Zaltrap — could be a sign of resistance to the unfettered increase in the prices of cancer drugs, some of which cost more than $100,000 a year and increase survival by a few months at best.

Zaltrap came to market in August at a price of about $11,000 a month. Soon after, Memorial Sloan-Kettering Cancer Center in New York decided not to use the drug, saying it was twice as expensive but no more effective than a similar medicine, Avastin from Genentech. Both drugs improved median survival by 2.4 months, doctors there said.

Three doctors at Sloan-Kettering publicized the cancer center's decision last month in an Op-Ed article in The New York Times.

"Ignoring the cost of care is no longer tenable," they wrote. "Soaring spending has presented the medical community with a new obligation. When choosing treatments for patients, we have to consider the financial strains they may cause alongside the benefits they may deliver."

Sanofi executives argued that the price they had set was very similar to that of Avastin. "The intent was not to charge a premium," Christopher A. Viehbacher, the chief executive

"At Memorial Sloan-Kettering Cancer Center, we recently made a decision that should have been a no-brainer: we are not going to give a phenomenally expensive new cancer drug to our patients. The reasons are simple: The drug, Zaltrap, has proved to be **no better than a similar medicine we already have** for advanced colorectal cancer, while its **price** — at $11,063 on average for a month of treatment — is **more than twice as high**"

Peter B. Bach, Leonard B. Saltz, and Robert E. Wittes. Memorial Sloan-Kettering Cancer Center. New York Times 14th October 2012

GALBRAITH WIGHT Re:thinking Market Access

There are ten steps of Market Access Planning – not just P&R

Following pricing & reimbursement approval significant work is required to ensure the appropriate **funding** streams, including issues such as J code or DRG inclusion, plus those instruments which surround the **ability to prescribe**:

- Formulary inclusion
- Guideline inclusion
- Prescribing protocols
- Prescribing software inclusion

Both Industry and Payers have an **obligation & responsibility** to address the access for patients post national pricing & reimbursement approval

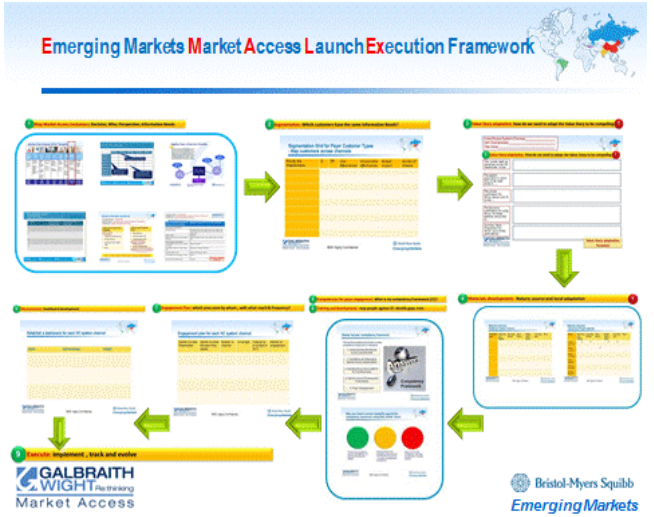
GALBRAITH WIGHT Re:thinking Market Access

Market Access planning must be considered at sub-national level in some countries – increasing the time delay to access for patients, & increasing costs for industry

The following regions have their own Health technology assessment agencies:

- Agencia de Evaluación de Tecnologías Sanitarias de Andalucía
- Instituto Aragonés de Ciencias de la Salud
- Agència d'Avaluació de Tecnologia i Recerca Mèdiques de Catalunya
- Axencia de Avaliación de Tecnoloxías Sanitarias de Galicia
- Agencia Laín Entralgo de Madrid, Unidad de Evaluación de Tecnologías Sanitarias, Comunidad de Madrid
- OSTEBA, Osasun Teknologien Ebaluazioko Zerbitzua, País Vasco
- Servicio de Evaluación del Servicio Canario de Salud

Market Access tools & processes to facilitate Funding and Enabling Prescribing have been developed & can be implemented locally



This example shows a 9-step market access execution framework process developed by GalbraithWight – a comprehensive & systematic process for segmenting Payer customers and adapting the Value Story to meet their specific needs & requirements. This framework was adopted for global market access competencies

GALBRAITH WIGHT Re:thinking Market Access

Solution: Senior Management Education & Engagement is vital to help them understand market access timing & investment

Senior Management **knowledge**, **understanding**, **buy-in**, & **commitment** to market access culture, processes & capabilities are a fundamental & **business critical** organisational requirement for future success – without this, you're sunk!

Engage with Senior Management to **educate** & help them understand fully what Market Access means & understand their concerns about the risks

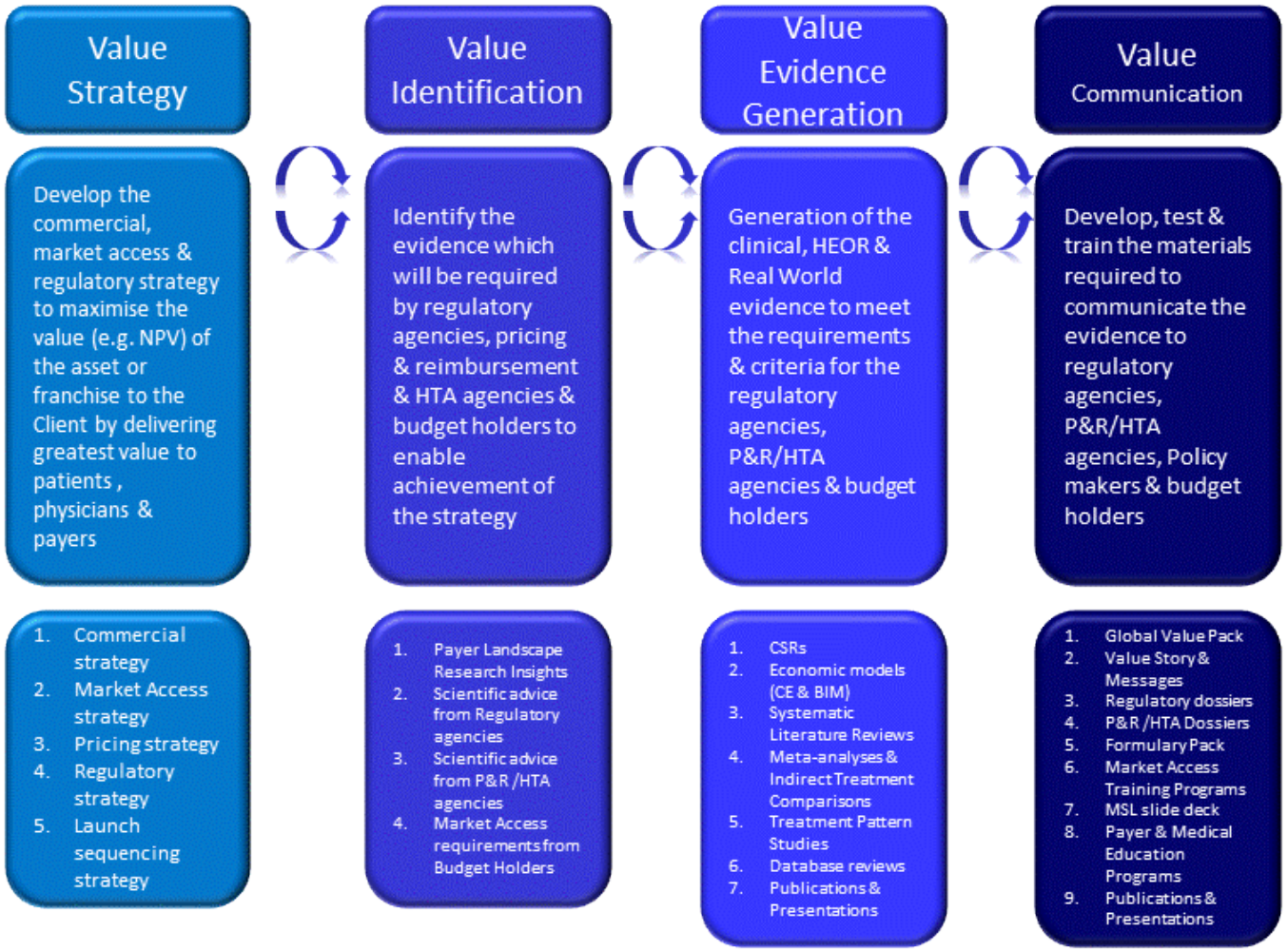
1. When it starts
2. What to do when
3. How much investment
4. Global, Region, Country

GALBRAITH WIGHT Re:thinking Market Access

Unforced errors - & how to avoid them

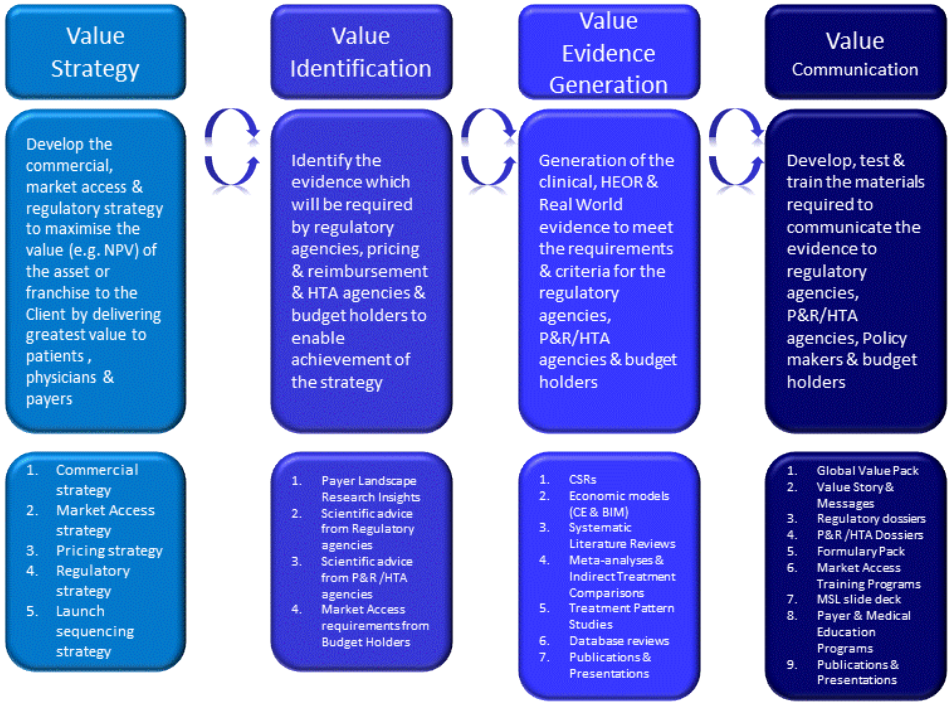
2. Starting early enough means **Commercial Strategy must be in time** for Market Access strategy to align – it often isn't!

Market Access must be aligned with Commercial Strategy – so Commercial Strategy must be developed before or in parallel



GALBRAITH WIGHT Re:thinking Market Access

Practical Application of Market Access process



While these are shown as linear & separate, the reality is they are iterative & integrated.

For example:

i. In Value Communication, you may uncover areas of evidence that have been missed, which would require further work in Value Evidence Generation.

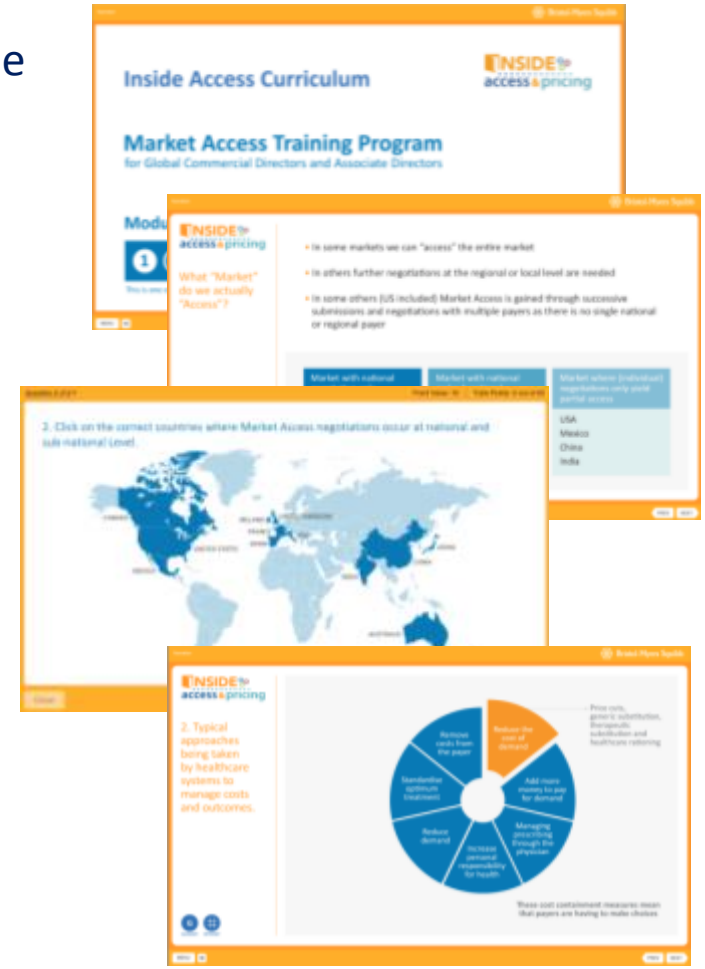
ii. In Value Evidence Generation you may get a set of clinical results which require a rethink on Value Strategy

iii. For an asset in Phase III (i.e. during Value Evidence Generation), much of the Value Communication work will be developed in parallel, awaiting results.

GALBRAITH WIGHT Re:thinking Market Access

Solution: Educate Commercial Teams on Market Access & ensure Commercial process timeline matches market access needs

Educate Commercial teams on the Market Access requirements for their brands, and the timelines required for development of Commercial Strategy to enable and facilitate early market access planning



GALBRAITH WIGHT Re:thinking Market Access

Unforced errors - & how to avoid them

3. Market access **capabilities** are **siloed** and **limited** with no clear definitions & performance standards

We need to change the perverse internal incentives around market access

Industry has tended to build functional or therapeutic **silos** in Pharma, & market access is the latest version. **Take the test....**

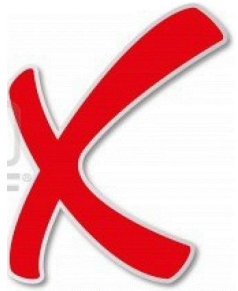
There is an apparent **complicity** between many Marketers that market access is **'too complicated'** with HEOR technical experts happy to agree with them to protect their own value to the company.

The result? No joined up thinking, planning & action across the brand teams at global, region & country level – so **no overall company capability** in market access

GALBRAITH WIGHT Re:thinking Market Access

Defining ‘unmet need’ for a Payer is not the same as clinical unmet need & must be shaped from a Payer’s perspective

“A new treatment for prostate cancer which delivers equal efficacy with few side effects is needed”



“Despite existing therapies for treatment naïve prostate cancer, patients continue to progress and die prematurely, and suffer a poor quality of life due to the side effects of subsequent chemotherapy. The costs of premature death and management of chemotherapy-related side effects are estimated to cost the healthcare system € per year”

GALBRAITH WIGHT Re:thinking Market Access

All functions need to closely align to work together to effectively satisfy the requirements of all Market Access stakeholders

No functional group on their own has the answer!

Market Access needs to be a **company-wide capability**

GALBRAITH WIGHT Re:thinking Market Access

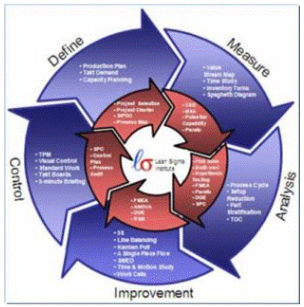
Solution: Build Market Access Capabilities Cross-Functionally & Build Market Access into all commercialisation processes

What companies & teams really need is **integrated processes** which promote **joined up thinking** & **cross-functional working**

Market Access, New Product Planning, Launch Excellence & Brand Planning are all elements of a **continuum**

Market access is a critical component of a wide range of R&D & commercialisation processes and needs to be embedded within;

- ✓ Clinical development from early phase
- ✓ Business development/licensing due diligence
- ✓ New product planning
- ✓ Launch excellence/launch readiness
- ✓ Brand planning
- ✓ Marketing/commercial excellence



LAUNCH EXCELLENCE

GALBRAITH WIGHT Re:thinking Market Access

Unforced errors - & how to avoid them

4. **R&D focus** is still **marketing authorisation**, not reimbursement

In most Pharma companies, R&D is still incentivised only on regulatory rather than reimbursement approval

1. R&D focus on explicit needs from FDA, EMA & PMDA to achieve marketing authorisation - best chance of regulatory approval is ‘cut & paste’ what got approved before

2. Little evidence of TPPs which addresses Payer needs & requirements – such as a Target Reimbursable Product Profile (TRiPP©)

3. Traditionally, commercial involvement starts at Phase III – too late to shape the brand

4. Not much focus on tools & processes for market access early on in development

5. Push back from R&D on fragmentation of Payer opinions (e.g. NICE vs G-BA) & ‘durability’ of Payer decisions relative to FDA/EMA

6. Early scientific advice still in it infancy, with ‘competition’ developing for income between agencies (e.g. NICE vs. EUnetHTA) – but **could** lead to a common EU clinical effectiveness assessment conducted by or with EMA

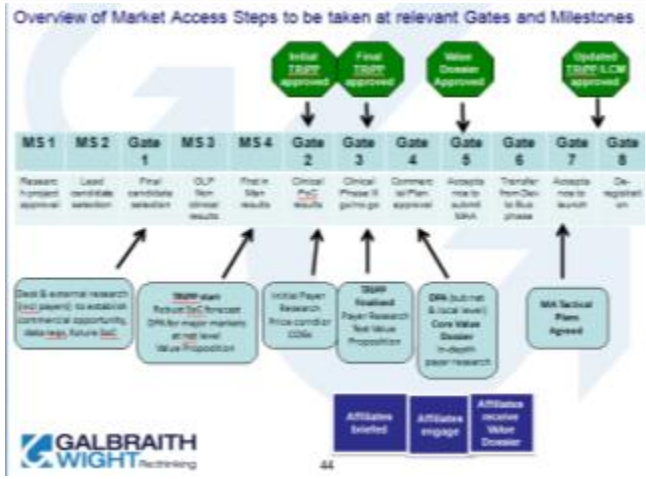
GALBRAITH WIGHT Re:thinking Market Access

Solution: Educate R&D & Help Embed Market Access Processes in R&D

Case Study: An agreed new process for what Market Access activities are required when, embedded into the organisation's existing process for R&D Gates and Milestones, rolled out to all teams across the organisation

- Full senior management support for the need for MA to be integral to all stages of product development
- Market Access tools bringing consistency in timing, format and standard of all MA activities, assessments & deliverables

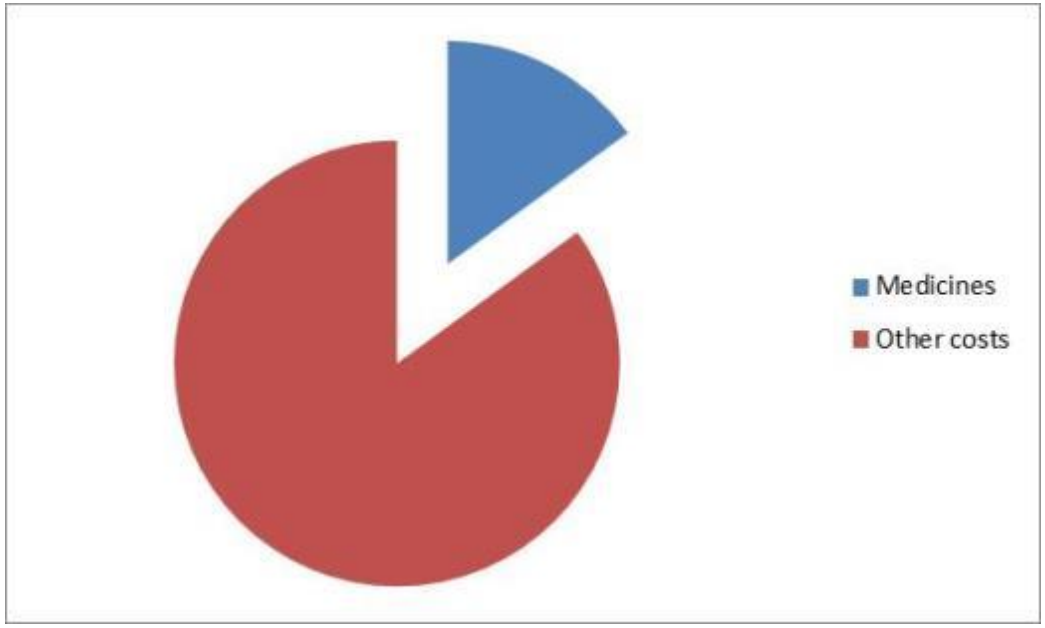
Market Access at the core of the organisation in a way that was practical and straightforward for the company to adopt



Unforced errors - & how to avoid them

5. Our **pricing** strategies are **stuck in the dark ages** when we used to be chemical manufacturers

In most countries, Medicines represent only ~15% of total healthcare costs - they are not the solution to the 'big issue' of managing healthcare costs



GALBRAITH WIGHT Re:thinking Market Access

We cannot be 'blind' to the economic realities which pay for healthcare....we must be part of the solution..


Market jitters as Spain credit downgraded

Spain credit rating downgraded

10th March 2011

France credit rating downgraded

13th January 2012


Moody's downgrades France's credit rating to AA1

Agency says outlook remains negative, despite Hollande's pledge that his reforms will reduce public deficit to 3% by 2013

Kim Willsher in Paris

The Guardian, Tuesday 20 November 2012

Moody's suggested that Hollande's proposed reforms were 'unlikely to be sufficiently far-reaching to restore competitiveness'. Photograph: Philippe Wojazer/Reuters


U.S. Loses AAA Credit Rating as S&P Slams Debt Levels, Political Process

US credit rating cut by S&P from AAA to AA+

6th August 2011

UK credit rating downgraded

23rd February 2013


UK AAA downgrade: Budget is now George Osborne's make or break moment

If next month's Budget wasn't already the make-or-break moment of George Osborne's political career, it is now.

Osborne staked his reputation on preserving the triple-A from the moment the Tories gave a cast-iron pledge "to safeguard Britain's credit rating" in their 2010 election manifesto. Photo: DAVE THOMPSON/PA

Italy credit rating slashed by Moody's from Aa2 to A2

4th October 2011

GALBRAITH WIGHT Re:thinking Market Access

UK Value Based Pricing: Four years of confusion


FOR HEALTHCARE LEADERS
HSJ
HEALTH SERVICE JOURNAL
JILL MABEN
Support staff to put patient care first

HOME | NEWS | HSJ LOCAL | LEADERSHIP | RESOURCE CENTRE | OPINION | EVENTS | AWARDS | JOB
COMMISSIONING | ACUTE CARE | MENTAL HEALTH | WORKFORCE | FINANCE | TECHNOLOGY | HSJ LIVE

Delay in pricing plan for new drugs

4 OCTOBER, 2013 | BY JAMES ILLMAN

The introduction of a pricing system for new drugs which attaches greater value to how much they benefit patients is to be delayed until late 2014, HSJ has discovered.

May 8, 2012 11:21 pm

Call to cut NHS price cap for new drugs

By Andrew Jack

Ministers are set to face fresh pressure to lower the price threshold above which new medicines are rejected for the National Health Service, amid claims that pharmaceutical companies are charging too much for groundbreaking treatments.

In research to be completed next month, academics at the University of York will make the case for a reduction by a third in the cap on new drug costs used by the National Institute for Health and Clinical Excellence (Nice), the medicines advisory board, which already rejects a significant number of new treatments as not being cost effective.

The findings are likely to fuel debate between those who believe new drugs consume a disproportionate share of the NHS budget and the pharmaceutical industry, which says price cuts would deter innovation and threaten patient access to the most advanced treatments.

While the academics at York's Centre for Health Economics have no formal policy role, their research was conducted with a £2m grant from the publicly-funded Medical Research Council, and they work closely with both Nice and the Department of Health.

Their analysis suggests the threshold for new drugs – based on the cost of each additional "quality adjusted life year" (QALY) for patients – should fall from £30,000 today to £20,000 and potentially as low as £10,000. QALY is considered the key measure of the benefit to patients of a new medicine.

Simon Jose, past President of the ABPI and President Stiefel Division, GSK

"**the devil is in the detail** in terms of how the VBP system will function. However, noises from (Secretary of State for Health) suggest an ex post system - which would mean companies could launch their drugs at whatever price they like and then face a review of prices some time after"

"... VBP should not be used to '**squeeze the medicines bill**'"
August 2010

.


PharmaTimes
online

News | Magazine | JobSearch | Competitions | Events/Meetings | Report
WORLD NEWS | CLINICAL NEWS | FREE NEWS HEADLINES | FREE RSS FEED
Where am I? > Article

NICE given central role in VBP scheme

UK NEWS | MARCH 22, 2013
BEN ADAMS

NICE will take on responsibility for assessing the full value of medicines when new pricing arrangements are introduced in 2014, the UK Government has announced.

The Institute says this will be "a crucial role" in the future value-based pricing arrangements for branded medicines, which are set to take over from the PPRS scheme from January 2014.

Related Links
MPs call for urgent decisions on new drug pricing regime
VBP alone will not solve new drug access issues, govt warned

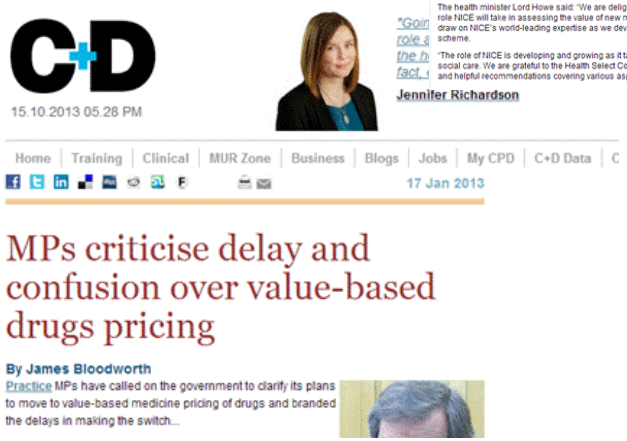
The new plans will allow the body to build on its current drug evaluation processes by giving it broader scope to assess a medicine's benefits and costs, rather than just its cost effectiveness.

NICE said that the aim is to make sure that the price the NHS pays for new medicines is more closely linked to their value to NHS patients and society, which are the main tenants of VBP.

The government confirmed the plans in its official response to the Health Select Committee's report on the future role of NICE which has been published this week. The HSC's report was damning in its criticism of the government for not having firm plans on value-based pricing and the role of NICE. It had to respond by the end of March, and it looks as if this should be enough to appease the MPs who were concerned over the drug pricing plans.

The health minister Lord Howe said: "We are delighted to announce the central role NICE will take in assessing the value of new medicines. This will allow us to draw on NICE's world-leading expertise as we develop the value-based pricing scheme.

"The role of NICE is developing and growing as it takes on new responsibilities in social care. We are grateful to the Health Select Committee for their detailed report and helpful recommendations covering various aspects of NICE's work.


C+D
15.10.2013 05.28 PM

Jennifer Richardson

Home | Training | Clinical | MUR Zone | Business | Blogs | Jobs | My CPD | C+D Data

17 Jan 2013

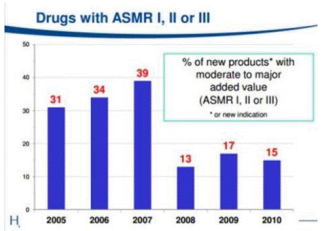
MPs criticise delay and confusion over value-based drugs pricing

By James Bloodworth

Practice MPs have called on the government to clarify its plans to move to value-based medicine pricing of drugs and branded the delays in making the switch...

GALBRAITH WIGHT Re:thinking Market Access

What have we learnt about the focus on medicines in EU countries? Governments are short term & politically expedient – it's in their nature



France

- HAS determines burden of disease (through SMR rating) and level of innovation (through ASMR rating) – ASMR is by indication – to be replaced by combined ITR
- Clear evidence of a **'downward' trend in ASMR ratings** awarded - likely due to economic pressure on French public sector deficit & Eurozone economic crisis

Germany

- New AMNOG law introduced January 2011
- Clinical benefit assessed by GB-A/IQWIG
- AMNOG requirement to deliver a €2b saving each year – so a conflict of interest with higher cost new medicines
- Clear evidence of **generics chosen as the comparators**, a likely means to push down prices of new products
- GB-A over rides IQWIG when it is politically expedient

GALBRAITH WIGHT Re:thinking Market Access

Considerations for us when thinking about Pricing & Reimbursement discussions with Payers….

- At filing we know very little about the **performance** of our medicines in **delivering health outcomes** in a range of different patients at launch due to the very controlled nature of Phase II & III trials – Payers now assume the 'real life' results will be less good

- We seldom know what the **'right' dose** is of our new medicines until they have been used for several years in many patients – Payers have been 'hit' by 'dose creep' (e.g. Zyprexa) causing greater budget impact than predicted, which makes Payers distrust our forecasts

- Most medicines are developed for **multiple indications** (~80% of a total brand value comes from indications & forms after the first marketing authorisation), **over several years**, many of which will have a **different value (ICER)** from each other

- We've told Payers for many years that the cost of our medicines to them is dependent on how much of it they use in each tablet, vial, infusion or injection – but **manufacturing costs rarely feature in making Pharma pricing decisions** – so why do we continue with this myth?

GALBRAITH WIGHT Re:thinking Market Access

Industry needs to do a much better job in leading the debate around measuring & rewarding 'value' for innovation

Mail Online

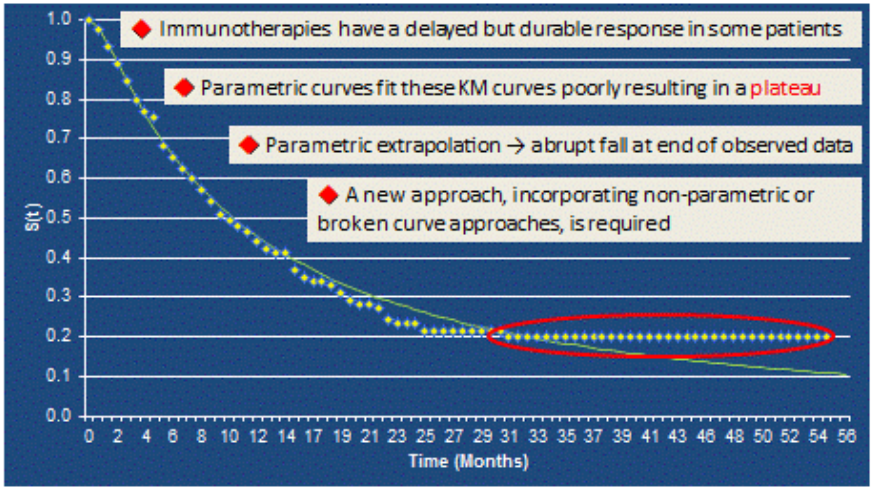
Home U.K. Home News Sport U.S. Showbiz Femail Health Science Money Rig

Don't give out cancer drugs if it's just to extend life: Treatment costs can't be justified, say experts

- NHS spends £5bn annually on cancer treatments up from £3bn in 2002
- Around 310,000 Britons a year are diagnosed with cancer

The life-prolonging drug called Sutent which is given to kidney cancer patients. Right, Karol Sikora who is one of the 37 experts who warn that the cost of cancer treatments cannot be justified

Given the importance of relative benefit in showing innovation, different measures may be needed (2)



Source: Annemans L, Asukai Y, Barzey V, et al. 2011. Extrapolation in Oncology Modelling: Novel Methods for Novel Compounds. Presented at the ISPOR 14th Annual European Congress, Madrid, 5-7 November.

30

"The Committee acknowledged that few advances had been made in the treatment of advanced melanoma in recent years and ipilimumab could be considered a significant innovation for a disease with a high unmet clinical need"

NICE FAD November 2012

http://www.nice.org.uk/nicemedia/live/12092/61322/61322.pdf

GALBRAITH WIGHT Re:thinking Market Access

Value delivered by the same medicine varies by disease

- Bevacizumab in combination with a taxane for the first-line treatment of **metastatic breast cancer** - ICER for bevacizumab plus paclitaxel versus weekly paclitaxel was between £110,000 and £259,000 per QALY gained
- Bevacizumab in combination with oxaliplatin-containing regimens as a second-line treatment for **metastatic colorectal cancer** the ICER was £103,000 per QALY gained.
- Bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of **advanced ovarian cancer** gave a range of ICERs from £128,000 to £161,000 per QALY gained.

- Etanercept for **active polyarticular-course juvenile idiopathic arthritis** whose condition has not responded adequately to, or who have proved intolerant of, methotrexate the ICER is in the region of £15–30,000 per QALY
- Etanercept for **first-line treatment for early RA**, the estimated ICER with methotrexate is £78,100 per QALY
- Etanercept in **adults with active psoriatic arthritis**, the ICER was £12,480 per QALY gained when compared with best supportive care.

GALBRAITH WIGHT Re:thinking Market Access

Source: www.nice.org.uk

The value of innovative medicines is delivered over decades, with the majority of benefit delivered by generic use post-patent expiry

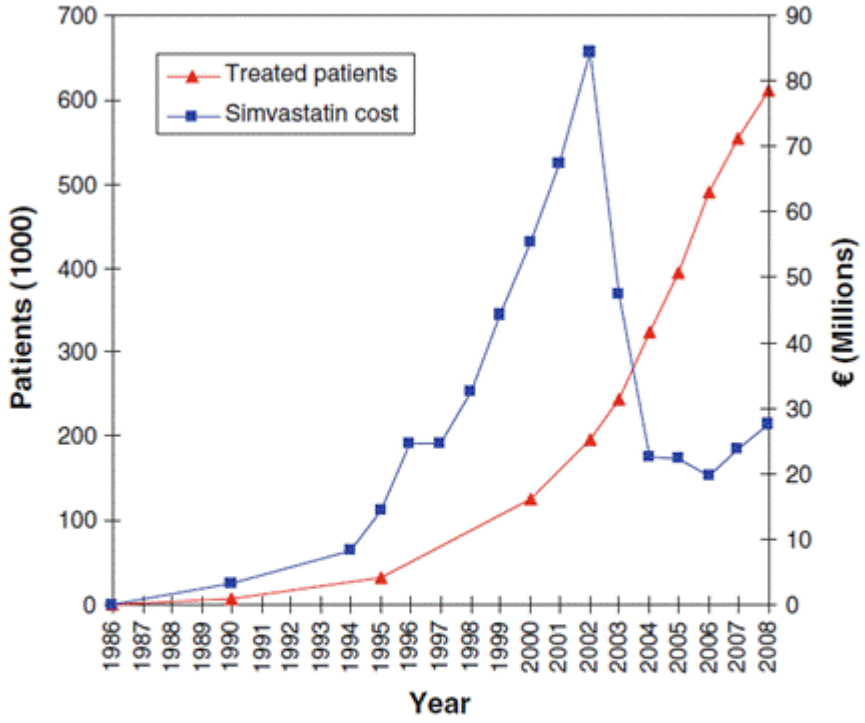


Fig. 1 The total cost of simvastatin prescriptions and the number of patients treated in Sweden 1987–2008. Source: National board of Health and Welfare [21], sales data from MSD Sweden AB and Apoteksbolaget AB (data on file)

"The fact that such a large proportion of the social surplus being appropriated by others than the innovator highlights the relevance of a societal perspective in economic evaluation. It may also make a case for considering looking a dynamic cost–effectiveness when assessing the introduction of new therapies."

Source: Cost–effectiveness of statins revisited: lessons learned about the value of innovation. Peter Lindgren, Bengt Jönsson. Eur J Health Econ (2012) 13:445–450

We need to forge Price based on value in terms of delivering Health Outcomes – which evolves over time

A pricing & value strategy which recognises the many unknowns at launch, but is based upon delivering improvement in health outcomes, not Kg of chemical.

A healthcare system which realises value is not all delivered at launch, that health outcomes take time to show, and that value changes over time – parametric evaluation is required

Patients, Healthcare Professionals & Payers want to pay for health outcomes, not 'pills'!

GALBRAITH WIGHT Re:thinking Market Access

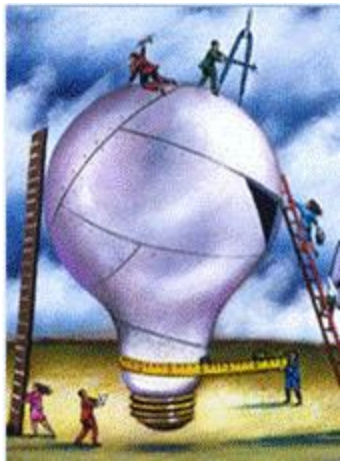
Solution: Innovative Pricing – some potential ideas

Medicines, (and the package of care around them), could be priced according to 'value' which would mean by indication

Issues such as fraud prevention can be managed through already existing Registries or other independent patient tracking measures

These patient tracking methods would also allow the prospective gathering of health outcomes & PROMs data, which could be of great importance to Payers, Patients & industry for future value assessments

These patient tracking methods can be managed by some of the innovative approaches of the supply chain companies such as Celesio & Alliance Boots/Walgreens



GALBRAITH WIGHT Re:thinking Market Access

Solutions already exist – in concept

Healthcare systems already conduct differential pricing by intervention – through DRGs

Hospitals routinely charge different amounts for the same operating theatre, using the same surgical team, but differentiated on the procedure, through the DRG system

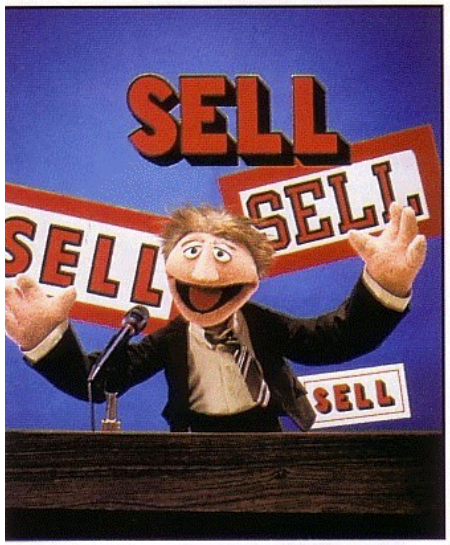
GALBRAITH WIGHT Re:thinking Market Access

Unforced errors - & how to avoid them

6. **Same old commercial model**

Same old commercial model – still….

"All big pharma sales force models are the same and have not changed since 1935 - it's time they did,"
Andrew Witty, CEO, GSK
Financial Times global Pharmaceuticals and Biotechnology Conference 2006



GALBRAITH WIGHT Re:thinking Market Access

Solution: Use every new launch to explore & Pilot new Commercialisation models

RWE

New methods of engagement

New locations for service delivery

Multi channel support

Prospective outcomes research

Innovative pricing methods

Customer Partnerships

GALBRAITH WIGHT Re:thinking Market Access

Unforced errors - & how to avoid them

7. Market Access is about **hearts & minds within the company**, not just processes & templates

GALBRAITH WIGHT Re:thinking Market Access

Unforced errors - & how to avoid them

1. Market access work starts **much too late** as many Senior Managers do not fully appreciate the timing and investment needs – **educate Senior Management**

2. Starting early enough means **Commercial Strategy must be in time** for Market Access strategy to align – **educate Commercial teams**

3. Market access **capabilities** are **siloed** and **limited** with no clear definitions & performance standards – **develop clear definitions, competencies, capabilities & cross-functional responsibilities – global, region, country**

4. **R&D focus** is still **marketing authorisation**, not reimbursement- **educate R&D teams & build market access requirements into R&D processes**

5. Our **pricing** strategies are **stuck in the dark ages** when we used to be chemical manufacturers – **develop innovative pricing solutions fit for 21st century**

6. **Same old commercial model** – **create opportunities to pilot innovative commercialisation models**

7. Market Access is about **hearts & minds within the company**, not just processes & templates – **build belief & passion among teams for Payer Customers & the Value of your medicines**

We need to work together on delivering better health outcomes for patients while managing total healthcare costs – that's what value really means

GalbraithWight is a team of **expert practitioners** with extensive **international**, **senior level operational experience**……

who **design** & **deliver** **Consulting** & **Training** solutions for the **global** healthcare business….

focused on
Market Access,
New Product Planning & **Launch Excellence** &
Brand Planning & **Marketing Excellence**….

with **class leading understanding & practice** of **Market Access** at their **heart**, because **Market Access** is the single most important determinant of commercial success, **globally**.

GALBRAITH WIGHT Re:thinking Market Access

GALBRAITH WIGHT Re:thinking
Market Access

Contact Us!

Contact information

GalbraithWight Ltd
GalbraithWight House
Chaucer Business Park
Dittons Road
Polegate
East Sussex
BN26 6QH
United Kingdom

Tel: +44 1323 482 208

www.galbraithwight.com

GalbraithWight is opening an office in New Jersey, USA in Q1 2014

GLOBAL

Colin Wight
E: c.wight@galbraithwight.com
M: +44 7889 413 075

Mary Skeels
E: m.skeels@galbraithwight.com
M: +44 7799 205 526

Mark Boyden
E: m.boyden@galbraithwight.com
M: +44 7723 098 657

Business School

Trudie Loveridge
E: t.loveridge@galbraithwight.com
M: +44 7788 452339

EUROPE

Carlotta Pellegrini (Italy)
E: c.pellegrini@galbraithwight.com
M: +39 342 1487703

Cathy Jordan (France)
E: c.jordan@galbraithwight.com
M: +33 677 177436

USA

Nicky Hall (NJ)
E: n.hall@galbraithwight.com
M: +1 732 647 6075

Taufi Ryder (NJ)
E: t.ryder@galbraithwight.com
M: +1 609 924 2872

Lori Katz (NJ)
E: l.katz@galbraithwight.com
M: +1 609 468 4882

ASIA PACIFIC

Glenda Crawford (Australia)
E: g.crawford@galbraithwight.com
M: +61 408 068 841

Jane Thomas (China)
E: j.thomas@galbraithwight.com
M: (on request)

GALBRAITH WIGHT Re:thinking Market Access

Patient Experience Network

www.patientexperiencenetwork.org

- Our mission is to recognise, share, measure and embed, sustain and celebrate best practice in patient experience.
- Improving the patient experience not only makes patients feel cared for, but also
  - Improves health outcomes
  - Improves healthcare system efficiencies
  - Improves employee engagement
  - Improves healthcare organisational reputation and goodwill.

PEN is a not-for-profit company established & supported by GalbraithWight

For more details contact:

Ruth Evans, Director

+44 (0) 7798 606610