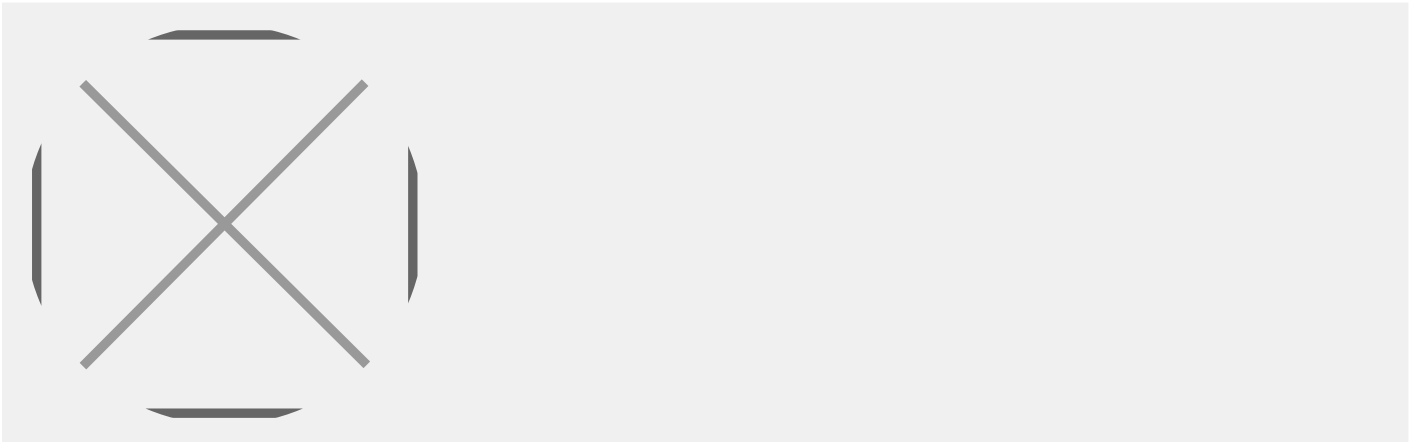
Interview: Tom Rönnlund, General Manager Nordic & Baltic Region, IMS Health



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Tom Rönnlund discusses the current state of the pharmaceutical industry in the Nordics in this time of austerity, and offers opinions on reference pricing and cooperation in the region.

How have the markets in Denmark and Sweden evolves over the past five years, since the financial crisis started and austerity measures started to be implemented throughout the European Union?

The Nordic markets are mature pharma markets that, like most Western European markets, have suffered from austerity measures and actions from governments and payers to control expenditures on pharmaceuticals.

At the same time, the period we are discussing is marked by massive generic losses. Today, we are still in the midst of the patent cliff; globally, some $150 billion innovative products are going off patent in the next five years. That has of course also affected the Nordic markets and the different actors in them.

Austerity measures and efforts to reign in expenditures on pharmaceuticals are coupled with a longer-term trend of changing rules for the way in which pharmaceutical companies are expected to interact with the healthcare system. This concerns rules for meeting and interacting with care providers, how companies are able to arrange different kinds of activities for doctors, nurses and other healthcare stakeholders, and so on.

This combination of developments has taken its toll on the number of people employed in the industry in Sweden, and changed the way they work. The entire sales force has been reengineered: the role of someone who is out in the field working with the healthcare providers has changed significantly. Most often, a sales rep of today works as a key account manager and with a much broader set of responsibilities than five years ago. Rather than just meeting with the prescriber and discussing the features, advantages and disadvantages of a particular treatment, today he or she plays an important role identifying barriers in the diagnosis of patients and in developing adherence solutions.

Is it fair to say that overall, the innovative industry in the Nordics is responding quite well to cost containment measures, taking it as an opportunity to rethink business models and work in more efficient ways?

I think that is a fair assessment. The change process, especially regarding the evolving business models, has been going on in the Nordics for a little bit longer than in other markets. That perhaps allows the industry to be slightly ahead of the game.

Many companies have also used the Nordic markets for piloting innovative approaches to act in the best possible way in this environment. From that perspective the industry has responded quite well. But again, there is still a job to be done; it is not happening overnight.

You mentioned that different players respond differently and with different measures of success. Which type of company responds best?

Broadly speaking, small and medium sized companies appear a bit faster responding to external challenges. They might not have the same resources as the big players, but they do have the focus and the agility.

This type of company sometimes has only one or a few therapy areas in which they are very active, and on top of that works with smaller teams. This allows them to move quickly to a new way of acting and behaving. This opportunity to act in a lean and nimble way can prove an advantage from that perspective. Medium sized players might have been faster, but the big ones are definitely catching up.

How much better off are the Nordics in comparison to other European countries today?

While volume of treatment is still growing in the Nordics, value of treatment is expected to show flat growth and perhaps even a decline in this period. Still, there is a shift from declining primary care driven treatments to growing specialty-driven treatments and specialty driven market

segments.

Even though there are pockets of excellent growth, the industry faces downward pressure that compensates that growth through patent expiries, prescribing guidelines, and more efficient use of resources.

The Nordics are no worse off than other European countries. Even though every country has its own specific challenges, the Nordics behave like other European markets in many ways.

Simultaneously, the authorities are not looking to significantly increase the 12-13 percent of overall healthcare bills spent on pharmaceutical treatments. This means that we will see a fight for ways to fund innovative treatments coming to the market.

Furthermore, in both the Nordics as well as many other parts of Western Europe, the headroom that was automatically created in pharmaceutical budgets as a result of blockbusters going off patent – and many markets also put in place mechanisms to ensure a swift switch to generics from the very moment a product goes off patent – is not going to be there in the future.

This would mean a rising bill and stronger future growth. Then again, I am not sure that the authorities are going to let that happen. Therefore, the discussion needs to focus on how we can ensure that we continue to fund innovation and let innovation come through, with the ultimate goal of guaranteeing access for the Nordic patient.

What would be the challenges of introducing international reference pricing in Sweden?

Sweden has fairly low prices on newly introduced pharmaceuticals. The country has an efficient system for generic entry and generic replacement, and price levels are generally considered quite satisfying. The area where some might feel that price levels are less satisfying compared to other countries is with slightly older products, five to ten years old, that still enjoy patent protection. The Swedish authorities found that they were paying more than European comparator countries. That is the issue that the proposal to introduce international reference pricing in Sweden tries to address.

I am not in a position to answer if international reference pricing is a good or bad measure. Sweden took a progressive stance very early on by introducing a value-based pricing model. I think this is actually a very good way of encouraging and paying for innovation that has proven to work and deliver. That is the strength of the model, and I am not sure I would be happy to see Sweden steer away from it.

General models of market development seem to repeat themselves all over the world, albeit with local nuances. How does IMS tailor its global services to the specifics of the Nordic markets?

Having local country presence in the market is a very important factor for us. We have teams deployed in this region that follow and focus on the Nordic market conditions and the Nordic market environment.

We also constantly draw on the experience of our global organization and from other markets and utilize that by making it relevant to our Nordic customers based on local market needs. We have plenty of examples of cases where we successfully took experiences from other markets, tweaked them to the Nordic environment, and delivered good value in our services to our customers.

Over the past few years IMS in the Nordics has worked more and more with other stakeholders outside of our traditional client base of pharmaceutical companies. Pharmacy chains, governmental stakeholders, care providers, payers, etc. With such assignments we can really add value around the international comparison aspects.

This is one of IMS' key strengths. We can help and support analysis through which clients can gain visibility on how price levels in other countries compare or how a certain model compares to other models in other countries. We have built a healthy business in that space here in the Nordics.

Is this type of cooperation particularly well suited for countries like Denmark and Sweden that are known for consensus based models of working in cooperation between different stake holders to improve healthcare outcomes?

That is a good point. The question is also, is the collaboration between industry, government, academia working as well as it should? There are many good initiatives but I sometimes do not see the effects when it comes to the delivery of innovation.

Healthcare systems in this region have a specific structure: they are funded through taxes, the government is the provider, and there are limited private options. Another shared characteristic is that most citizens are quite happy with the system and feel that it is delivering perhaps not great, but good value at least.

Is there room in that model to also make sure that innovation continues coming through? Is the collaboration between industry, medtech or pharma, government and the academia really strong enough? I do not feel that is the case today.

There are good initiatives, but they sometimes feel a little bit like a late wake-up call. Only when AstraZeneca shut down a big chunk of its research operations in Sweden the government hurried to drum up plans and policies around innovation.

In Demark there is a stronger recognition of the domestic pharmaceutical industry. It is a very important employer and a very important export for the country. It also draws brain power that the entire country can benefit from. The Danish government and their ambitions, together with the pharmaceutical industry association and other players, are slightly more concrete.

Collaboration has to deliver concrete outcomes that benefit the patient, help companies grow, help create future employment opportunities, and create future export income. There is a good model and a willingness to reach consensus and collaboration, but we are not there yet.

Given our expertise, knowledge and network, IMS can play a role in helping other players progress in setting up that kind of collaboration.

Our capabilities and competences are well suited to help care providers, care payers, governments and authorities in their work. That is our clear ambition: to create a stronger alliance with all stakeholders in the healthcare environment.

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