Interview with Stephen Turley, Managing Director, Lundbeck Limited (UK)

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Lundbeck Limited (UK)

If we look at Lundbeck globally, the company has been doing very well. Last year was a record year for profits. From a UK perspective, can you provide an overview of how you have seen the company performing since you arrived in 2009, and what your outlook is for 2011?

For Lundbeck, the UK has been seen as a market that has been difficult over recent years; the company, in the UK, even had a period of decline. But now we are showing growth across the entire promoted portfolio. There are some things to be positive about, and there are some things that we should still see as ongoing challenges.

On the positive side of things, across the portfolio, all of our promoted brands grow in terms of cash sales. They grow in excess of the market growth rateâ??so if you look at either the overall market, or indeed, the markets we compete in, we grow in excess. But the biggest challenge is how to move market share. That is very difficult in a marketplace that is, first of all, in some ways conservative in its medical practice. And second of all, it is a market that has had, and continues to have, significant financial constraints.

So we definitely have growth opportunities, but they are going to be, I think, harder to unlock than you might perceive in other markets. The thing that we take, loud and clear, is that the model of the past, whereby you just put more and more promotion and noise behind a product, and then you get a sales return, is not going to work. In fact, for us, there is a bit of a two-pronged challenge. One part is: how do we engage in a way that is effective for the marketplace? The second is: how do you do this in a way that is understood at headquarters level, and still positions the UK as a key market.

For Cipralex, and Ebixa, Lundbeck has up to 20% market share in Europe. Do you have a similar proportion in the UK?

That is not an untypical position. If you look at something like Cipralex, across Europe, you have got growth rates that are still double digit; you have got market shares that are over 20%. In the UK, you have a brand which is now growing again, but was in decline in 2008, was flat in 2009, and had some modest growth this year. We find ourselves with a market share of about 4.5%â??so that obviously lags well behind what you see in countries such as France, Italy, and Spain.

How important is the UK for the growth of the group worldwide?

Especially for a company like Lundbeck, where presence in the U.S. is still quite immature, the reliance on non-U.S. marketsâ??and the reliance, therefore, on European marketsâ??is greater than

it would be in some other companies. And the UK, although it is underperforming, is still a major contributor to revenues. So the country is of great financial importance, and great strategic importance, to the company. Whilst the UK might not deliver the market share, and it might not deliver the percentage growth, of some of our other markets, the absolute sales base is still very, very significant.

What are your main growth drivers now for the UK, and how well is your portfolio aligned with the customer, the NHS?

Our focus this year, and into next year, is still very much around Cipralex, Azilect, Ebixa and Circadin. Each of those brings their own challenge.

I think that we have a very nice opportunity because our products fit very well with what the NHS needs, on a number of levels. First of all, it is clear a lot of the decision-making power sits with payers. And payers are less interested in just having individual product discussions; they want to have wider discussions. So the fact that we have a portfolio helps, and the fact that that portfolio is centered on a common strategic themeâ??which is mental healthâ??helps as well.

Then if you look a bit deeper and put yourself in the customerâ??s shoes and you ask, â??What will be important to the customer in the next couple of years?â?• It is clear that as we go through the changes of the moment, there is a very good chance that the quality standards that are going to be developed by NICE are going to be of increasing importance. Of the first three that were developed, one of them is for dementiaâ??so that fits right in with our area. And then of the ones in the current wave of development, there is one for depression, and there is one for alcohol dependence. So although there are going to be 150 standards announced over the next five years, already some of the very early ones are right in the middle of the areas that are of interest to Lundbeck.

So it looks that, if quality standards are going to be of importance, there is going to be a very strong common agenda regarding where our interests lie, and where the customersâ?? interests will lie. That gives us an opportunity that maybe some others might not have.

Just last week, you implemented a new sales structure. How do you see this benefitting the companyâ??s positioning within the changes that the NHS is undergoing?

We should consider that customers will only deal with a pharmaceutical company if they think that they will get value from it. In the jobs that we doâ??we are all busy peopleâ??you would not sit easily with suppliers coming to see you if you didnâ??t get value from the interaction. Maybe you would see them once, but if you got no value, you would certainly not see them again. So we have to get our head around the fact that the customers are not obliged to see sales reps. They are not obliged to see the pharma industry. If we are really honest and reflect on how much value we are bringing to customers at the moment, it is probably not enough.

One of the things to note is that, ok, we are a commercial organizationâ??we are not philanthropic, let us be clear about that. However, if we are to achieve our commercial aims, it is fair to say that a valid route to do that will be through having a focus on the customer. So what does the customer want? Through the current NHS changes, it is clear that there is more and more autonomy, accountability, budgeting, decision-making power, etc. being pushed out from a central to a more local level, through the GP commissioning groups and so on. The fundation of what we are trying to do is to say that if the customer is going to get a much more autonomous environmentâ??where they have to deliver to local needsâ??then we also have to engage with that. We also have to have people with a certain amount of autonomy to do what is right for the local need that the customer has. That is one building block.

The second building block is to say that, if the customer wants to engage with industry, and they want to get value, that is likely through being able to engage with someone that is able to operate at an appropriate level. So somebody that has the right knowledge, the right skills; somebody that has the appropriate decision-making powers; and somebody that, of course, has the budget responsibility that goes with that. All we have tried to do is tie those things together and make sure that, in tune with our commercial goals, we are operating in a way that is consistent with the customer agenda, rather than going against the customer.

The days of, say, a pharma company not liking some PCT guidance, and therefore throwing loads and loads of reps at the GPs and trying to overcome it by forceâ??those days are gone, they are history. The NHS has some powerful mechanisms, and if they wanted to close the doors tomorrow, they could do it. So the only way that we will succeed is through actually trying to get ourselves into the customersâ?? shoes, and engaging with them. And having them engage with us, as wellâ??it has to be a two-way thing.

Do you think that, with all of these changes in the NHS, the UK is headed in the right direction?

There is huge uncertainty. If you put a gun to the head and say, â??Is this going to work?â?• then you cannot guarantee it. You can just note that, based on all of the options that are available, this seems to be the most logical way forward.
If you talk about joint working as being an appropriate model, then logically that makes sense; logically it should work. For me, though, the jury is still well and truly out. I know that some people have put forward case studies for joint working and there are some interesting examples, but I have not seen it been absolutely proven just yet.

At the moment, we have something that looks to make sense on paper, but we have to prove it works in reality.

Mathew Speers, Chair of EMG, recently said that the slow uptake of medicines here in the UK is a critical challenge for the industry. Is this true for Lundbeck UK?

Yes, I would say that it is a significant challenge. There is no doubt that one of the things that frustrates us as an industry is the fact that the UK has, across Europe, some of the lowest prices; and yet we have, with that, some of the lowest uptake. If you look at the international variations project that was done in conjunction with the Department of Health, the industry, and IMS earlier on in the year, then you see that it is not across every therapy area that we have low uptakeâ??but there does seem to be a pattern emerging. The pattern suggests that if we haveâ??for want of a better wordâ??cheap generics, you get decent uptake; if we have innovative new medicines, you get lower uptake. This is compared to other European markets. So uptake is certainly a point.

There is an absolute fixation with cost rather than value. And people talk value but what we see increasingly is cost. I think you see that with, for example, the QIPP initiative. The new government is supporting QIPP. On its own, I do not think you can argue with anything that tries to improve quality or anything that tries to improve efficiency. The concern that I, and many others, have is that QIPP is actually a misnomer for cuts. The easiest thing to manage is the drugs budget. And in looking at the drugs budget, you just look and see, â??What are the most expensive drugs? Let us cut those.â?• This, rather than looking and scrutinizing how to get better value from the system.

This is where I think that we as an industry can help. We can say, â??Look, we are prepared to work with you.â?• Take Cipralex for example. Cipralex is a branded medicine that is operating in a market where there is a lot of generic choice. But we are prepared to come to the table and consider how we can appropriately position Cipralex and allow you to get the best value from a marketplace where we recognize that there are some generic options.

What initiatives are you taking to increase the attractiveness of this brand relative to generic competition?

We are on the journey. For Cipralex, there are two areas where I think we can help. We are starting from a point wherein many prescribing advisors are saying that Cipralex is simply an expensive branded medicine in a market where people should be using generic. If you look at NICE guidelines, they do indeed stipulate that a generic SSRI should be a first choiceâ??we will not argue with that. Pragmatically, we will accept that.

However, what we would like to do is to work with customers and say, â??Cipralex may be more expensive on a per-unit basis than a generic, but as an absolute amount of your relative prescribing budget, it is a relatively small amount.â?• If a prescriber is really after making efficiency savings, then targeting Cipralex is not how you will do it. You have many other anti-depressant medicines that are being used that are not supported by NICE; or patients on a medicine that are well past the review date and should not be on that medicine any longer. If we work with you to identify those patients, then that will give you far bigger efficiency savings than simply trying to reduce by 20% your Cipralex expenditure. What is more, you may then be able to benefit from some of the benefits of Cipralex that were acknowledged by NICE. So that is one area.

And the second area involves the question of whether there is any evidence that there is an outcome benefit to using our branded medicine instead of a generic. And with Cipralex, that might be, for instance, a reduction in hospitalizations. I think that that is where the industry probably must work a bit harderâ??yes we have to show the clinical profile of the drugs; we have to show the basic efficacy, the basic tolerability; but we also have to be prepared to answer the question, â??And so what?â?• Cipralex works well, and it will control your depressionâ??but the payer will say, â??And so what?â?• Hopefully, we can say that, used in the right patients, you will get less hospitalizations. Hospitalizations are a massive cost.

What we are doing at the moment is not just a structural shift in the companyâ??it is what we are calling an organizational shift. Because yes, there is a huge component to it which is structure, but we then have to get that structure to work in a different way, and we have to do a lot of work behind the scenes. Above and beyond the clinical profile of the drugs, we are thinking of the value proposition that we are going to carry to customers.

The UK is quite a generic market overall, with the highest generic penetration rate in Europe. Do you think that Lundbeck is well positioned in a generic market like this?

I think Lundbeck is well-positioned because we have, across the portfolio, products thatâ??if we characterize the proposition correctlyâ??genuinely make a difference. We do not have, in our portfolio, anything that I would call a â??me too.â?? And that is very important.
If we look at Cipralex, then yes, it is a branded medicine operating in a generic marketplace, but there is an evidence base to show that there is a position for Cipralex. I think that if you speak to most payers, they will accept that there is a position for the drug. It is up to us to work with them to carve out that position.

If you look at Ebixa, it is the only medicine, within Alzheimerâ??s Disease that is indicated for those patients at the more severe end of the disease, and has now been endorsed by NICE. We know that dementia is a huge, huge issue, both in terms of the core diseases, and also the governmentâ??s desire to see less anti-psychotic medication used in dementia patients. Ebixa can really bring some value in that component.

If we look at Azilect and Parkinsonâ??s disease: Parkinsonâ??s is a well-established market, but Azilect brings some unique attributes, because we have data that proves it has a real impact on the

clinical progression of the disease.

If we look at the future pipeline, we are developing Nalmefene for alcohol abusers. This is an area that is a high public health priority, for which there is nothing above and beyond abstinence that is proven to help.

I think we are really well positioned because we have products that, be it in a wide population or a niche population, have a very specific proposition. I think that that is what the industry must increasingly ask themselves, in a brutally honest way: why should my customers use this product? You cannot try and pretend that you do not need data. Customers are quite discerning these days. Unless you can genuinely answer this question, you should not be there. But I think that Lundbeck can genuinely answer the question.

How have you managed to retain some clinical trials in the UK?

Like many companies, we have a very limited number of trials in the UK. One of our major challenges is trying to attract good Phase III trials to the country. With Phase III trials, we are obviously talking larger populations, hands-on experience, the big KOLs getting involved, etc. Typically, other countries can offer either faster recruitment, or better KOL support, than the UK.

Where the UK still has a strong reputation is in some of the early trialsâ??particularly around Phase I type of work. If I look at Lundbeck and other companies, we get a lot of early stage work, but we really struggle to get some of the really meaningful Phase III work.

I think there are two factors in retaining clinical trials in the UK. The first thing is that the UK needs to demonstrate that this is a good place to do trials. In other words, that we are able to get trials set up quickly, we are able to recruit patients quickly, and it is not going to cost a fortune. That is not currently the case, so it must be addressed.

The second thing is you have got to prove that the UK is a worthwhile market to operate it. So if I am in a global headquarters, and I have the opportunity to do a trial in the UK or do a trial in France, all other things equal, I am going to go to the country that will offer me the biggest business return. That is reality; that is a fact of life.

Given the fact that the UK is slow, expensive, and offers a bad business returnâ??you tell me why a company would want to do a trial here?

I know from working in global headquarters ,for another company earlier in my career, that when you set up Phase III trials, you of course recognize that if you want to have a certain amount of KOL exposure, you want a certain amount of big names participating in your trials. But above all else, speed to market is really important. So you will look and say, â??Where do I get the right KOLs from?â?• And then you will go to the places that offer you the greatest speed to market. And over the last five or ten years, that has typically been Eastern European markets. In some cases, Northern Scandinavia, but generally Eastern Europe.

Can you explain what the Lundbeck Institute brings to the UK, and how important it is for you to educate local healthcare professionals to better contribute to society?

It is important to Lundbeck, being a company owned in large part by a foundation, that we bring added value to the medical profession beyond just the drugs that we sell. Through academic support, research grants, etc. A lot of the work that is done at headquarters level through the Lundbeck Foundation, and what we try to do at a local level though the Lundbeck Institute in the UK, is to in some small way continue that philosophy. To engage with some of the high-level thinkers in

the UK around research topics and academic topics that are going to help spur thinking within the fields of psychology and neurology.

Looking at corporate philosophy, yours is represented by the â??C.O.R.E.â?• principlesâ??clarity, opportunity, responsibility and excellence. How do you instill this vision in the minds of your employees here in the UK?

Any leader coming into an organization is going to have some ideas regarding where they would like to go. It would be very easy on day 1 to say, â??Here is the vision, here is how we are going to achieve itâ??let us go and do it.â?• If that happened, I think there is a good chance that people would comply with it, but would they commit to it? There is a big difference between commitment and compliance.

The starting point as a leadership team is to have some sort of vision, but figure out how that can be a shared vision. We spent quite a lot of time at the outset getting peopleâ??s ideas regarding not only the validity of the vision, but also regarding the barriers that sit between where we are today, and our achieving that vision.

The thing that we wanted for our vision was to be a highly successful, medium-size pharmaceutical company in the UK. And we said that that was going to require three things: first of all, to deliver compelling financial results; secondly, to bring real value to customers; and third, to be seen as a great place to work. If we could achieve those three things, then that would deliver the highly successful company that we wanted.

Then we were able to identify, with the whole organization, a number of things that are stopping us from achieving that today. And that becomes the action plan for what we have been trying to do through 2010, and into 2011. Underpinning all of that is the core philosophy. The â??Eâ?? in the C.O.R.E. is â??excellence,â?? and excellence is what we are ultimately trying to do. If you are going to get excellence, it is very simple that that will be derived from: having absolute clarity about what the goal isâ??which we have already developed as a team; understanding the opportunities that will lead us towards that goal and the responsibility that each individual takes to deliver it; and the excellence then will follow.

What will we see from Lundbeck UK in two years?

In two years, if you take a random sample of 10 people in the industry, and ask them to name a successful medium-sized company off the top of their head, I would want most of them to say Lundbeck.

What has been the most rewarding aspect of your job in the pharma industry?

Generally speaking, the most rewarding things for me are being able to see when something actually works. To see that something is not functioning, and operating as it should be, and then to be able to formulate a plan and see it through to make it work. Whether that is through getting an organization operating more efficiently, or whether it is getting a product operating more efficiently.

For example, when the last Alzheimerâ??s appraisal was started, there were some that said not to bother; that the possibility of reaching a different outcome from the last review was low. Within Lundbeck UK, there was a determination to say, â??No, if we get this right, if we really make clear our proposition, then we can get something from it.â?• So it was fantastic to see that we did get something from it. It is things like that that give me satisfaction.

But ultimately the big satisfaction has got to be sales success. From a Lundbeck perspective, it is too early to judge that. We are one year into a journeyâ??you have to deliver, you cannot just wait until the end, I know, but in two yearâ??s time, certainly, we will.

What is your final message to your peers in the UK?

The message would be: look at what the customers want, look at what your business needs, be really clear on what you are going to do, and then do it very well.

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