INTERVIEW WITH:

Ales Tichopad, General Director, CEEOR

Focus Reports: What do you believe differentiates your outcomes research services from the more established consultants we see in the industry today?

ALES TICHOPAD: I believe that a persistent trend in our industry is the hiring of consultants, but are actually positioned as single players holding particular knowhow, having previously worked within or alongside the industry. These individuals operate somewhere in the interface between companies' needs and the needs of the regulator. Companies utilize such people as instruments to deliver their key messages.

However, what I believe is missing in the Czech Republic and in the CEE at large is something that I learned in Germany. My career started in a rather large international CRO called Kendle (recently acquired by INC research). Kendle had a structured approach of putting a team on a project, delivering in accordance with deadlines, and delivering something that really looks like a project rather than advice over the phone.

Ales Tichopad, *GENERAL DIRECTOR, CEEOR*

I believe that CEEOR has made quite a successful step simply in declaring ourselves a commercial provider of team expertise that is totally independent both from the state and the pharmaceutical industry. We hold the necessary capacity to accumulate enough people on a project, and, moreover, we have the capacity to take on many projects at the same time-relative to an individual player that can maintain only a limited capacity.

FR: To what degree does CEEOR overlap with mega data providers such as Cegedim and IMS?

ALES TICHOPAD: Surprisingly, we overlap in an area that was not original to our business model. As I mentioned, in addition to outcomes research, we also conduct market research. In this sense, since 2008, we have penetrated the markets of Cegedim and IMS quite heavily: we all work in the field of promotion and sales data, as well as ad-hoc market research.

However, in the small markets of the CEE, these organizations are not active in health economics, so we do not compete there. It seems that it remains difficult for them to find the right experts in these countries on a cost-effective basis. In general, the large service providers that I am familiar with have not been successful in establishing health economics branches in this region. Hence, there is substantial room for skilled

local players.

Local knowledge does not consist only of understanding the system; it consists also of understanding the needs of stakeholders, knowing the language, and understanding the bit of permanent chaos that we see here. Things are not perfect; things are in transition. Local expertise lies, therefore, also in the ability to monitor the situation, predict outcomes, and flexibly manage business parameters.

FR: *You are an expert in the seeming impasse that we see today between pharmaceutical companies and the payer in terms of market access for innovation. Can you delve into the challenges we see in this regard for the industry?*

ALES TICHOPAD: It is obvious to me that innovative pharmaceutical companies are making a great effort to establish health economics argumentation as a strong tool for bringing their innovations to market. Within the industry, there are people that have substantial knowledge in this field, and are able to provide material of reasonable quality-i.e., they know what to look for and how to present it.

On the other hand, there are still pharmaceutical companies that are missing the right people in the right positions. I still see market access managers that are not very skilled in health economics-unskilled in the terminology, in the meaning, and in the goals. Today, health economics is still unfortunately misunderstood as a way to save money, or to make healthcare cheaper by some. This is definitely not its direct intention-and yet people in the business accept this view.

Originally, health economics originated within the governments. It came from regulators. The concept was actually to pay more money for more innovation and better health outcomes. This philosophy has not been clearly established in this region. We have the impasse you mentioned: pharma companies want more money for products whose added value they have insufficiently proved; the payer, meanwhile, wants to cut costs. This is where the two sides have met. CEE government stakeholders have a generics-oriented approach: they want the same quality, at a lower price, without considering if there is outstanding innovation that they should pay a premium for.

I believe that people are missing whose mentality is progressive: people who want to balance cost and innovation delivery, rather than simply look at cost.

For pharmaceutical companies, it is essential to get the right people into these positions, and such people should be involved in the interface activities such as to attract people from the regulator side to a negotiation, organize education as well as initiate a dialogue that will better establish the concept of adequate payment for innovation.

Another problem that I see is that there is a bit of mistrust on the part of the regulator: they often believe that the quality of the argumentation is not sufficient; that it is tendential or produced unprofessionally. Many of the pharmaco-economic studies produced in the CEE that I have personally reviewed have also been very biased. This is a very damaging trend that ruins the evidence power of this instrument.

The Ministry of Health in the Czech Republic has recently made a tangible effort to establish an HTA decision-making body. The steps have been taken, and I believe that this effort will be successful. There will be reasonably good policies available soon that will provide for a more sophisticated receptor of this kind of argumentation.

On the side of the manufacturers, they must ensure that the supporting data that they deliver is of a high quality. There can be no compromise. I feel that this goal has not yet been accomplished-a lot of poor-quality evidence is out there.