International Alliance of Patients' Organizations

A global voice for patients

Biologic Medicines Advocacy Handbook

Part 1 Advocacy Theory

Preface

At the 70th World Health Assembly in Geneva in 2017, the International Alliance of Patients Organizations and our partners hosted a side event to celebrate the contribution made to healthcare over the past 70 years by conventional chemically synthesised medicines and to explore the potential of biotherapeutics in improving healthcare over the next 70 years.

This event highlighted the enormous possibilities now offered by biotherapeutics to address a number diseases and disorders for which we have no treatments or cures. Delegates heard the remarkable case of how innovative biotechnology and biopharmaceutical processes had helped create recombinant DNA insulin to treat diabetes type I patients, vastly improving the quality, safety and effectiveness of treatment when compared to the use of animal sourced insulin in the past.

The introduction of biologic medicines into our healthcare systems requires timely, accurate and relevant information that is in an accessible format to help patients make informed decisions. It is up to patient organisations and patient advocates to oversee that we can provide this high quality information on biologic medicines to improve healthcare for all.

The International Alliance of Patients Organizations has produced two toolkits on biologic medicines in the past. This toolkit updates them and adds a new dimension of universal health coverage by 2030.

This tool kit prepares patient advocates to join the global campaign to set-up Universal Health Coverage (UHC) and advocate a non-discriminatory access to and availability of a sufficient quantity of quality, safety, and accessible, acceptable and affordable biologic medicines within their own healthcare systems, irrespective of whether they are biologic originator (reference) or biosimilar medicines.

As we build the momentum towards universal health coverage by 2030, big debates will surface on the inclusion of biologic medicines on the Essential Medicines List in every World Health Organization Member State. As most Essential Medicines Lists in low and middle income countries rely upon generic medicines, most of the debate will centre on the inclusion of and striking a balance between biologic originators (reference) and their biosimilar medicines in these lists.

The patient advocates, regulators, pharmaceutical industry and payers need to reassure patients about the quality, efficacy, safety and pharmacovigilance issues relating to biologic originator and biosimilar medicines. The payers and providers within our healthcare systems are under pressure to ensure sustainability of their UHCs by providing a range of innovative originator and biosimilar medicines on their Essential Medicines Lists

Part 1 Setting the Scene

Background

In order to develop patient advocates' capacity to advocate effectively on issues relating to biologic medicines, the International Alliance of Patients' Organizations (IAPO) produced two tool kits, one in 2013 and the other in 2018. These toolkits covered both the reference (originator) biologic and their biosimilar medicines. [For Definitions See Our 2018 Toolkit https://www.iapo.org.uk/biosimilars-toolkit]

The primary objective of the 2013 tool kit was to raise awareness and educate patient advocates about the biotechnology and biopharmaceutical processes involved in the manufacturing of these innovative medicines and introduced them to the lexicon of biologic medicines.

It was important in 2013 that we raise the differences between biologic medicines when compared with the conventional chemically synthesised medicines. Special emphasis was placed on highlighting differences between the regulatory and pharmacovigilance regimes put into place for biosimilar medicines when compared with those put into place for conventional generic medicines.

The second toolkit was released in a 'maturing market' in biologic medicines. Patients now had access to even more biologic medicines than in 2013. There were more originators (reference) and their biosimilar biologic medicines licenced for use in 2018 than in 2013; and even more were waiting in the development pipeline.

The second tool-kit had a joint research report by IAPO and the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) Biologic Medicines: Delivering on their potential for patients (2018) at its centre and eight factsheets that gave patient advocates additional information and resources for their advocacy.

The 2018 tool kit specifically covered global guidance from the World Health Organization, European Medicines Agency, Food and Drug Administration (USA) and Health Canada on the regulation of biologic medicines and how this was being implemented and enforced nationally. The tool kit highlighted the challenges posed to patient advocates by the diverse regulatory and licensing pathways now emerging for the approval of biosimilar biologic medicines around the world.

The second tool kit also looked at what was happening on the frontline in the clinics and pharmacies. Divergent clinical, therapeutic and dispensing practice was emerging inter and intra countries. Healthcare policy and practice guidelines issued on biosimilar medicines by national and federal health authorities varied. The practice of switching and substitution between the reference and their biosimilar biologic medicines needed to be understood better. The tool kit flagged that as health systems are registering more biosimilar medicines on their essential medicines lists, the issue of naming and post licencing monitoring, traceability and pharmacovigilance regimes needed to be robust and clear.

While the two tool kits have gone a long way in bridging the knowledge gaps on biological medicines amongst patient advocates, there is now a need for a capacity building resource that addresses the issue of how to structure patient advocacy on biological medicines (reference and biosimilar) within the framework of universal health coverage by 2030.

This new toolkit aims to help patient organisations and patient advocates to mobilise and organise themselves to ensure that we have a non-discriminatory access to a sufficient quantity of quality, safe, accessible, acceptable and affordable biologic medicines (reference and biosimilar medicines) by 2030.

Introduction

This new toolkit relies on the two previous toolkits to provide the patient advocates with the basics of the biopharmaceutical science involved in the manufacturing of biologic medicines. The previous two toolkits have also adequately covered the differences between the regulatory frameworks involved in the prescription, pharmacy dispensing and pharmacovigilance of reference and biosimilar biologic medicines.

This new toolkit wants patient experience to be the cornerstone of advocacy on biologic medicines. Patients see and experience the clinical and therapeutic practice within the clinics, and the pharmacy prescription fulfilment practice at their local pharmacy or chemist. Their perceptions are important.

Just as we want all advocacy recommendations to be evidence-based (putting research into practice), we also want patient advocates to use patient experiences on the frontline to feed back into the research process (putting practice into research).

In this toolkit, IAPO is sharing global patient experience and insight about how to structure your advocacy campaigns on biologic medicines for UHC 2030. We are starting from the position that all patient advocates want a non-discriminatory access to a sufficient quantity of quality, safety, accessible, acceptable and affordable biologic medicines within their own healthcare systems, irrespective of whether they are originator (reference) biologic or the biosimilar medicines. The World Health Organization has defined these terms in the right to health and its human rights based approaches to health and universal health coverage.

Term	Definition
Non-Discriminatory	The patient's race, ethnicity, religion, gender, age, sexual orientation, disability and political allegiance should not be used to deny treatment.
Sufficient Availability	There should not be shortages, rationing or other restrictions to the supply. A sufficient quantity is sometimes defined as a planned three month buffer stock kept in well-functioning healthcare facilities, medicines supply chain, healthcare services and programmes.
Accessibility	A patient must be able to physically access the biologic medicines. The biologic medicine should have accessible information-the labelling, patient information and even helplines and patient support websites should be age-appropriate and linguistically accessible. Hard of sight and hearing disability accessibility must be provided. Particular focus placed on an accessible pharmacovigilance system.
Acceptability	Biological medicines labelling etc and services associated with dispensing and treating patients must be respectful of medical ethics and culturally appropriate, sensitive to age, gender and language.

Quality and Safety	Quality is defined as medicines and healthcare that is scientifically and medically appropriate. This means all biologic medicines must be approved by national and regional medicines regulatory agencies using evidence based approaches and recommendations. Patient safety is the prevention of errors and adverse effects to patients associated with health care. This means preventing medication errors in prescribing (physicians), fulfilling prescriptions (pharmacist) and administrating treatment (nurse- dose and injections safety) See Fact sheet 2: Regulation of Biologics Introduction to the regulation of originator biologic medicines https://bit.ly/2Kil297 Fact sheet 3: Introduction to Biosimilars & Regulatory Requirements Introduction to the regulation of biosimilar medicines https://bit.ly/2KjV9pd
Affordability or economic accessibility	As we are driving for universal health coverage, we want every WHO Member State ensure we establish UHC by 2030. WHO says that patients should be protected against financial-risk, ensuring that the cost of using medicines and services does not put people at risk of financial harm.

Change Framework

The IAPO advocacy approach relies upon framing patient advocacy around five elements:

- Change Framework
- Social Marketing Approach
- Policy Instrument Grid
- Power Constellations
- Policy Windows

Biologic medicines and their regulation, marketing, prescription, pharmacy, monitoring and pharmacovigilance are affected by an international, regional and national framework comprising:

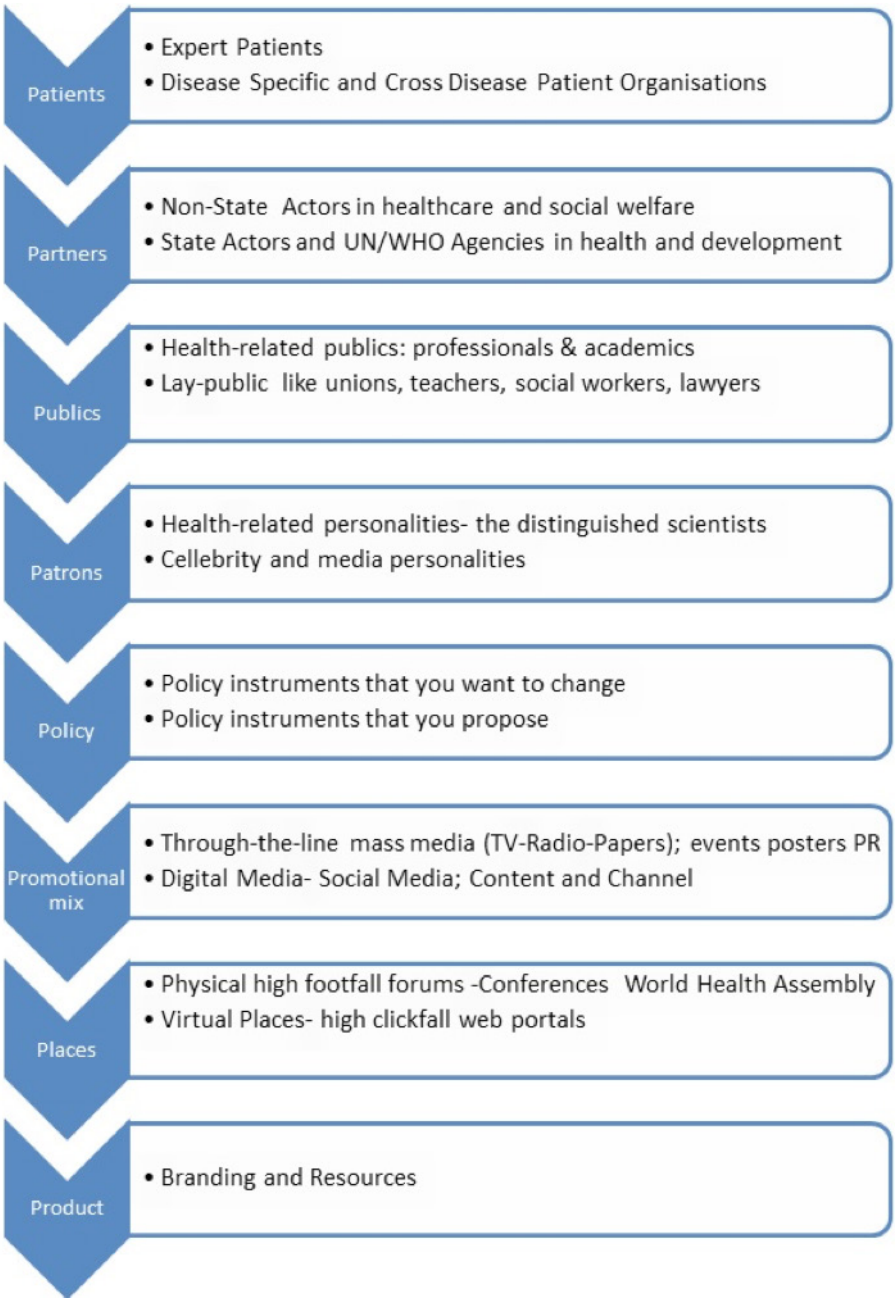
- Institutions
- Legislation
- Policy
- Practice
- Standards

As health is a 'sovereign matter' your national institutions, law, policy, practice and standards will be the dominant change agents. You can, however, leverage international support from the global patient community and international organisations to support your national advocacy campaigns.

In order to effective and efficient, patient advocates need to engage with all the five elements of this framework appropriately. You need an alliance of national and global patient organisations with the right experience, knowledge and skill sets to engage with each of the five different elements of this Change Framework.

Social Marketing Approach

This model approach has been borrowed from public health. Social Marketing is being used by many strategists to influence the five elements of the Change Framework. Social Marketing uses traditional marketing approaches to achieve a social objective. It relies on the marketing four 'Ps' of product, place, promotion and price, and then adds to this several social 'Ps'.



IAPO has adapted this Social Marketing approach for advocacy on biologic medicines in selecting about seven or eight Ps. The IAPO Social Marketing mix requires the patient advocates engaging with and influencing the:

- **Patient Community** - create an enabling environment for the engagement of patients on the biologic medicines. They must have capacity to debate and participate in the decision-making. Mobilise your existing community of practice and recruit new member organisations. You need to lead, organise and develop their advocacy capacity
- **Partnerships** - you need a robust partnership comprising State and non-State actors to engage with the institutional, legislative, policy, practice and standards Change Framework. You need to mobilise your existing partnerships and develop new strategic partnerships. Each partner brings additional resources, skills, networks, influence and power.
- **Publics** - these are your audiences. Traditional publics in healthcare have been the legislators, health lawyers, social activists, health professionals and academics. We now have new publics emerging with the Sustainable Development Agenda 2030. These new communities now comprise aid and develop ment professionals, the human rights community, and the gender equality and environmental groups. Health advocates and the 16 other SDG 2030 advocacy partners are now interrelated.
- **Patrons** - advocacy campaigns can sometimes be defined by celebrity or visionary leaders. This can be their unique selling point (USP). UNICEF goodwill ambassadors like football stars or a Special Envoy of the UNHCR like actress Angelina Jolie are examples. You need international, national and local inflential patrons to support and enhance your advocacy.
- **Places** - old school public relations experts used to say that it was important to be seen with the right people (patrons and publics) in the right places to influence policy. Today the physical places have also been extended into 'virtual places'. You need to be seen, heard and read in the company of right people on the right digital platforms like Facebook, Twitter and YouTube, in addition to the traditional health related forums like the UN High Level Panels, World Bank and G20 meetings.
- **Promotional Mix** - this can be a simple letter to the editor or a Minister, or it could be much more elaborate campaign using traditional broadcast media (TV and radio), narrow cast SMS and emails, Direct Marketing (leaflets and newsletters) or Digital Social Media (Facebook, Twitter and Youtube) backed by a comprehensive online presence as a portal or a website. The use of marches, protests and stunts is also covered.
- **Product** - the product in a social marketing campaign is the change you want. This can be achieved by YOUR proposed evidence-based changes to the institutions, legislation, policy, practice guidance and standards framework. This 'new product' will hopefully deliver a sufficient quantity of quality, safe, accessible, acceptable and affordable biological medicines (reference and biosimilar medicines) that we desire by 2030.

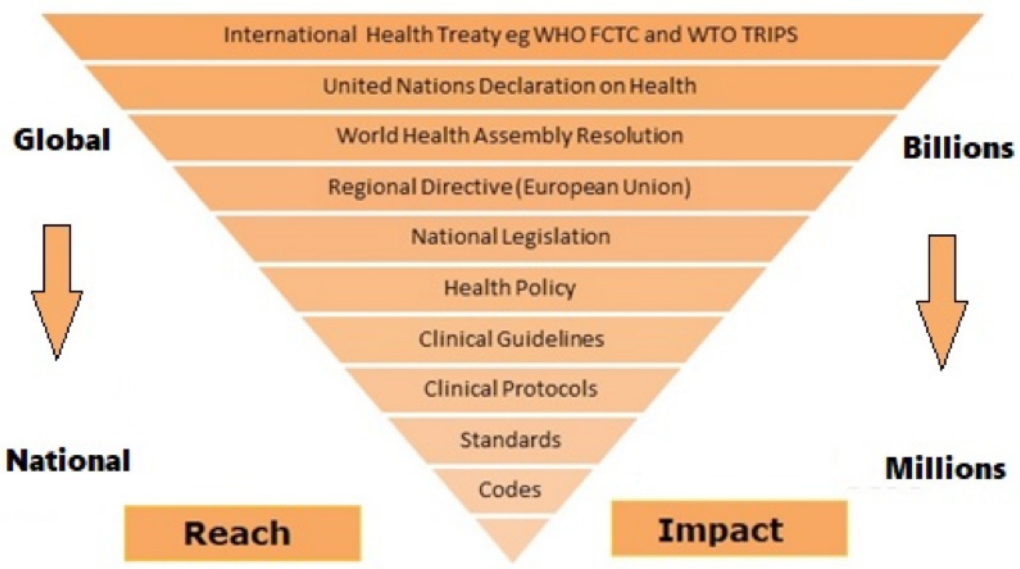
Policy Instruments Grid

Policy Instruments are normally defined as interventions made by a State to achieve the desired national objectives. In this toolkit we are adapting this to include ALL interventions made by global organisations like the UN, WHO and the World Bank, and tie them up with regional, national and local State and non-State actors' interventions made to ensure non-discriminatory availability of quality, safe, accessible, acceptable and affordable medicines.

We have used a standard policy grid and enlarged it with a range of policy instruments that patient advocates can adapt to their national settings to achieve the outcomes they desire in their own biologic medicines markets. The spectrum of policy instruments ranges from using or proposing patient registers and a listing in the WHO International Classification of Diseases, to then recommending much more complex changes to law, policy, practice and standards affecting health systems and biologic medicines.

The key focus here is that you must propose and use evidence based policy instruments. This requires thorough research and analysis before you can propose a policy instrument. We want evidence-based policy instruments on biologic medicines that are most effective, efficient and proportionate. If a simple briefing on a biologic medicines to the pharmacists through their representative body will help change dispensing practice, then why propose a law change through the parliamentarians that will take years and a lot of resources. We are looking for timely and most effective and efficient solutions.

Tier 1 Disease Level	Tier 2 Practice Level	Tier 3 Policy Level	Tier 4 National Legislation	Tier 5 Global and Regional
Nomenclature and Controlled Vocabularies	Practice Guidelines	Medicines Regulatory Authority policy and guidance	All-Party Parliamentary Group on Health and Medicines	WHO Guidelines and UN High level Panel Reports
Patient Registers	Protocols	Department of Health Policy	Green and White paper Consultations	UN Political Declarations
Meta-Data Analysis of RCTs	Standards	Federal and Provincial Policy. European Union Policy	Draft	International health Regulations
WHO ICD 10/11	Health Technology Assessment Bodies National Institutes of Clinical Excellence	General Medical Councils and other Ombudsmen and their policy	Subsequent Stages of Debating on Draft Legislation Bill	Bilateral Treaties and Trade Agreements like WRO TRIPS
			Parliamentary assent-Bill Becomes Law	WHO FCTC global Health TReaty



Power Constellations

The British Medical Journal said that: Health is a political choice, and politics is a continuous struggle for power among competing interests.

This toolkit wants patient advocates to be aware that patient advocacy on biologic medicines is not being conducted in a 'power vacuum'. There are competing political interests all vying for a slice of the same national budget pie. The farmers lobby, or even the defence lobby, will be trying to 'win the battle of hearts and minds' and trying to persuade parliamentarians to allocate more funding to them.

Power is the ability to influence or control the behaviour of an organisation, State body, national institution, and even the whole Government. Very often power is shared and distributed in constellations.

In institutional democracies, these power constellations may become complex and multi-layered having evolved over many years; power maybe shared amongst a number State and non-State actors. These 'power-houses' can not only drive change, but they can also resist change.

In countries with a 'democratic deficit' these power constellation can sometimes develop into power cartels that operate above the law. The healthcare cartels are unaccountable and lack transparency. Patient participation in decision-making is barred or restricted in many healthcare systems.

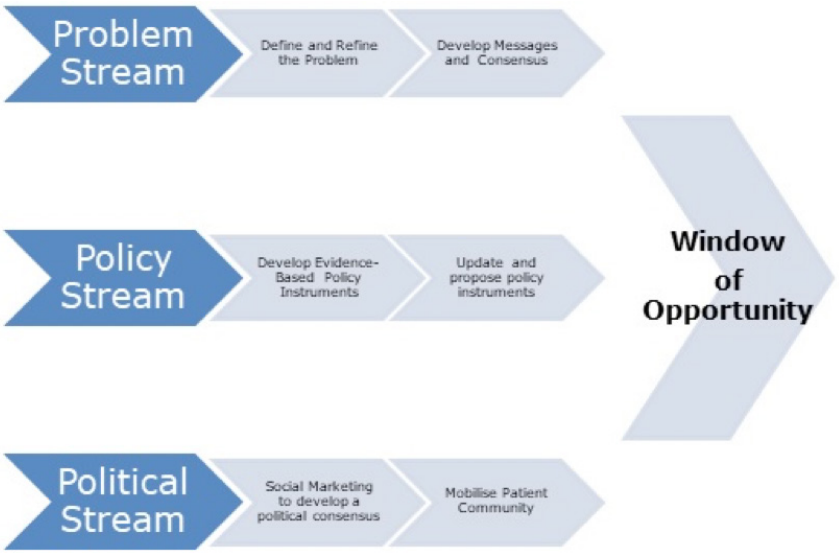
Big Tobacco, through their lobbyists, had established control over health policy makers in many countries. They had created power constellation that the tobacco control advocates had to overcome. It was one of the toughest challenges faced by advocates when they were driving forward the ratification of the WHO Framework Convention on Tobacco Control-the world's first global public health treaty.

The lobbying by patient organisation for their own particular healthcare issue is one of the most challenging aspects of these 'power games'. Cancer or Diabetes Organisations could vie for a bigger share of the health budget competing with patient organisations representing rare diseases and disorders.

In advocacy on biologic medicines, the power to change the institutions, law, policy, practice and standards related to biologic medicines maybe shared between several 'power houses'. They may have:

- Legal power- this is power given by law. The National Medicines Regulatory Agencies have legal power as they have been set-up by an act of parliament.
- Expert power-scientific and academic bodies may have expert power. They can use this power to advise governments on biologic medicines. Health Technology Assessment bodies invite experts to give their input.
- Referent power (informal power) - some organisations and people/patrons may attract loyalty and support through their character and impact. Save the Children and March of The Dimes , two charities or non-Profit organisations, may be in a better position to change laws, policy and clinical practice relating to access to biologic medicines in paediatrics than others because politicians, society and patients groups respect and support them. Legislators know that public opinion for these organisa tions is a 'vote-winner' and doors of the powerful open to them.
- Reward power-A local health authority may reward doctors by sharing a portion of the annual cost saving of the medicines bill by encouraging them to write out prescriptions for generics and biosimilar medicines. This changes the use of proprietary and reference biologic medicines. Wholesale distributer offering heavily discounted reference biologic medicines to retail pharmacies has reward power to change aspects of access and use of medicines.
- Coercive Power- in many autocratic healthcare systems, coercive power is often used to implement changes. The Department for Health may use coercive power to impose the 'generic prescribing' rules (you must only prescribe non-proprietary and biosimilar medicines) by making it a disciplinary matter. If a doctor does not comply with this, their employment can be terminated. This can be in conflict with the doctor-patient relationship and the ethics of the best interest of the patient.

Policy Windows (Kingdon's Three Stream Policy Window Mode)



Health policy does not change overnight. Patient advocates have to create or cultivate the right environment for this to happen.

Kingdon proposed that advocates must work along three streams to ensure that the window of opportunity opens for your issue to become the law and policy of the land. The three streams proposed by Kingdon are:

- The problem stream- you research, map and accurately identify the needs and problems being encountered by patients. You then frame them creatively and promote your issues (using social marketing) onto the public domain. When the media, patients and policy makers recognise that there is a problem, you have legitimised it. Then power-houses and supporters (patrons and partners) will join you to drive change.
- The policy stream (solutions you offer)- you cannot call for change to current biologic medicine policy and practice without offering alternative solutions. You must provide alternative policies based on new evidence-based solutions. Your alternative solutions must be robust and be able to withstand intense scrutiny and criticism. Always generate alternatives and give a choice to the decision-makers. Always have a 'Plan B'
- The political stream- you must create political will to back your issue. Politicians always sit on the fence until public opinion forces them to change. You must put your issues on to the public agenda. Your proposed solutions (policy instruments) must be evidence based. Health is a political choice driven by public opinion. The decision-makers will always sway towards the majority and most vociferous public voices and opinion. In 1990s, when IBM was at its height and selling massive com puters systems to local governments and ministries of health, IBM used a slogan: 'No-one got fired for choosing IBM' to assure politicians and decision-makers that public opinion trusted IBM public finance computing machines as good value for their tax dollars.

To best illustrate the point that you need all three policy streams work together and to meet-up in time to open the window of opportunity to allow you to implement your changes, you have to understand the history of tobacco control advocacy and smoke-free public places.

Smoke-free public places, tobacco advertising bans, increases in tobacco taxes and availability of smoking cessation treatments became law and policy in many countries around 2007-2010. This took over 50 years from when the Problem Stream first started flowing in 1960's. Scientists had already linked tobacco use with cancers in 1950s. The landmark Royal College of Physician's Report Smoking and health 1962 and the US Surgeon Generals Report on Smoking and Health 1964 reframed the problem with great clarity.

Despite the problem having been identified and all the evidence base and causal relations between tobacco use and cancers, lung and heart disease having been established by irrefutable scientific randomised control trials for over 50 years, things didn't start happening until the World Bank moved the Policy Stream with its landmark financial analysis Curbing the epidemic - governments and the economics of tobacco control 1999. Curbing the epidemic reframed the tobacco control issue from health into economic terms. This suddenly resonated with tax-payers (voters) and healthcare providers (payers)- why should they bear the burden of Big Tobacco's product liability. This was now a political hot potato. The World Bank then offered the policy-makers evidence-based policy instruments and solutions. These were accurately costed out strategies to reduce demand and control supply of tobacco, along with creation of smoke-free public places.

With both the Problem and Policy Streams now flowing, the World Bank as a power-house could now use its expert, reward and even coercive powers to move the Political Stream. Countries requiring developmental loans or debt relief had to ensure they had tobacco control policies in all other developmental policies. Why should the World Bank fund coffee plantains when you are supporting tobacco growing in your agricultural policy, why should the Bank pay for a lung cancer hospital when you have not banned smoking?

Power constellations that opposed tobacco control were a great challenge to overcome. The power constellation created by the hospitality and bar industry opposed smoking bans in restaurants and bars. Their counter economic argument was that this will destroy leisure and recreation industry and affect many global tourist cities. The tobacco advocates and the World Bank provided refined analysis that showed a smoking ban would actually improve the financial position of bars and restaurants as more non-smokers would go and stay longer.

But political will was firmed up globally when politicians from Republic of Ireland and the City of Rome, two places where smoky bars and cafes formed the bedrock of their cultural and economic life, banned smoking. This was the dam that burst on the Political Stream and ushered in the WHO Framework Convention on Tobacco Control. The Framework Convention Alliance now reports that 181 WHO Member States had ratified this first global public health treaty (July 2017).

Conclusion Part 1

In Part 1, we have established that patient advocates need a structured approach to advocate on non-discriminatory availability of quality, safety, accessible, acceptable and affordable biologic medicines within their own healthcare systems, irrespective of whether they are originator (reference) biologic or the biosimilar medicines.

Part 1 has introduced an advocacy approach that can be structured around five entities:

- Change Framework
- Social Marketing Approach
- Policy Instrument Grid
- Power Constellations
- Policy Windows

In Part 2 will develop this in detail.

Acknowledgement

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