

THE OUTSOURCING DILEMMA

If the drug industry has finally accepted the need to outsource expensive, risky R&D, why not farm out the commercial side, too?

BY ROGER LONGMAN

- With sales productivity down, and the costs and risks of internal commercial infrastructure rising (given the increasing likelihood of losing marketed and late-stage products), the argument for outsourcing sales is growing stronger.
- But neither big nor small pharmas want to use contract reps any more than they do today given their firm belief in the necessity of controlling their own sales forces.
- Commercial outsourcing is nonetheless happening, though, as junior partners in licensing deals insist on roles in selling their own products, and as Big Pharma is forced to investigate cost-saving solutions
- Outsourcing will change in kind: from longer-term contracts for detail reps to spot-market contracting in a managed-care and specialist-medicine dominated world.

THESE TEA LEAVES DON'T REQUIRE specialists to read them.

- Clopidogrel (*Plavix*) – which **Bristol-Myers Squibb Co.** and **Sanofi-Aventis** have co-promoted into the second-biggest selling drug in the world – was legally sledgehammered by **Apotex Inc.** into an at least temporary generic coma, five years earlier than expected. Regardless of whether Bristol's preliminary injunction against Apotex is upheld, its sales force will likely be downsized.
- An independent study of data from Allscripts, the clinical information company, shows that preferred drugs in managed care formularies have exactly the same market share among both managed care and cash-paying patients. "This is the strongest spillover I've ever seen in my life. Why even have a sales force?" asks the study's lead analyst.

- Indiplon, the sleep compound which in 2002 garnered perhaps the richest deal terms of any biotech drug up to that date, got a surprise non-approvable letter for its most important dose; **Pfizer Inc.** pulled out of the companies' collaboration. **Neurocrine Biosciences Inc.** had to fire the sales force Pfizer had been paying for.
- Karen Katen, Pfizer's top commercial executive, presiding architect of the world's largest sales force, and once upon a time a candidate for the CEO job, unceremoniously leaves the company in a management shakeup. So does her number-one sales and marketing lieutenant, Pat Kelly. The unexpected stalling of atorvastatin (*Lipitor*) sales, and thus questions about how much Pfizer's commercial management understood the changing sales environment, were big reasons for the ousters.
- Two-thirds of the triumvirate which ran marketing at **Merck & Co. Inc.** resign after the company reaches outside pharma for its new commercial boss.

Big changes are coming to sales and marketing strategies, particularly for the long-dominant power of the large, internal pharmaceutical sales force.

Everything seems to call for sales flexibility. Products are more likely—like *Plavix* and indiplon—to fall off the market or never reach it, leaving sales reps to twiddle their thumbs on the company dime. Managed care's power to influence prescribing decisions—even, as Allscripts found, outside those patients in managed care plans—could soon outstrip even the most persuasive sales force. Some of the most powerful sales and marketing executives are losing their jobs as boards of directors come to recognize the problems in over-reliance on sales-rep-driven commercial strategies.

One logical outcome: the variabilization of the sales force expense. Companies who see decreasingly effective sales forces with increasing risk that product recalls or non-approvable letters could leave them with little to do, could decide to trim their internal sales forces and start to rely more on co-promotions and contract sales organizations (CSOs). And yet there have never been more detail reps, according to data from Verispan on the top 40 drug companies:

almost 102,000 – 36% more reps than in 2000. (See Exhibit 1.)

To some extent, the drug industry has faced a similar problem in R&D. There, internal productivity failures have forced a huge externalization of research spending—a way to simultaneously bring in new ideas and more highly motivated workers and to variabilize this once-fixed expense. In an increasing number of alliances, Big Pharma is handing over responsibility for *managing* critical R&D programs to the biotech, sometimes successfully (as **Roche** has done with **Genentech Inc.**), sometimes unsuccessfully (as Pfizer did with Neurocrine on indiplon). If Pharma is ready to outsource R&D—still advertised by most companies as their primary *raison d'être*—why not do more outsourcing of its commercial activities?

In fact, they have. Plenty of things drug companies used to do themselves they now routinely contract to a variety of service firms: medical education, patient assistance, sample management, fleet support – even, sometimes, sales force recruiting and training.

But they've balked at significant sales force outsourcing. According to data from **inVentiv Health Inc.**, only about 6% of the industry's total US detail force is accounted for by contract reps, a percentage which hasn't changed in several years. Indeed, most marketing and sales executives we spoke with aren't interested in increasing their use of outsourced reps. They're worried about CSO quality; and they still want total control of the sales force. "They're willing to outsource everything but what they see as the top-line driver, says Charles Saldarini, the former CEO of PDI Inc., a CSO. In the short term, that top-line driver isn't a new product. "It's the sales force."

At least they've been unwilling so far. A number of observers note that as the financial screws tighten, and as more powerful government and private payors increasingly put their own oars into prescribing decisions, drug companies will have no choice but to further reduce their large sales forces. That's not to say that they'll turn to CSOs in great number. Just as likely will be near-term increases in co-promotions, particularly as biotechs build sales forces and look for more products their reps can sell. Likewise, with more specialty injectable and IV products coming on, there will be decreasing need for GP-oriented detail reps – the stock-in-trade of most CSOs.

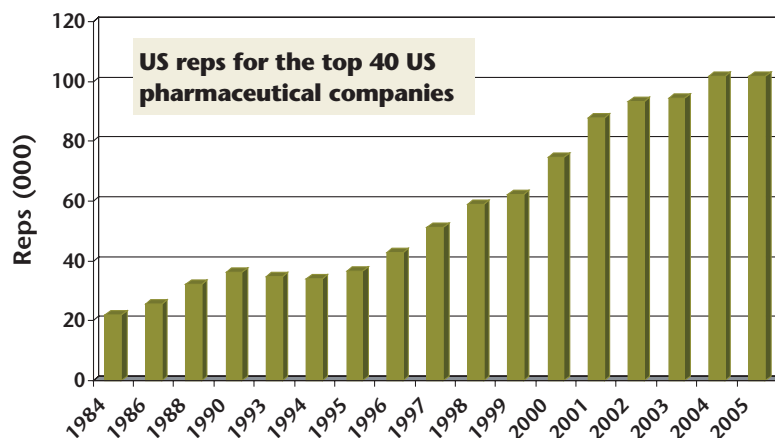
SUPPLY AND DEMAND DRIVERS OF OUTSOURCING

To Eran Broshy, the CEO of inVentiv, the future of the contract sales force should be bright. He ticks off a set of reasons why the drug industry must increase their reliance on outside sales forces.

On the demand side, he says, drug companies increasingly need reps in fits and starts. The larger companies are seeing fewer of their own products coming to market: in 2001, 63% of NME approvals came from the top-20 Pharmas; in 2005, just 39% did. Part of the problem is the pre-approval FDA process, he notes, which is more

Exhibit 1

US Sales Forces Continue to Grow



SOURCE: Verispian LLC

uncertain. And part is a more aggressive effort to get generics on the market much sooner than expected—most recently seen with *Plavix*. "If both pipelines and the number of marketed products are erratic, you need variable infrastructure," says Broshy.

Meanwhile, the more productive side of the industry—small pharma and biotech—have few drugs per company and can't be sure when any new products are going to arrive. To get the launch resources they need without taking the

risk of hiring all the required infrastructure, biotechs "can partner with Big Pharma," says Broshy, "but Big Pharma is restructuring so partnerships are often a risky proposition." And since many of these products will sell less than \$500 million, he contends, Big Pharma won't always be interested enough to sign a deal. So biotechs are likely to need CSOs and the pay-as-you-go flexibility they provide.

On the supply side, he says, the available outsourcing capabilities are much stronger. "As recently as four or five years ago," says Broshy, "the quality was pretty schlocky." At inVentiv, voluntary turnover in the sales force was about 30%—double that of most Big Pharmas. Training industry-wide wasn't particularly good, he says.

But inVentiv's turnover has now dropped to 10-12%, he says, at the low end of the current Big Pharma range (10-15%). This, he contends, has risen from the mid- to high-single digit range given the uncertainty in many large drug company sales groups as costs are cut throughout the business.

Broshy claims that, in terms of salary and bonus, reps make about the same at a CSO as at a Big Pharma, but the "reps of a more entrepreneurial bent are likely to get more experience under their belts in a three-to-five year period" by working for a CSO. The top performers are likely to get promoted faster. And as job security at Big Pharma decreases, the relative security of life at a CSO increases. With 35 CSO clients, says Broshy, "we have a lot of life rafts in the event of a water landing."

And then there are all the cost and tactical advantages of a contract sales force. Because of lower overhead costs, smaller benefit packages, and smaller ratios of support expenses per rep, a CSO's fully loaded cost per rep is about 20-25% less than that of a large drug company — \$120-140,000 per rep vs. \$150-200,000 at a large drug firm.

CSOs are also much faster in pulling together a sales force than are companies which aren't constantly in hiring mode. Thus inVentiv, says Broshy, can usually pull together and train a sales force in two-to-three months; the process typically takes three-to-six months at a drug company.

And in bad times, they're balm both to managerial consciences and P&L pain of layoff charges. Take the US unit of **AstraZeneca PLC**. In 2004, its late-stage pipeline problems began to make themselves obvious: anticoagulant ximelagatran (*Exanta*) received a

non-approvable letter from the FDA; diabetes treatment tesaglitazar (*Galida*) saw its filing delayed (both drugs were eventually killed outright); cancer therapy gefitinib (*Iressa*), failed to show survival benefit; and FDA's David Graham and private groups began raising safety concerns about cholesterol-lowering rosuvastatin (*Crestor*). With its launch schedule now in disarray, AstraZeneca nonetheless didn't fire its own reps. Instead, it let PDI do the work: AZ first cut back its deal with PDI, who suddenly had to redeploy or let go an estimated 500-600 contract reps. And when the problems continued, AZ cut its entire PDI relationship, or an additional 800 reps. For PDI, the cuts were painful – it lost potential revenues over two years of some \$111-116 million. AZ had been one of its top three clients (who together contributed 70% of its revenues). But AZ's sales force has remained more or less intact, according to SG Cowen's March 2006 *Pharmaceutical Industry Pulse* report.

For Bristol-Myers Squibb, the problem was more complex. In 2004, as it was evolving away from its status as a primary care house, Bristol-Myers contracted with inVentiv to promote its primary-care antibiotics cefprozil (*Cefzil*), which was due to go generic in 2005, and gatifloxacin (*Tequin*). The deal: once *Cefzil* had lost patent protection, Bristol could substitute another product or allow the inVentiv reps—who needed at least one more drug in their bag to make their sales calls profitable—to sell another company's non-competitive drug along with *Tequin*. For a year and a half, the deal worked well, says Broshy, whose company had fielded 375 reps for the project. When *Cefzil* went generic, inVentiv added the anti-arthritic meloxicam (*Mobic*) from the US pharma unit of **Boehringer Ingelheim GMBH**.

And then *Tequin* hit a disastrous speed bump: in March 2006, its labeling was sharply restricted when new data showed the drug could cause blood sugar problems. Bristol quickly dropped out of the deal with inVentiv, which took on another Boehringer drug, telmisartan (*Micardis*). But Bristol didn't have to significantly pare back its own sales force—at least not until its most recent product problem, the sudden genericization of *Plavix*, on which it had no CSO relationship, and thus no way to spare its own reps.

But outsourcing can provide growth as well as flexibility. In terms of internally generated sales increases, Boehringer Ingelheim has probably been the most successful of the top 20 non-biotech pharmaceutical companies, having grown from about \$5 billion in 1999 global revenues to what observers think will be \$12 billion in 2006, without any significant acquisitions. During this period, it has dramatically increased its internal sales force. But in this time a significant part of its sales effort, says Michael Leonetti, head of health care partnerships, has come from reps it does not employ—thanks to five US co-promotions with **Abbott Laboratories Inc.** (all now concluded) and Pfizer (one of which is still ongoing—for the respiratory drug tiotropium, *Spiriva*), plus its contract sales relationship with inVentiv.

SALES FORCES DRIVE EPS; R&D DESTROYS IT

But Boehringer Ingelheim's enthusiasm for outsourced reps is a rarity in the industry—more about a European company creating a bigger business in the US than an established business looking for other advantages. And now that Boehringer has close to 3000 reps in the US, it isn't looking for any more co-promotion or out-sourcing help on its own products. Instead, it will compete with CSOs, looking to co-promote other companies drugs. So far it's only found one deal—and that didn't work. The US portion of a global co-commercialization alliance with **Eli Lilly & Co.** on duloxetine (*Yentreve*) died when the drug failed to get approved for stress urinary incontinence.

Meanwhile, at NovaQuest (formerly PharmaBio Development),

the investment and partnering arm of **Quintiles Transnational Corp.**, commercial partnerships have slipped dramatically in number, says its president, Ron Wooten. In its first four years, 2000-2003, 60% of NovaQuest's partnership portfolio was focused on commercial activities, largely using Innovex—the Quintiles CSO—to build and run sales forces. But now, says Wooten, "90% of our pipeline is R&D oriented partnerships. The wave of demand for our development resources is driving our strategy."

The fact is, he says, drug companies see sales forces as "driving EPS. Development money is a destroyer of EPS. Even biotechs are told they need to commercialize themselves – that's the bigger value proposition for shareholders." In short, he says, half of the reason NovaQuest's business mix has flip-flopped is the market: with fewer launches, there's less demand for contract reps. "But the other half is the mentality: drug companies will never aggressively partner on the commercial side because it has the most positive impact on earnings."

inVentiv hasn't been blind to the growth challenges of sales-force outsourcing. Over the last four years, Broshy has transformed inVentiv from a CSO into a much broader commercial services company. In 2003, inVentiv's CSO business constituted 80% of its revenues. It now contributes just 30% —although the 30% represents a doubling in absolute dollars from contracting since 2003. The company has made eight acquisitions over the past two years, bringing on a variety of largely commercially oriented businesses including advertising, branding, medical education, sample management, and, to a limited extent, clinical staffing (after its last major acquisition, inChord, the company changed its name from Ventiv to inVentiv).

Investors have liked the new inVentiv. Its shares have risen about 300% over the last three years. But inVentiv's success is in fact a direct acknowledgement that a business focused primarily on providing contract reps remains difficult. inVentiv's only major pure-play public competitor, PDI, has diversified a bit, into medical education, brand advocacy programs, and market research. But with nearly 90% of its revenue from sales services, it remains largely a CSO, with uninspiring growth and little stock appreciation.

OUT-SOURCING PHOBIA

The fact is that both large and small companies continue to resist greater reliance on contract reps. The basic reason is fear. Internal sales forces nurture and protect the very heart of the pharmaceutical company's economic basis: the relationship with its customers. Messing with that relationship in any fundamental way—like bringing on reps you don't employ—is scary, at least in part because the relationship is so heavily influenced by matters other than the pluses and minuses of specific drugs. Notes the top commercial officer of one of the top pharmas: "The rep has to have an emotional tie to the product and to the company and to the physician. The reps at CSOs aren't as motivated. It's really a matter of commitment: if the company is committed to the rep, then the rep will be committed to the company." That's hard to do with a contract rep, says this executive: "When you outsource a clinical trial, you're outsourcing a transaction-based process. Whether the doctor is motivated or not, you'll get the same outcome. But with a sales rep, you're talking about something much more emotional."

That's not to say drug companies won't use contract reps. But they'll use them mostly in special and temporary circumstances. For example, as president of the US pharmaceutical unit of **Altana AG**, George Cole was responsible for creating a selling effort that would allow it to co-commercialize the company's new products,

in particular roflumilast (*Daxas*), an experimental respiratory therapy which the company hoped would become a massive blockbuster, perhaps as big as its \$3.5 billion anti-ulcer drug pantoprazole (*Protonix*). While Altana won some minor co-promotion duties with *Protonix*, its partner **Wyeth** did the majority of the work in the US.

But Altana's roflumilast deal with Pharmacia, and, after Pharmacia's takeover, with Pfizer, allowed it much more significant co-promotion rights, including a quid. While it waited for *Daxas*, whose launch could have come as early as 2005, Altana needed a sales force quickly, to help with *Protonix* and then to sell Pharmacia's incontinence drug, long-acting tolterodine (*Detrol LA*), and then Pfizer's antidepressant sertraline (*Zoloft*). So Altana hired inVentiv "because we wanted to spread risk. We didn't know when our products would come and wanted the flexibility a CSO provided."

As it turned out, Cole was right to choose flexibility over control: Phase III results for *Daxas* were disappointing. Pfizer returned the rights to *Daxas* in July 2005, taking back *Zoloft*—which left the Altana sales force with nothing to do but make its share of *Protonix* details. Meanwhile, the *Daxas* story got worse: in November, Altana had to pull its European approval application for the drug. But Altana didn't have to fire any reps: it simply ended its contract with inVentiv.

Indeed, new market entrants like Altana are the most obvious market for CSOs, given the greater impact on their business of new-product failures—they have no other existing products to absorb the revenue blow—and their requirements for fast hiring of sales forces once their drugs are approved. "Big Pharma has been running out of launches," says David Stack, CEO of Stack Pharmaceuticals Inc., a commercial consulting firm, and a former president of the CSO Innovex and the specialty pharma firm **The Medicines Co.** Without new launches, they don't need additional sales reps, either to take on the responsibilities for older products or to give an extra boost to the new ones. Instead, says Stack, "it has been the spec pharmas, emerging pharmas and European pharmas that have been demanding sales forces," and the only company positioning itself to serve them, he says, has been inVentiv.

THE SKEPTICISM OF, AND COMPETITION FROM, LITTLE PHARMA

And yet small companies aren't going to rejuvenate the CSO industry in the very near term. Argues Chuck Saldarini: "Emerging pharma will convert" their CSO sales forces to internal sales forces. "All these deals are basically lease-to-buy. So [the small-company market] is in fact a double-edged sword: it's great as long as there are enough biotechs and emerging pharmas coming along to compensate" for the biotechs who decide to internalize the sales force.

Indeed, most small-company marketers with whom we spoke don't see CSOs as a long-term solution, both because their products—often high-tech, specialist medicines—don't look like the drugs CSOs have traditionally detailed and because they too want to own their own sales forces.

For example, now that Cole is Chief Operating Officer at **Encysive Pharmaceuticals Inc.**, a biotech with a phase III pulmonary arterial hypertension drug, sitaxsentan, in phase III trials, "I wouldn't use a CSO here," he says flatly. "With a PPI [proton pump inhibitor, like *Protonix*], you can take a CSO sales force and train it. It's a numbers game; you're going for share-of-voice. But

sitaxsentan is a highly technical drug for an orphan indication, and the level of scientific knowledge and training required to sell it is a lot higher. I just wouldn't want to give up the control I have with an internal sales force; I want to make sure that all the i's are dotted and t's crossed."

Moreover, for small companies, the cost difference between an internal and a CSO rep, contend several marketing executives, isn't as great as it is for Big Pharma. The small companies, notes Saldarini, don't have to amortize the huge cost infrastructure of the Big Pharma. "They could in fact offer their sales forces" to partners for prices comparable to CSOs.

Which is in fact exactly what **Icos Corp.** is doing. The Bothell, Washington biotech and maker of tadalafil (*Cialis*) is that odd duck—a biotech with a primary care product, an aggressive user of contract reps...and a contractor to other companies of its own reps. Thus, as part of the Lilly Icos LLC joint venture through which it commercialized *Cialis*, Icos brought on several hundred contract reps from two different CSOs to help its own 165 reps (plus many more from Lilly) sell *Cialis*. The deal worked well, says Leonard Blum, Icos SVP of sales and marketing, at least in part, he thinks, because his company is small enough to manage the CSO reps closely. If he'd been at a large company, managing the CSO "at arm's length, I can understand that I'd be disappointed. We work closely with our contract reps so we can assure they're operating at the same standards as our own employees."

But Icos' pipeline has been problematic – and so its sales force has had nothing to sell but *Cialis*. Thus in January 2005, the company signed a pay-per-detail deal with **Solvay SA's** US drug unit on its testosterone gel *AndroGel*. The deal ended a year later when the **Watson Laboratories Inc.** generic unit of **Watson Pharmaceuticals Inc.** won approval for a generic version of the product. Now Icos is about to sign a new co-promotion deal, this time with a major pharmaceutical company. "We offer the ability to provide additional coverage very economically, more economically by far than for a drug company to send its own reps into those offices," says Blum.

Still, Blum would have preferred—all things being equal—to own his own sales force. He won't be specific about why Icos had to work with contract reps, but, apparently because of the complexities of working within the Lilly Icos joint venture, "there are internal reasons we're piecing the organization together with Lilly, Icos and the contract reps fulfilling different roles. But if Lilly Icos didn't exist, I'd rather have them as Icos employees, having a long-term commitment, with stock options." That's why, he says, before *Cialis* launched in November 2003, "we talked to a lot of CSOs but decided, no, we'd rather make them employees."

THE QUALITY ISSUE WON'T GO AWAY

But control is only part of most marketing executives' concerns about CSO reps. "It's really not a matter of controlling the message," says one senior Big Pharma marketing executive, who argues that indeed messaging can be well managed. "It's the quality of the rep."

And the quality issue becomes especially important when CSOs stress the speed with which they can put together a sales force. "Is there an inverse correlation between speed [of bringing on a sales force] and the quality of the sales force?" asks George Cole. Altana, he says, managed the process by becoming very closely involved with hiring "setting the criteria and even the interviewing. But not every pharmaceutical company gets that involved."

With some reason. For the client who insists on higher quality reps—who will be harder to find, more expensive, and perhaps,

because more specialized, less easily moved to another client—the CSO will necessarily insist on a longer-term deal. “The more you demand specific requirements, the longer the contract will be for,” says Michael Inouye, the former SVP, commercial operations for **Gilead Sciences Inc.** and who now holds the same job at **Telik Inc.**

But Inouye goes further: it’s just not likely that the best reps will join a contract sales force. “If he’s that good and could get a high salary and longevity with a pharma company, the CSO can’t offer the same things. CSOs offer flexibility – so you get people who need that—single mothers, new mothers. But the best rep in the field won’t get the best deal with a CSO.”

That’s an argument that drives CSO executives nuts. “You hear it all the time,” says Terrell Herring, CEO of inVentiv’s CSO unit, inVentiv Commercial. “But it’s not true.” Eran Broshy points out that after three quarters promoting fluvastatin (*Lescol*) for **Reliant Pharmaceuticals Inc.**, the inVentiv reps had basically the same minutes-per-detail and the same rep rating by doctors as the reps promoting competitive statins for Pfizer, Bristol and Merck. And a slightly higher percentage of the doctors visited by inVentiv reps said that they’d increase prescribing of the inVentiv-detailed product (See Exhibit 2.) He cites similar success in other primary-care and specialist categories—but those data are all blinded.

The real barrier to CSOs’ acceptance isn’t quality, argues inVentiv’s Terry Herring. It’s unexamined faith: “The true belief among marketers that if I control the sales force, it will have better spirit, more devotion to the product—that ownership directly relates to performance.” And the truest believer is the head of sales, says Herring—who often makes the decision to hire or not hire a CSO. “He’ll never believe that someone else’s soldiers will outperform his own. After all, it’s his job to be better than other sales forces. How could he admit anything else?”

WHY TAKE A CHANCE

And yet in the absence of long experience and unblended, objective data, companies are afraid to trust the fewer and therefore more valuable launches to someone else. “Look,” says Encysive’s Cole, “I’m probably not being fair to the CSO industry. They’re better than they get credit for. But when it comes down to the question of whether to hire a CSO or not [for a specialist product]: why take a chance?”

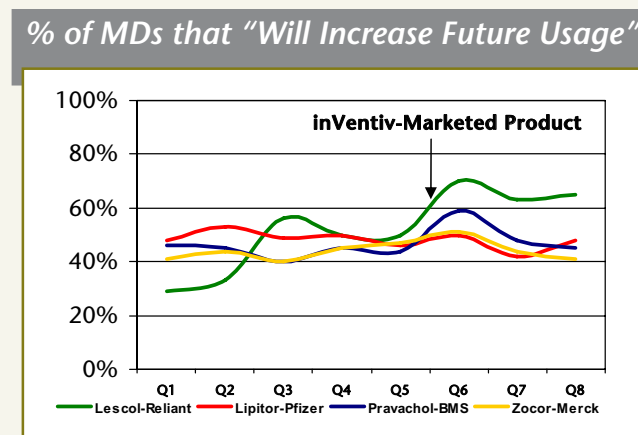
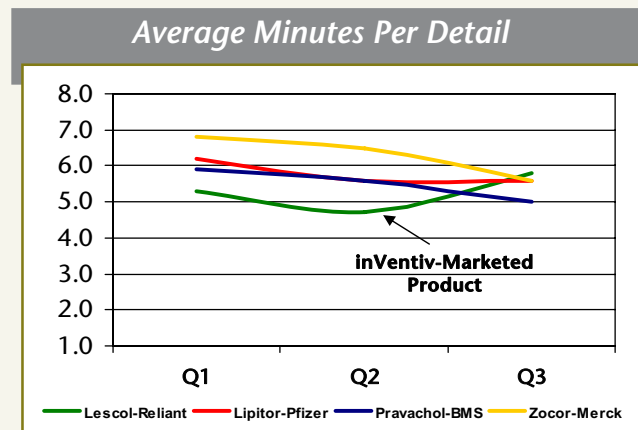
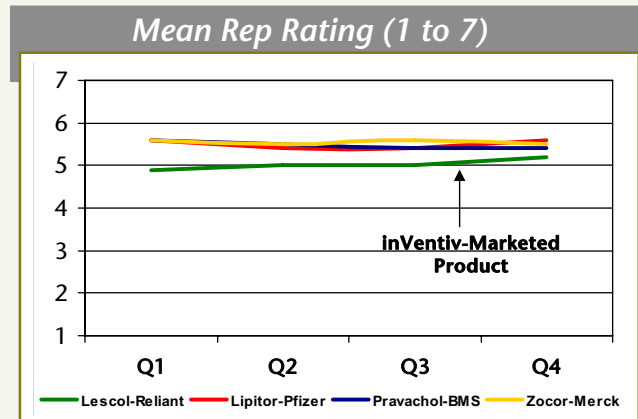
Adds Inouye: “You’re weighing the risk of a poor launch vs. the risk that the product will be pulled. The second risk isn’t too likely. Maybe higher than it was, but still relatively small. But the risk for a small company of a poor launch is great. And since first year sales are highly predictive of second year sales, analysts focus on the launch.” Missteps at launch, therefore, carry long-term financial consequences for companies who are likely to need highly valued stock to fund additional commercial or development activities.

“Maybe you’ll save some money—say \$5 million” on a 100-person sales force, adds Inouye. “But if you’ve got a \$100 million product, that \$5 million is only 5%.” It’s a worthwhile insurance cost, he says.

And finally, argue a number of executives, CSOs don’t solve the fundamental challenges of commercialization—though they may ameliorate some of the consequences of not solving them. The biggest problem for sales reps, argues George Cole, is getting enough face time with doctors. “And contract reps don’t get any more face time,” he says, than internal reps. “CSOs won’t change our problems with commercialization,” says Cole. “They face the same challenges we do.”

Exhibit 2

One Example of Quality: inVentiv vs. Pfizer, Bristol & Merck



SOURCE: InVentiv, from MPA Panel (HPR) -Cardio

THE EXPERIMENTERS

But in fact outsourcing *does* address some key issues. In the first place, if the detail call is declining in productivity, and drug companies need to spend their marketing dollars elsewhere, then they also need to cut down the cost of the sales force. Small companies with highly targeted sales forces like Telik might not save much with contract reps, but large companies with large overheads looking at detail forces of several thousand reps can save bundles — figure a savings of about \$20-25 million on a 500 person sales force, according to inVentiv estimates.

But there are commercial executives willing to experiment. Novartis, for example, is bringing on a 500-person contract cardiovascular sales force. “We’ll see what happens,” says a Novartis executive. The rent-to-own deal minimizes the launch risk of the first-in-class rennin inhibitor aliskiren (*Rasilez*), which was filed for approval in the US in April. Like all new drugs for conditions for which there are existing therapies, *Rasilez* will get plenty of regulatory scrutiny: its blood pressure data looks good, but there’s still no data on end-organ protection, which, if positive, would provide the efficacy required to really distinguish the drug. And if it does get approved, it will face plenty of competition from existing therapies, including Novartis’ own \$3.5 billion valsartan (*Diovan*), against which *Rasilez* will have to be carefully positioned to minimize cannibalization while maximizing the new drug’s sales. If *Rasilez* doesn’t get approved, or doesn’t do well, Novartis can end its CSO contract without cutting its own employees.

Plenty of other companies, too, will be facing Novartis-like launch risks: products which could get lumped in as me-too’s or which get extra scrutiny by the FDA. That’s why one senior marketing executive notes: “If I could see that CSO reps were just as good as internal ones, then I’d definitely consider” bringing more on—maybe even up to a level of “30% of our total sales force. We’re carrying an enormous cost.”

Joseph Mahady, president of Wyeth’s Americas and Global Businesses, couldn’t agree more—but comes to a very different conclusion about a solution. “We need to decrease the cost of the physician visit,” he says, and at the same time add flexibility to the sales infrastructure. But Wyeth isn’t substituting contract reps for internal reps. Instead over the last eight months, the company has reduced its sales force by 500 full time equivalents, through a combination of attrition and layoffs, and by adding about 500 part-time reps in a total primary care sales force of 2600.

These part-time reps, mostly women, have on average 6½ years of sales experience, come from a variety of companies, and don’t get benefits or a car, so are much cheaper than full-time reps. Says SVP sales Robert Repella: “We’ve essentially created our own CSO. We’ve got the flexibility to add where we need and we’re not paying the CSO’s margin.” Part of what Wyeth is responding to, he says, is simply market-forced changes: if, because of a managed care program in a particular geography, “all you’re going to get is a simple quick detail, you need to use a more economical resource”—like the part-time reps. Eight months into the program, says Repella, results are good: “it has been a win in the primary care office and it has allowed us to find a different [expense] balance.”

Wyeth wasn’t the first company to experiment with part-time reps—Pfizer’s Vista Rx sales force is made up of Pfizer reps who wanted to work part-time. But Wyeth’s program is a novel tactic in a broader strategy to increase the value of each detail call—in part by reducing its cost, in part by increasing its productivity by deepening the relationship between rep and physician. Thus

Wyeth has also eliminated the mirrored sales forces in which several reps from different sales forces detailed the same drug to the same doctor. In Wyeth’s new organization, most reps are responsible for one doctor or physician practice, and details all products relevant to him. The part-time reps add in the requisite flexibility: under the old mirrored system the company almost had to add 500 reps if it was going to add any. But with the new system of one doctor-one rep, it can add part-time reps as individual geographies need them. Says Cavan Redmond, VP and GM of Wyeth’s BioPharma Business Unit: “The model has been to hire a contract sales force for an extended period of time. But we may need support only for shorter periods. As the data for our products come out, or as payors’ needs change, we’ll need specific kinds of help, quickly. I see a kind of spot market developing”—one which could be at least in part satisfied by a force of part-time reps.

THE PRICE OF CONTROL

The Wyeth program—granted continued success—exemplifies the fact that there will be multiple ways to solve the cost and flexibility problems. Moreover, it may be that reps aren’t the most important commercial resource to outsource. Wyeth, for example, is expecting six launches between now and 2010, most of them biologicals. Says Redmond: one potential role for CSOs will be to provide more medical help—nurses, for example, who can train providers on the first set of IV infusions. And since most of these therapies are relatively targeted, with small patient populations, “you might need these training people only maybe three times a year.” Same for reimbursement specialists, he notes, as payor programs change and both doctors and patients need occasional guidance on specific drugs.

In short, the industry will outsource more and more of its commercial operations. Companies will need the flexibility to account for situations like *Plavix*, or they’ll need to lower costs when their own product sales aren’t growing, or they’ll need biotech products and the biotechs will insist on sharing commercial rights. Contract reps will undoubtedly be part of the mix as will sales forces from biotech and Big Pharma and alternative commercial channels, like Wyeth’s part-time reps or electronic sample management systems.

But the biggest driver to outsourcing, in whatever guise it appears, will be new managers. The cuts among top commercial managers at Pfizer and Merck should be sending chills up the spines of marketing and sales executives who haven’t seen the need for new ideas. What the smart ones will recognize is that, like their R&D colleagues, they can’t afford to keep all that internal infrastructure. Shareholders simply won’t continue to tolerate paying the price of total control. **IV**

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