



**AstraZeneca  
commercial  
brand leaders  
Matt Lehmann  
(center), Steve  
Davis (left) and  
Ken Graham**

# SHADOWING THE REPS

Drug companies still love their reps—just a lot less of them, especially on many mature brands where tier-two placement, not physician awareness, is the problem. That’s the take-away from undercover observations of hundreds of sales calls at primary care doctors’ offices. **Matthew Arnold** reports

Several years into the much-ballyhooed pharmaceutical sales revolution, a picture of the brave new commercial model is coming into focus. It looks a lot like the old commercial model—but scaled down quite a bit and with a few important differences.

“A few years ago, everyone was saying ‘The sales force is dead, and E-this, that and the other,’” says Mike Luby of consulting firm BioPharma Alliance, “but at the end of the day, doctors vote with their feet, and they’re spending time with these guys, engaging them on the resources, and clearly valuing a lot of what they bring.”

That was the upshot of a secret shopper-style study in which the firm conducted in-office observation and surveys of 461 primary care physicians as well as 209 nurses and other non-MD medical professionals. The firm sent undercover former drug reps into 219 primary care physicians’ offices. They observed 661 rep visits and sat in on rep lunches and breakfasts in 108 of those offices. Upon leaving, company reps were asked to answer a few questions for some market researchers.

They came away with a treasure trove of data points. Among them: calls lasted an average of six minutes; 90% of them occurred standing up; less than half resulted in meaningful discussion. Sales aids, used in 47% of calls, and the offering of food, seen in 16% of calls, had dramatically positive effects on depth of discussion.

They also showed the enormous value not only of reps but of resources like samples and co-pay cards in the marketing toolkit.

“The co-pay card is very popular and to some extent neutralizes

the payer impact, becoming essentially an end run on the payer,” says Luby. “We saw that reps are talking about them very frequently. They’re gold in the marketing mix because they do so much to help doctors and patients that want to be able to access the products.” And much as they might loathe them, payers haven’t really clamped down on them for fear of being seen to squelch consumer choice.

BioPharma Alliance also found that, much as physicians like co-pay cards, they greatly prefer samples, offered in 80% of calls.

**6** is the average number of minutes per sales call in BioPharma Alliance’s study of rep details

It doesn’t require a \$200,000 rep to dispense samples and co-pay cards, and companies have pared down their promotion of established brands, with many moving to a two-tiered sales force or to contract sales organizations (CSOs) for more flexibility.

“Once the market really understands the product, and in the absence of new indications, new data, etc., you really shift to more of a service mindset,” says Luby. “You stand to lower your costs and actually improve customer service without compromising your competitive advantage.”

That’s meant big reductions in US sales forces—from more than 100,000 to 66,000 in 2012, a year which saw continuing layoffs as AstraZeneca shed 3,700 sales and marketing jobs, Novartis downsized



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by 1,630 and Sanofi cut 1,000-2,000 from its commercial organization. ZS Associates forecasts cuts to continue for another few years as companies absorb the impact of another \$50 billion-worth of medicines set to go over the patent cliff, with rep numbers projected to bottom out at 55,000 in 2015.



**“Doctors vote with their feet, and they’re spending time with these guys”**

— Mike Luby, BioPharma Alliance

“Everywhere in the country, there was a red, blue and green rep,” says ZS Associates’ Chris Wright, managing director. “The red rep did two products, the blue rep did two, the green rep did two.” But with patent losses and increasing pressure from payers, many of those reps were left with only one product to detail, “so the companies have changed their models to let them take these two half jobs and combine them to make a purple rep,” says Wright. “It sounds simple and obvious, but it was not easy for pharmas to pull off.”

ZS Associates sees in the increasingly multi-channel sales model a role for the rep as quarterback, moving the physician from a face-to-face meeting to follow-up journal articles and video links—that take them to the brand site, that sends them to a call center, that issues an invite for a company-sponsored conference, and so on.

BioPharma Alliance data shows that physicians who see reps value expertise on newer products, but what they want out of reps on established products is resources—samples, co-pay cards and patient support materials.

Where companies once promoted a brand heavily from launch to patent expiration, now there’s often a sharp drawdown in spending as

**90% is the amount of product details that occurred standing up in the BioPharma Alliance study**

products mature. Bristol-Myers Squibb proved the test case for this approach in 2005 when, with Pravachol approaching patent expiry, the company halved sales calls on the lipid drug, a BMS cash cow. Sales held steady, and BMS’s competitors followed suit as their own drugs neared loss of exclusivity.

“But nobody’s really going down to zero,” says Luby. “For blockbusters, they might reduce the level somewhat, but they’re still putting a fair amount of investment into the sales force right up to the end.”

### A tale of three drugs

Few companies have gone as far in rethinking the commercial model as AstraZeneca, which four years back created its Cornerstone division to house such mature brands as Nexium, for which the company slashed sales support without seeing any slippage in market share.

Today, the reflux drug, which became the No. 1 brand by US sales this year, after Lipitor and Plavix went over the patent cliff, is supported by a hybrid model combining service reps and a call center targeting primary care doctors with contract reps calling on gastroenterologists.

“At the end of the day, I don’t think there’s really a replacement

for face-to-face impact,” says Ken Graham, commercial business leader for Nexium. “I just think the market and where we are with the brand allow us to do some different things with it.”

Nexium is just the sort of brand that doesn’t need to drive awareness. The Purple Pill has universal awareness, a well-regarded clinical profile and favorable second-tier formulary status almost everywhere. But the brand team still needs to stay close to the category’s specialists and provide them with info on new indications while dropping samples with primary care docs and educating them about access.

“We have a small CSO sales force that calls on the majority of the gastroenterologists in the US,” says Graham. “They’re the thought leaders and they want to know what’s going on with the brand clinically. And then we have a service channel where we have folks out there talking not clinically, but about access and affordability and providing samples to a good contingent of the primary care physicians. They’re there to reinforce access so that the healthcare professional is confident that when they write the script and hand it to the patient, they will show up to the pharmacy and get it.”

That post-script nexus of pharmacy and formulary is where the battle has shifted for many brands.

“What happens is the patient shows up at the pharmacy counter and that’s when everybody finds out that this patient actually has to pay \$50, not \$20,” says ZS Associates’ Wright. “Some patients put up with it, but increasingly, they say, ‘Call my doctor, I want



**“As organized customers surface, it’s a very different kind of sales process”**

— Chris Wright, ZS Associates

something else.’ So the pharmacist calls the doctor. The doctor hates that. The doctor is very busy. This is a big disruption. The doctor has no idea how much it really costs, but they do know that when they write prescriptions for this, they get a high percentage of patients complaining and so they start to avoid the medicine.”

Even second-tier drugs like Nexium often carry co-pays ranging from \$45-\$60, and these drugs are competing with generic alternatives priced at a tenth of that. And Nexium, which loses US patent protection in 2014, is well-situated, given its deep brand equity.

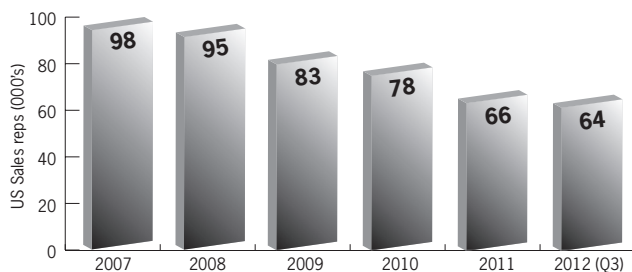
AstraZeneca has taken quite a different approach with Arimidex, which was, as commercial business leader Steve Davis says, “the analog for the loss of exclusivity,” a blockbuster that, faced with 10 generic competitors, saw revenues dwindle to under \$50 million in the blink of an eye after going off-patent three years ago.

“The thing about Arimidex was, I checked the information center, and we were getting calls all the time from consumers about how they could get branded Arimidex, and once we started digging into it, we realized that the cash price for patients for the generic was really quite high. That got the wheels spinning. Breast cancer is such an emotional issue, and we thought we could do something different.”

And so the brand team put the bulk of its budget into creating a strong direct-to-patient effort, the fruit of which is Arimidex Direct, which has enrolled over 2,000 patients to date. The program has been promoted through the website and through word of mouth via patient advocacy groups and breast cancer blogs. In October, the company created a social media badge for the site to make sharing easy and

## US sales forces continue to shrink

This year's sales/marketing layoffs by Novartis (1,630), AstraZeneca (3,700) and Sanofi (about 1-2,000) contributed to another decrease in US sales force size



Source: ZS Associates analysis

posted a video on how easy it is to register for the program, which has shown a marked jump in adherence for enrollees.

"The science says Arimidex helps breast cancer survivors if they stay on Arimidex for five years," says Davis. "The average person stays on six months."

Davis, who handles AstraZeneca's Foundation Brands portfolio



**"If you have an individual sales goal, that's what drives a lot of the behavior"**

— Eric Dube, GlaxoSmithKline

of 18-plus mature drugs, says these brands "have already established brand equity and doctors have usage patterns for those brands and know how they would be using them, so a lot of my effort is really tapping into that brand equity and doing it in cost-effective and efficient ways." His team does very little on the professional side, and most of that is directed at non-physician healthcare professionals.

"Consumers should have a choice," says Davis. "Do you buy a store brand, or the real thing? When a brand goes mature, they're never going to be the size that they were, but we can compete and continue to drive revenue that helps fuel further R&D."

For antipsychotic Seroquel XR, given the complexity and fast-changing nature of neuroscience, foregoing sales support wasn't an option. "We rely first on a highly-trained professional sales force," says Matt Lehman, commercial business leader for the brand. "But it used to be that the commercial formula was one of reach and frequency at pretty much any cost, and the game has completely changed. Now we're reaching a very focused group of physicians and trying to do that at a frequency that makes sense for them, and for us and our business."

For Seroquel XR, AstraZeneca supplements a robust direct sales program calling on psychiatrists with phone and digital outreach, along with a direct-to-patient program. It's a far cry from the one-size-fits-all approach of the pre-patent cliff era.

"We're listening to the market dynamics better than we have in the past," says Lehman. "Not every brand is in the same scenario, so we handle them all differently."

## Glaxo's gambit

Another company that got out front of reworking the commercial model was GlaxoSmithKline, which in 2010 dispensed with an incentives structure that rewarded individual achievements and replaced it with one based more on qualitative measures.

"The shift from volume to value is a major driver not just for pharma but really all of the stakeholders in the US healthcare market," says GSK's Eric Dube, SVP for strategic planning and operations. "We see it in the accelerated pace of consolidation and integration of our healthcare delivery systems, and with that, there's been a big shift in sophistication of our customers."

Those changes, sped by the Affordable Care Act, are sure to continue, whatever the balance of power in Washington. The shift from quantitative to qualitative reimbursement has taken root in healthcare.

GSK has eschewed the service rep model, instead trying to increase responsiveness to customers. The company's incentive program is called Patients First. Two years out, feedback from physicians suggests it's working, says Steve Sullivan, head of corporate and independent accounts.

"We've had customers comment that we show up and engage them differently," says Sullivan. "In fact, it's enabled us to gain access to customers that had been shut off and we've renewed our relationship with them through having a different type of dialogue with them."

Fostering collaboration, rather than competition, among the sales team is making the difference, says Dube. "I think we underestimated how the traditional incentive model was an impediment to strong collaboration around the customer in the field," he says. "If you have an individual sales goal, that's what drives a lot of the behavior."

"You might have had two territories in a large metropolitan area, with two different reps in the same therapeutic area selling the same products but with individual goals, [so] any success they were having, they would keep to themselves," says Sullivan, "because they'd be ranked directly against the person in the territory next door. There was no incentive for them to share the insights garnered broadly."

Now, says Dube, reps are psyched to share information and best practices for the benefit of the customer rather than focusing solely on driving the next prescription.

GSK has downsized its sales forces sharply over the past five years while making investments in technology and analytics and building an account management organization calling on the leaders of large provider organizations, health systems and associations.

"There, we're spending more and more time with the folks who lead these organizations, and who are charged with delivering better value and better patient care within them," says Sullivan. "Through these discussions, we've really heightened our understanding of the business, and we're sharing that broadly across our team, so that when our reps show up and talk to a clinician who cares directly for patients, they're much better informed on the objectives of the broader business."

On some occasions, says Dube, healthcare company execs have asked these key account reps to share information with care coordinators for offices that don't see reps. "We say we don't have access to those offices, and they say 'Well, tell them I sent you.'"

**80%** is the amount of sales calls in the study during which product samples were offered

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“As these organized customers surface, it’s a very different kind of sales process,” says ZS Associates’ Wright. As physicians’ practices are swallowed up by bigger and bigger group practices, “some of those groups say, ‘We don’t want you visiting with the doctors directly,’ so they’ve agreed to a protocol.” Increasingly, Wright notes, hospitals reimburse doctors according to an outcomes-based incentive program, too. Formularies often figure into those incentive schemes, and the challenge of securing favorable placement falls to the key account rep.

“Our sales reps are product experts and therapeutic experts,” says Sullivan. “Our account management organization, they’re really customer experts, charged with understanding the customer, their business, their practice, their patients, and what their goals are to deliver care. We share that information across our organization to align the best resources we have and deliver value to the customer in a way that’s aligned with their goals and objectives.”

### No-See No Choice

There’s been much handwringing over the growing number of “No-see” doctors who will not see reps, which now constitutes as

**54%** is the amount of “No-see no choice” docs who expressed interest in seeing reps if their practice would allow it

much as a fifth of all physicians. BioPharma Alliance said more than three quarters of such docs are “No-see” not by choice but because the hospital or group practice they belong to has a policy prohibiting interactions with drug company reps. Most of them would like to see reps and feel that they and their patients are missing out as a result.

Assuming that 20% of primary care physicians fall into the no-see category, Luby estimates that only around 4% of physicians are “No-see by choice.”

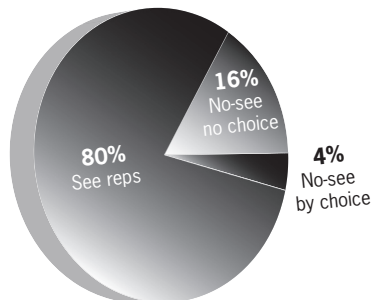
But the group that’s really growing is that other 16%, as more and more institutions are closing their doors. And we asked them: Does your practice miss out on resources of value by not seeing reps? And in that group, 70% say they miss out.” Those docs said, by the same ratio, that their patients miss out, too. When asked what they’re missing, they said not tchotchkes, but info on new drugs, samples, co-pay cards and patient support resources. Lunches were mentioned, said Luby, but didn’t stand out. More than half of these “No-see no choice” docs expressed interest in seeing reps if their practice’s policy against it were reversed (54%).

There’s also evidence that these no-see doctors are slower to respond to emerging clinical information. A study by ZS Associates and AstraZeneca looked at prescribing habits following three events: the October 2006 launch of Januvia; the August 2007 black box warning on Avandia; and the January 2008 release of discouraging clinical trials data for Vytorin. No-see docs who maintained “very low” rep access to their offices were up to 4.6 times slower to introduce Januvia to patients than were those who imposed a “medium” level of access, as determined by the authors. The “very low” access docs took four times longer to reduce their use of Avandia than their “medium” access colleagues, and showed “significantly less” response to the Vytorin data than did their less restrictive colleagues.

“Policies that promote physician ignorance of new medical infor-

### The “can’t-see” doctor

Among the 20% of primary care physicians who do not see reps, about three-fourths do not see reps because that’s the policy of their group, practice or institution



Source: BioPharma Alliance

mation resulting from access limits runs counter to protecting patient health,” said the study’s lead author George Chressanthis, a former AstraZeneca exec who is now acting director of the Center for Healthcare Research and Management at Temple University’s Fox School of Business.

BioPharma Alliance’s study found that reps are easily the No. 1 source of info on new products for those docs that see them, with nine out of 10 reporting being detailed on new treatments three or more times per month. Those that don’t see reps cited journals as their top info source, with 64%-68% reading about new products in journals three or more times per month, followed by colleagues (52%-53%), websites like Epocrates, Medscape and UptoDate (46%-52%), apps (27%-32%) and package inserts (25%-29%). Similar numbers were seen for learning about established products.

Luby says the firm employed the “more or less than three times a month” benchmark to distinguish doctors who occasionally dabble in a medium from those who regularly engage it. E-detailing and other forms of non-personal promotion, once expected to transform the commercial model for established products, haven’t moved the needle on that mark. Just 4%-7% of docs surveyed reported participating in online or e-detailing three or more times per month.

**31%** is the amount of sales calls in which co-pay programs were offered

Most never do e-details—that’s what 75% of no-see no choice docs, 74% of no-see by choice docs and 60% of docs who do see reps said.

“A lot of non-personal promotion has ended up being impersonal promotion,” says Luby. “You still have a lot of these experiences that aren’t customized to an individual doctor, and so the doctor is getting this generic detail, whereas a rep can, within legal bounds, tailor a discussion to and have a back-and-forth with the doctor. The rep is really an on-demand resource, whereas e-detailing is hard to personalize.”

There’s also the convenience factor.

“All the doctor has to do with a rep is break stride in the hallway,” says Luby. “It doesn’t really cost them anything, it’s just a couple minutes between patients that they can make up elsewhere in their day. They don’t have to go to a website or tap an app or anything,



## No-See By Choice: the hardcore 4%

Around 15%-20% of primary care physicians don't see sales reps. BioPharma Alliance puts the figure at 20%, and of that, less than a quarter—4% of the total population of physicians—are so-called “No-See By Choice” docs for whom not seeing reps is a matter of conscience rather than practice or hospital policy. While “No-See No Choice” docs' ranks are growing fast as institutions bar their doors to drug companies, that 4% has remained static.

“They just don't want to see reps,” says BioPharma Alliance's Mike Luby. “It's a very cynical crowd. ‘Lower your darn drug prices’ pretty much sums up what they have to say.”

Unlike those that don't see reps because they're barred from doing so, who report having a harder time than most docs keeping current with drugs and biologics, No-See By Choicers find it easier to keep up than their colleagues who do see reps or who might like to. They consult journals and websites at a higher rate and rely on their colleagues more for medical information. Their go-tos for new products are Epocrates, UptoDate, Medscape, meetings and conferences and the *New England Journal of Medicine*. For established products, they prefer—again—Epocrates, UptoDate and *NEJM*, along with PDR and colleagues.

A little over half of No-See By Choice docs accept samples (55%), according to BioPharma Alliance, which surveyed 85 such docs. That's a shade more than No-See No Choice docs (52%). Just a quarter of all docs that don't see reps say they use co-pay programs, and they report low satisfaction with them—but not that much lower than docs that do see reps (28% of No-See By Choice docs said they get “a great deal of satisfaction” when a patient is able to use a co-pay program they've referred them to). Their preference for samples over co-pay programs tracks about evenly with other docs—which is to say that it's no contest (79% prefer samples).

One No-See By Choice doc is David Evans, MD, whose rural Oregon family practice banned reps in 2006. In a qualitative case study published in the *Journal of Family Practice*, he and his colleagues reported that their clinic functioned more efficiently without reps underfoot, that they and their patients felt better about the integrity of their practice, that they didn't miss samples and questionable information from industry. They even preferred their clinic-funded lunches to those the reps brought in.



David Evans, MD

“For years, we were heavily detailed,” says Dr. Evans, who is now at the University of Washington, Seattle. “We were seeing something on the order of 30 visits a month, and it was really interfering with patient flow, and so this was a practical as well as an ethical decision. When it's one rep, that's one thing, but three a day is a lot of time—that's a couple patient visits.”

Dr. Evans and his colleagues worried about bias in scientific info that came from companies.

“It became increasingly difficult to distinguish valuable info from propaganda,” says Dr. Evans, who at one point asked reps to bring in only peer-reviewed materials. “But we eventually decided it just wasn't worth it and now information access is a lot easier. There are other ways to get information now.” Dr. Evans likes The Medical Letter and The Prescriber's Letter.

“I find sampling to be particularly bothersome, actually. Maybe a couple of our patients benefited, but for the most part I don't think they missed out. Data I've seen shows that samples don't wind up in the hands of the indigent.”

Patient feedback was overwhelmingly positive. “They get the conflict of interest issue a whole lot better than doctors do,” said Dr. Evans.

because as simple as that sounds, it requires walking to your desk, finding the e-detail and the product you want to do, clicking on it and engaging in it. It's hard to fit in during the frenzy of the day and it competes with too many other things for their time outside of the office.”

ZS Associates' Wright says some companies are getting around the impersonal-ness and inconvenience of e-details and other digital offerings by having a live rep introduce them.

“They used to go around the rep, but now they're engaging them in it, and they see a very different outcome when the rep says, ‘Hey, doc, listen, I know you're busy and can't make it to that dinner meeting, but Mr. Fancy Doctor Who We All Respect is going to speak, and I can provide you with a podcast of it.’ Well, the podcast saves them time, but their willingness to view it is because it was recommended by someone they know.”

Wright is bullish on e-promotions, including video detailing, webinars, eCME, email marketing, physician communities and social media. While these media make up only 3% of all marketing spend (around a half-billion dollars), his firm predicts that pharma use of them will triple by 2014, but cautions that “getting it right will require Amazon-like predictive techniques.” ZS found that a mash-up of predictive models combining a doctor's history with that of “like” doctors can enhance email open rate predictions.

With doctors increasingly pressed for time and NPs and other office staff playing a greater role in dispensing samples and co-pay cards, companies are directing more of their attention toward non-physicians. In BioPharma Alliance's study, non-MD contact occurred in 43% of calls, lasting an average of six minutes. Two-way conversation was observed in 70% of those calls, with just-small-talk accounting for 47%. Sales aids were used in 19%, and the healthcare professional asked a question in 5%.

For Arimidex, calling on nurses and other non-MD office staff has been a big part of the brand's spare professional efforts. “A lot of doctors tell us, ‘Please make sure my staff knows this, okay?’” says AstraZeneca's Davis. “In oncology offices, they have a lot of advocacy programs, and nurses help out the patients.”

“Certainly, with the increased number of patients that are going to flow into the system, we're hearing more about team-delivered healthcare, about allied healthcare professionals working at the top of their licensure to free up physicians,” says GSK's Sullivan.

“The focus is really shifting to the office staff,” says Luby. “They're the ones handing out the co-pay cards, the samples. They can be influential in the choice of the script.” Their role is sure to grow as the “Silver Tsunami” of Boomers hits doctors' offices.

“Doctors still hold the power, because you need them to believe in the product and write the script—that's the reality that was heavily weighted back in the late '90s and early 2000s,” says AstraZeneca's Graham. “We've just had other market forces playing in since then, and now there's a gauntlet the patient has to run through after getting the script. The patients are much more informed, and they are more involved, especially when there's cost pressures on them. So it's no longer a one-size-fits-all model.” ■

**8%** is the amount of samples sent via mail. AstraZeneca, Publicis and Sanofi send them the most

