e-Detailing: Where does it fit in Pharmaceutical Sales?

How web-supported promotion could reshape sales activity

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Face-to-face promotion is the dominant promotion tool for pharmaceutical, medical equipment and biotechnology companies. However, there is a growing level of discomfort with the current selling model. It is incredibly expensive. And inefficient. Physicians don't like it much.

At a time of increasing economic pressures, companies are putting heightened scrutiny on the economics of their selling processes. Investigating new concepts, they find an abundance of new technologies and options. Being blinded by the latest technological bells and whistles and jumping on the next bandwagon would be an easy, but potentially costly, mistake to make.

This article helps pharmaceutical executives sort through the various options. It provides a framework to put alternative approaches into perspective, investigating the following key questions: Will there be a dominant approach among all these models? Will traditional ways of promoting the products be replaced? And if so, how? Is there a first mover advantage, or should we wait until salient models emerge? How steep is the learning curve? What issues and trade-offs need to be considered in selecting promotion channels and optimizing resources across the communication mix?

Perspectives on rep detailing

Face-to-face promotion, or product detailing in "pharma-speak", is the dominant promotion tool for pharmaceutical, medical equipment and biotechnology companies, often making up 60-70 percent of their total promotional budget. In the US alone, pharmaceutical companies spend more than $ 10 billion on field force promotion.

The reason is simple: it works. Pharmaceutical companies are keeping a close eye on the impact of this major investment. And their studies are showing time after time a strong correlation between detailing effort and product sales. No wonder that giants like Pfizer and GlaxoSmithkline are engaging in a regular arms race with larger and larger armies of sales representatives crowding physicians' offices. According to The Economist there are now 63,000 pharmaceutical sales representatives in the US.

Detailing also works for their customers, otherwise they would have shut the doors to sales reps long ago: it provides physicians with important information about new products and helps them in their continuing medical education.

Still, there is a rising level of discomfort with detailing. From the pharma company's perspective, detailing time is incredibly expensive. Consider this: The average cost for a sales representative, including salary, benefits, expenses etc. is US$ 160,000. In some specialist fields US$ 200,000 is not rare. Optimistically, a sales representative makes

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perhaps 1,600 calls per year, which on average last not longer than 3 minutes each. Thus, one hour of face-to-face selling time costs easily US$ 2,000 or more. Not only is detailing expensive, it is also inefficient. With 8 customer calls per day, a rep is spending 90% of his day travelling and waiting. And half of the time the rep does not even see the physician.

Nor are the customers particularly pleased. Physicians feel “ambushed” by sales reps pounding them with messages of diminishing value, with increasing frequency. Detailing disturbs the physician’s workflow and cannibalizes valuable time. And they have hardly any control over the information flow. How do physicians react? Certainly their attention span has become small. And an increasing number simply refuse to see reps.

The discomfort with “traditional” detailing is exacerbated by recent economic and technological trends. In the current economic environment most companies are facing lower sales growth. Cost control and improvement of financial ratios are a key management focus again. The inefficiencies of detailing thus become all the more apparent. At the same time technologies like the World Wide Web offer enhanced capabilities at lower costs, and most importantly, with increasing customer reach. For example, most physicians in the US use the Internet in one form or other (even if it may be just to check their stock portfolio).

The question that arises from these observations is this: is the “traditional” model of rep detailing still the best approach? Many pharmaceutical companies have started to investigate alternative ways, looking at new technologies and their promise of new promotion models.

It’s a jungle out there…

As new technologies and promotion models go, there seems to be a great new idea every minute.

At Pharmadetailing.com, for example, physicians have access to drug information, can order samples, and schedule offline visits with drug reps to answer specific questions.

At Physicians Interactive, physicians can get “self-service” product presentations on the Internet or over the phone using voice response. Physicians earn awards sponsored by major pharmaceutical and medical products companies for participating. Access is 24 hours a day, 7 days a week.

Rxcentric.com offers a similar service. Physicians can access an online drug information service, interact with online product details and communicate electronically with sales representatives.

ePocrates, a network of handheld computing devices for physicians, cooperates with leading pharmaceutical companies to provide physicians with news, clinical information services, drug reference guides as well as articles from medical journals and clinical content providers.

iPhysicianNet has probably taken the e-detailing concept furthest in the US. The company has signed up about 8,000 physicians and given them a video-conferencing enabled desktop computer and high-speed telecommunications connections for their office. Physicians participate in face-to-face two-way interactive video calls with sales and medical affairs representatives of pharmaceutical companies. So far, about 10 major

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pharmaceutical companies, including Bristol-Myers Squibb, Merck, Pharmacia and Novartis, are experimenting with this approach.

Zestica is a Swedish company offering similar capabilities like iPhysicianNet, but utilizing narrow-band technology. This has the advantage that no investment in a special broadband infrastructure is required, increasing the potential audience to any physician who has access to a telephone and the Web. The physician is simply sent a URL via email and clicks on it to initiate a 2-way interactive web-session, with the rep talking on the phone.

Applications for palm PDAs, online detail aids, digital detailing, online communities, multimedia videoconferences, vice response systems, chat rooms, disease websites, e-CRM etc. - pharmaceutical companies looking for new concepts are being offered an abundance of opportunities.

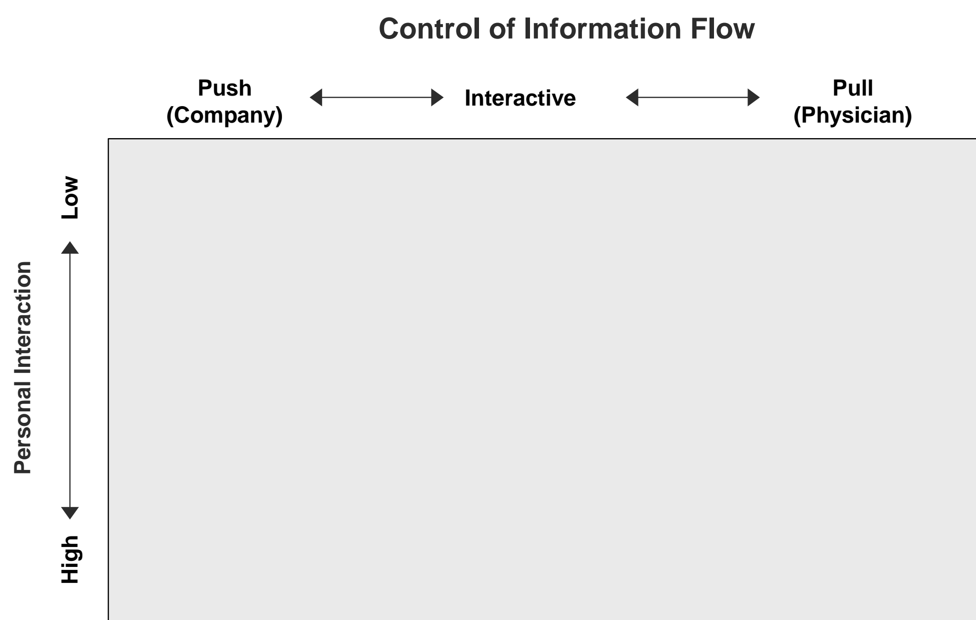
But where will it all go? Will there be a dominant approach among all these models? Will traditional ways of promoting the products be replaced? And if so, how? Is there a first mover advantage, or should we wait until salient models emerge? These are some of the key questions pharmaceutical executives are facing.

Making sense of the CRM landscape

All these new approaches are very flashy, boasting the latest technological bells and whistles. They are also being promoted in this way by the respective vendors. Being blinded by technical capabilities and jumping on the next bandwagon would be an easy, but potentially costly, mistake to make.

A useful approach to put different models into perspective is to map out how they fit with a company's promotion objectives. This is illustrated in exhibit 1.

Exhibit 1: Communication Dimensions



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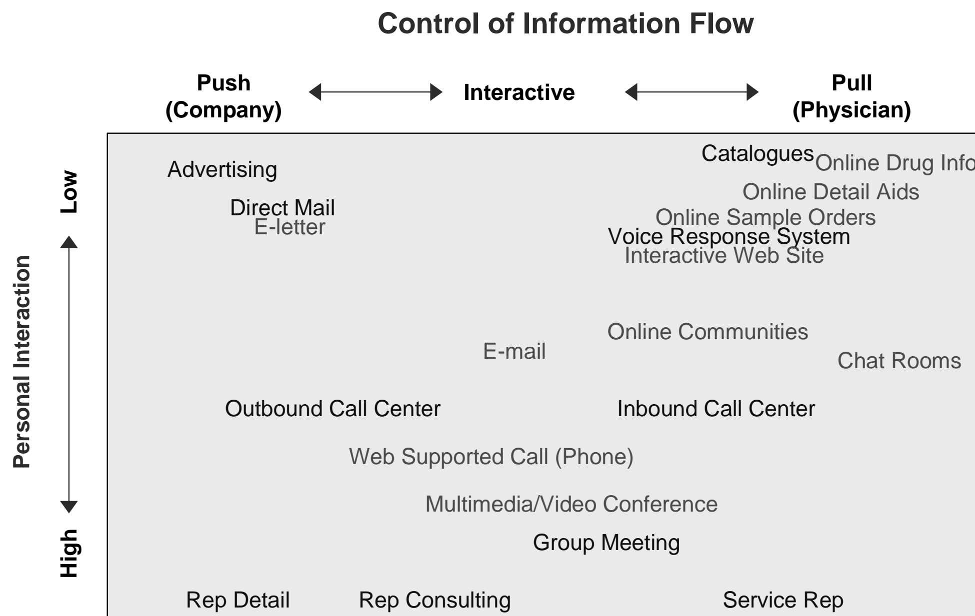
Two critical communication dimensions are investigated.

First, it is important to understand to what degree the company wants to control the information flow. Do we want to push a specific message, do we want to engage in a dialogue with the customer, or should the interaction be initiated, and controlled, by the customer?

Second, we need to decide the degree of personal interaction, or “human touch”, that is desired (or required) in the promotion.

We can now map different types of customer interactions into this grid (exhibit 2). As a whole, they make up the customer relationship management (CRM) model of the company. For example, advertising in a medical journal is in the upper left-hand corner of the grid. Here a message is “pushed” out into the market, without any personal interaction. Similarly, “traditional” rep detailing is also on the left-hand side of the map (in many cases a few key messages are pushed by the reps). In other cases, reps may have a more consultative role, or, as for example in medical devices such as pacemakers, it may be service representatives whose presence is requested by the physicians.

Exhibit 2: The spectrum of communication options is wide



It is interesting to note that most of the new promotion approaches occupy space that is not covered by “traditional” promotion vehicles. Thus, it is unlikely that they will replace them directly. Among the few exceptions may be direct mail being replaced by sending out an email letter, or catalogues and brochures being replaced by online drug information.

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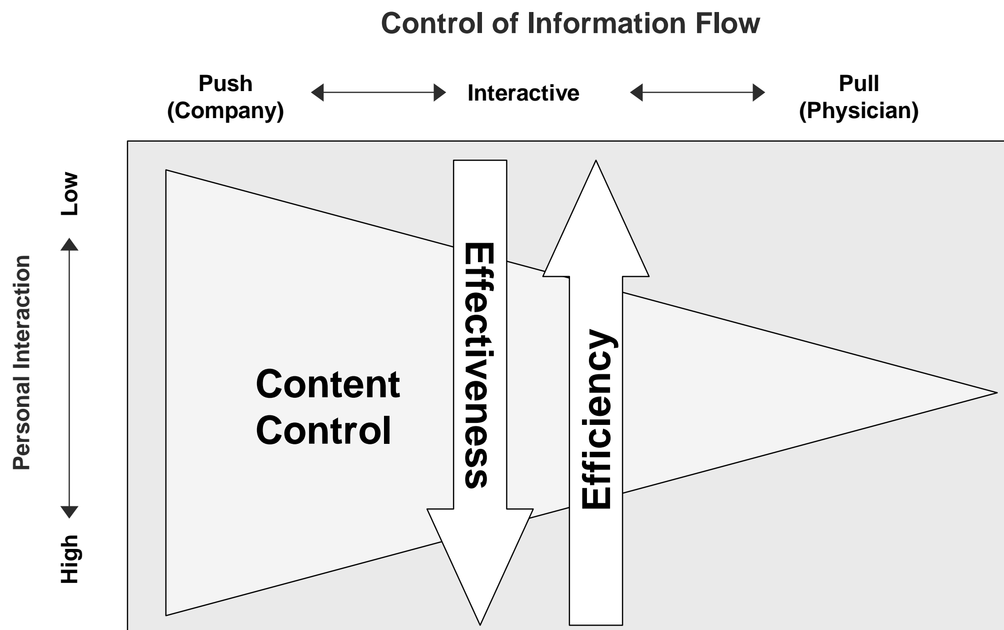
Rather, the new approaches offer *additional options for communicating with physicians*. Today, coverage decisions are almost binary, with discrete coverage cut-off points. If a physician is valuable enough to be called on, he receives personal visits. If he has lower value he will not be visited. He may be reached via direct mail, but the company does not really have a relationship with him. Now, some of the new approaches enable pharmaceutical companies to play on a *continuum of coverage options*.

Trade-offs of different approaches

How will a company chose between the different promotional tools? Different issues have to be considered, as illustrated in exhibit 3. The first trade-off is between effectiveness of promotion, and efficiency.

Exhibit 3: Important trade-offs need to be considered in selecting promotional tools



Effectiveness, the impact per customer contact, generally increases with the degree of personal interaction. In a face-to-face setting, the rep can read the body language of the physician, see how he reacts to the message, and adapt his presentation accordingly.

Efficiency, which can be expressed as the cost per interaction, however tends to be higher if the degree of personal interaction can be reduced. For example, a call center rep can make perhaps 50 calls per day, compared to 8 calls of a field representative.

The third issue is content control. Interestingly, this dimension is currently often overlooked when pharmaceutical companies think about e-communication. Depending on the strategy driving the promotion, we may want to have more or less control over what is communicated. For example, during a product launch it is imperative to exactly position the product on key dimensions against key competitors. This can only be done with a

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“push” approach. Organizing a therapy website or an online community where physicians can discuss disease states and treatment protocols may be perceived as nice and useful by physicians, but will unlikely help the company meet their message objectives.

The customer segment, the product, and the lifecycle of the product determine where a company needs to be on this spectrum of trade-offs. These considerations are discussed in more detail below.

What is the best promotion strategy to address segment-specific issues?

Exhibit 4 gives an example how a pharmaceutical company might partition its customer base. In this case, customers are segmented based on the two dimensions market potential and market share. For each segment, strategic objectives may be different.

For example, the company may want to protect their business in the high potential/high share segment with the most *effective* promotion. The potential per customer and sales response in this segment is high enough to cover elevated promotion costs. The best approach for this segment may be face-to-face promotion, combined with multimedia presentations and peer-to-peer discussions on the web, where the company is giving up some control over the information content.

Exhibit 4: Strategic marketing issues vary by customer segment (illustrative example)

Potential \ *Sales*	High	Low
High	**Effectiveness**	**Access**
Low	**Efficiency**	**Pulse Check**

The segment below, low potential/high share, requires a very *efficient* promotion approach. A web-supported call center approach may offer the best ROI in this segment.

The segment high potential/low share poses an *access* challenge. Most likely, we have to build relationships first – a personal selling approach may be called for. Also, we want to precisely position our product against competitors’ products the physician is currently

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using, content control must therefore be high. Later, as the customer is migrated to the left-hand side of the grid, other promotion tools may be added.

Finally, the low potential/low sales segment requires only a “pulse check” in order to see if circumstances have changed. This is perhaps best done through an outbound call center, or (e-)mail.

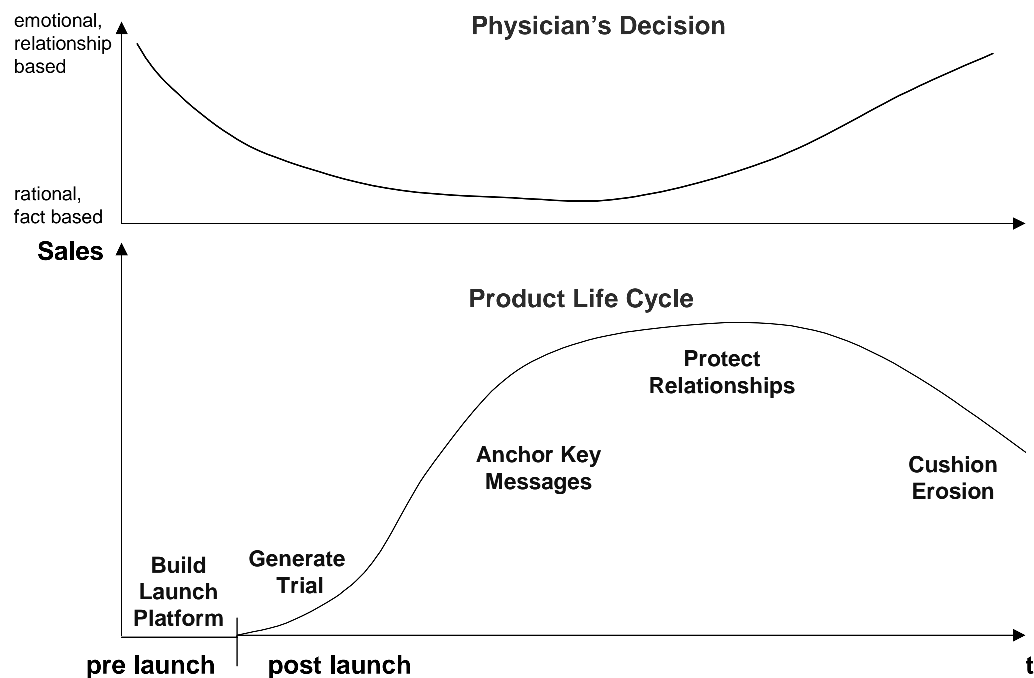
Of course, the illustrative segmentation discussed above is simple. In practice there would be a larger number of segments, incorporating many more segmentation dimensions such as behavior, demographics, relationship with the company, technology orientation, preferred communication style etc. The optimization task becomes thus much more complex, but also more impactful, as it takes into account even subtle differences in customer requirements. This enables the company to optimally target promotional resources where the impact is greatest.

What is the best promotion strategy to address product life cycle issues?

Strategic objectives may also vary over the product life cycle, as illustrated in exhibit 5. The different choices of promotional tools have different impact given these objectives.

Intuitively, many pharmaceutical companies are considering use of approaches like e-detailing in the later stages of the life cycle, regarding them as an efficient way of covering a business that is slowly fading.

Exhibit 5: Marketing objectives and the motivators for the physicians' prescribing decisions change over the course of the product life cycle



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However, this may not be the most appropriate life cycle stage for e-promotion. This becomes apparent if we consider the degree to which the physician's decision to use a product is emotional and relationship based, versus rational and fact based.

Before launch, and immediately after launch, not much is known about the product. The physician will most likely base his interest on the trust he has in the company or the rep, experiences in the past etc. These are all emotional dimensions. A few months into the launch, as more and more studies become available, knowledge about the product is increased, and the physician may have had his first product experience. At this stage the prescription decision is much more fact based and rational.

At or after maturity, when other new, presumably better, products become available, physicians will continue to prescribe the older product because they are used to it, trust it, have a good relationship with the rep etc. Thus, at this stage the pendulum swings back to emotional, relationship based decision making. It may therefore be a mistake to replace face-to-face communication with less personal interaction like e-detailing at this stage of the life cycle.

Technology supported promotion works best where the content of the interaction is information rich, where a lot of complex facts need to be communicated with graphs and tools with 3D capabilities, animation effects etc. The best life cycle stage may be just after launch, when the company is anchoring key messages and supports these messages with facts and information.

Implication for pharmaceutical companies

There is a place for e-communication in the pharmaceutical sales environment. However, *most efforts are additive, facilitating rather than replacing traditional communication*. Thus, e-communication will only be a part of the communication mix, however potentially significant.

This has important implications for pharmaceutical companies. Companies need to *optimize across the communication mix*, determining:

- Which approach is optimal for each customer segment?
- Which approach is optimal for certain types of products?
- Which approach is optimal over the lifecycle of the drug?

Key issues to be taken into consideration are:

- What are the communication objectives, for the brand, for the campaign?
- What access do we have to our audience, with which technology?
- What is the return on investment of each promotional tool, for certain segments and brands?
- How do we integrate the various promotional vehicles for consistent brand management and customer relationships?

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Optimizing across the promotion mix means that companies must take a holistic view of their sales resources. New approaches like e-detailing are part of the available marketing mix, and *must be part of the regular resource allocation decisions*.

The structure in which most pharmaceutical companies organize their e-communication efforts should facilitate this process. To date, most companies have appointed separate groups, which are not imbedded in the sales and marketing organization. This may create barriers between the functions in the long run.

Outlook

Of course, many new approaches are still in the experimental stage, and final outcomes are not certain. Most importantly, not enough data is available to verify if the observed sales impact of these tools is sustainable, or to what extent novelty effects play a role.

Still, the new options offer interesting perspectives for pharmaceutical marketers. For example, the way pharmaceutical companies align their sales territories in the future may be very different from today. Today, all territories are based around geography, constrained by the area a rep can cover. A rep may have in his territory customers from all segments – loyalists, spreaders, innovators, laggards, generic or branded product fans, technology oriented or relationship driven. And he has to be very effective in dealing with all of them.

If the geographic constraint can be removed – as e-detailing promises to do – territories could be organized around specific customer segments, rep capabilities (e.g. “hunters” and “farmers”), or product requirements. This idea is not so far fetched – in other industries, such as investment management – customer to rep assignments on a national level are reality today. “White space” – valuable customers in geographies that do not justify a territory, can be eliminated as well.

Where today we have low call rates due to travel and waiting, e-detailing promotion is more efficient. Companies report that they can make at least 20 calls per day with their e-detailing reps. And the average duration per call is 8 minutes compared to 3 minutes for traditional calls. Thus, companies will be able to reach customers they could not profitably reach before, and they will be able to cover many of their existing customers at lower cost.

Physicians may welcome the new approaches as well. They regain some control on when and where they want to interact with the pharmaceutical companies. They can avoid disruption of their workflow by choosing to talk with them in the evening from home, or wherever they have access to the Internet. The first e-detailing experiences have shown that these calls have a much higher information content than “traditional” detailing. In fact, the approach forces the pharmaceutical companies to constantly produce new material, *just because* the discussions are more content driven, and longer.

What will be the dominant concepts? In the long run, most likely, approaches based on technologies that do not require specific infrastructure investments, and which utilize technology to enhance core business processes rather than substantially alter them.

The first argument is simply that of adoption and reach. Pharmaceutical companies should not put themselves into a position that is equivalent to having to give phones to physicians to be able to talk to them. The problem is always that of putting special technology in place. Adoption is usually slow and expensive, and it is doubtful that a wide audience can be reached in the end. Companies should also be careful not to become too much reliant

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on broadband and high-speed wireless technology too soon. Financially stressed telecom companies are slowing down the roll out of broadband, prices for high speed internet services are rising, and subscriber growth may be lower than currently expected. Much better to leverage technology that is already widely accessible.

The second argument is based on the experience that just because technology may be available to change business processes dramatically, this does not mean employees and customers welcome a complete shake-up. The early years of the Internet have been a learning process. The Internet was supposed to change everything. As it turned out, such an extravagant promise could not be fulfilled. So far, the highest payoffs are where companies have leveraged the Internet to enhance core businesses processes, and where they marry virtual with live interactions. For example, online stores soon discovered that without “human touch” in the form of telephone support, shopping carts remained largely empty. And even in areas where the Net can effect profound change, business inertia and institutional barriers, such as the reluctance to give up control of patient records and insurance claims to third parties, may mean that the big revolutionary change may not come for quite a while. This is illustrated by WebMD’s and Healtheon’s frustrated efforts of moving claims processing and related services to the Net, which was shunned by insurance companies and HMOs.

Should companies wait until dominant models emerge? It is doubtful that there is a first mover advantage in the sense of locking competitors out by using a certain approach or technology. Even if it would appear that competitors could be locked out with proprietary systems, the risk of simply being bypassed by a simpler or ubiquitously available medium is extremely high.

However, there is a *significant learning curve*. It is beneficial to go down that learning curve quickly.

This can be illustrated by the example of e-detailing. Implementing an e-detailing approach is more complex than configuring online sales aids and picking up the phone to call physicians. Because e-detailing discussions are different from traditional details, the current detailing aids cannot be simply transferred to online media. A whole new process of creating and continuously refreshing new sales support materials needs to be set up. To implement well, sales processes will have to be reviewed, selling roles defined, performance metrics developed, sales reps selected and trained. Customers need to be segmented, promotion response studied, and resource allocation optimized across the field forces and the e-detailing team.

Important implementation questions arise: Do e-detailing sales reps need different skills than our traditional reps? Can we move our reps from the field to make e-detailing calls, or should we set up new teams? What can be the role of contract sales forces? What makes an e-detail most effective, and how are success factors different compared to field based sales reps? How do we coordinate with the field teams? What is the optimal organizational structure to manage the field teams and the e-detailing teams? How do we get the physicians to participate?

There is significant scope for learning and developing best practices. The company that goes down this learning curve fastest and excels at these issues can set the gold standard, both in terms of customer expectations, as well as internal efficiency. Both will translate into higher economic returns.

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