Pharmaceuticals – the consolidation isn't over

Overcapacity still costs the industry almost half its value ◆ What premiums? Savings can amount to 40 percent of an acquisition's costs ◆ Could all medical needs be met with 247 drugs?

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THESE ARE UNEASY TIMES for pharmaceutical companies. Many of the industry's traditional ways of making money are gone. Generic drugs are gaining increasing acceptance, contract sales are undermining the role of direct selling, and companies can no longer introduce a me-too drug and expect a "fair share" of the market.

But there is one certainty amidst the turmoil – the industry's consolidation is far from complete. The reason is excess capacity. We estimate that in the US alone overcapacity totals between $12.1 billion and $17.5 billion of annual spending, or about 26 to 37 percent of the industry's total cost base. That is the equivalent of between $60 billion and $90 billion worth of net present value (NPV).

To put that number in perspective, the total value of fulfilling all unmet, disease-based medical needs in the US through drug use is about $120 billion NPV. It means that the potential savings from capacity rationalization account for up to 43 percent of the total value the industry can create.

For companies that can capture cost synergies through acquisitions there are considerable opportunities to create value. For some, in fact, horizontal integration may be their best value-creation opportunity in the near term. In the longer term, products and "pipelines" – products in development – as well as marketing skills and access to distribution channels will remain the key requirements for success, but horizontal integration can create a lot of value for companies right now, in a way that is relatively easier to achieve than that offered by traditional innovation.

From our assessment of recent pharmaceutical mergers, the range of actual savings achieved has been 15 to 25 percent on R&D, 5 to 20 percent on manufacturing, 15 to 50 percent on marketing and sales, and 20 to 50 percent on administration. (The level of functional savings varies according to differences in geographic, product, and pipeline overlap.) All together, these savings can amount to 30 to 40 percent of the acquired company's cost base. In short, not only is the excess capacity real, but companies are finding quick ways to identify and eliminate it to generate real returns.

Different waves, different logic

The pharmaceutical industry's first wave of consolidation took place in the late 1980s, with combinations such as those between SmithKline and Beecham and Bristol Myers and Squibb. Increased scale and scope, especially as a result of salesforce efficiencies, justified these mergers. At the time, when traditional detailing (a detail is the slot a sales representative has to discuss a specific drug with a prescribing physician) was a clear key factor for success and there was a direct relationship between details and sales, the logic for consolidation was sound. While companies also benefited from reduced costs, the primary synergies were revenue based, as detail forces were combined for increased physician and geographical coverage.

In the 1990s, however, new forces are at work that have changed the underlying logic for horizontal integration. More government intervention, reduced prices, greater competition from generic drugs and significant pressures from managed care have combined to create slow (or no) real growth in the US and increasing pressure on margins – a situation that pharmaceutical companies have not traditionally needed (or had the strategic skills) to deal with.

The result is growing uncertainty, as companies grapple with the many possible ways the healthcare industry might evolve. Each of these "scenarios" of the future will be defined by different factors – including the role of generics, the degree to which pharmacy benefit managers, especially captive ones, will influence sales, and the number of truly closed formularies (the lists of drugs from which doctors prescribe) – which will in turn shape the way companies must compete. Since achieving success in each scenario will require different skills and strategies, it is unlikely that pharmaceutical companies will be able to stick to the "one strategy fits all" approach with which they have competed in the past.

In response, some companies have concentrated on their core business in the belief that innovation will be the key to success, and that they will be successful innovators. Others, like Merck, Lilly, and Zeneca, have vertically integrated into different areas of the value-added chain. And still others (AHP and American Cyanamid, Glaxo and Wellcome, Hoechst and MMD, Upjohn and Pharmacia) have merged or made acquisitions to gain the benefits of horizontal integration.

This time the logic for horizontal integration is not to increase detail size or reach. Traditional detailing now plays a much reduced role in sales – indeed many companies have cut their salesforces over the past few years, in direct response to market changes. Nor is it to gain scale economies. All the companies involved are far larger than any minimum critical mass necessary for R&D, and it is still unclear whether such a concept is even valid for larger enterprises. Instead, the new logic is cost synergies.

We aim to show that there is still substantial value to be realized from horizontal integration, that the pharmaceutical industry is in fact now no different structurally from many other industries which have had to recover

from excess capacity (such as steel and chemicals) and that it too must restructure to reduce capacity.

A new definition of capacity

To best identify this value-creation opportunity, pharmaceutical companies need to think of capacity in a different way. Most industries view it as the maximum volume of product that can be "manufactured." But in pharmaceuticals, manufacturing is rarely the function that determines how much can be produced and sold. By using a more creative and expanded definition of capacity that is more applicable to pharmaceuticals (that is, development and detailing capacity), it is possible to start to identify where there is excess capacity. Since all capacity incurs a cost, removing the excess capacity can translate directly into cost savings and value creation. Such logic can be seen to be sound from both a "top-down" industry perspective, and from looking at individual deals and reverse engineering their value-creation needs.

The main drivers of excess capacity are:

- Too many drugs chasing the same needs
- Too many salespeople
- Too much development capacity
- Too much overhead.

Too many drugs filling the same needs. Increased use of formularies will continue to result in buyers needing fewer drugs, and will all but eliminate the need for multiple similar drugs in any one therapeutic area ("drug" here means a unique chemical entity, whether branded or generic). Even where there are minor differences in drug formulas, or to provide for multiple sourcing when a drug loses its patent, the number of drugs available to treat a given condition can be reduced to three or four, whereas at present there might be more than 10 that are largely interchangeable. This has been confirmed in interviews with buyer groups and is consistent with a detailed review of existing managed-care formularies.

To demonstrate the point, we created a formulary that would cover all the main therapeutic areas. We designed it to meet 95 percent of current drug needs, and to include not only unique or distinctive drugs, but multiple sourcing of drugs where there are no clearly differentiable products. The results are sobering for manufacturers. The formulary could meet all market needs *with only 247 drugs.* Worse, 70 percent of these are already generic, a figure that will rise to almost 90 percent by 1998. Of course, some new chemical entities would probably make this formulary shortlist, but a separate analysis of all the products in the pipelines of the 40 largest pharmaceutical companies indicates that fewer than 50 new drugs will achieve peak-year sales of $100 million. So, even after adding some new, distinctive drugs, most true pharmaceutical needs could be met with only a small fraction of the drugs on the market.

Excess sales and marketing capacity. Too many resources are dedicated to marketing and selling drugs. The situation is exacerbated by the shrinking number of customer contact points and the centralization of buyers. More drugs are being purchased through managed-care organizations and pharmacy benefit managers, often in large-volume deals made at senior level and not driven by the detail force. In addition, formularies and other managed-care tools give doctors less choice in prescribing, making them less open to detailing calls, especially for me-too drugs. Consolidation in the hospital industry, furthermore, combined with more centralized purchasing and even stricter formularies that allow physicians little leeway to prescribe unlisted drugs, is reducing the number of hospital contact points and physician choices.

Instead of the current system of detailing – in which companies view their detailing decisions independently – let's look at detailing from a systemic point of view, and optimize detailing levels to reduce industry costs. To do this, we can estimate the required number of details needed for all non-generic drugs using the 247-drug formulary. This optimum level would assume that all drugs on the formulary (plus major new drugs approved) would still be detailed and that sole-source drugs would receive heavy detailing. It would also allow for three companies to detail multiple-source and me-too drugs.

When the optimum level is compared with the number of details actually being done, the difference is staggering. The optimum level is just 31 percent of the number of details carried out in 1994. In other words, the industry could reduce detailing by 69 percent. Even if companies continued to detail all other drugs with sales of $100 million or more (some of which already have generic equivalents), 35 percent of details could still be eliminated. Reductions of this magnitude translate almost exactly into an equivalent reduction in sales calls and sales staff.

Excess development capacity. Formulary-driven purchasing – combined with customer-driven product rationalization and declining overall drug margins – means pharmaceutical companies need to improve their return on R&D spending. Since development spending is not significantly lower for me-too drugs, it will be increasingly difficult to generate positive returns from marginal products.

Analysis of all the leading drug manufacturers' pipelines indicates that development of drugs that are clearly me-too accounts for 35 percent of current development costs. Excess development is defined only as work on drugs where a comparable drug has already been approved or where three or more comparable drugs are at least one phase ahead in development ("too-late" drugs). So the optimal industry development level is only 65 percent of current spending. This allows for full development not just of drugs that appear to be distinctive or unique, but also of drugs of unclear potential (Exhibit 1).

Excess overheads. The staff and over-head functions of pharmaceutical companies are not unique. If two companies merge, therefore, they

can generally combine many administrative activities as well as support areas such as quality assurance, manufacturing management, information services, legal services, and human resources. Recent deals have shown that reductions of 40 percent of the smaller company's cost base in these areas are common.

When all these elements are combined, excess capacity accounts for 26 to 37 percent of the industry's total cost base, equal to $60 billion to $80 billion NPV after tax (Exhibit 2). This is a "top-down" analysis of the industry, and indicates that there is a tremendous need for rationalization but, at the same time, a tremendous opportunity to create value for companies bold enough to act. The next question is: Can these theoretical numbers actually be achieved?

The answer is yes. From our assessment of pharmaceutical mergers so far, we have seen that companies are achieving rationalization gains in line with these industry optimal numbers – up to 30 or 40 percent of the acquired company's cost base – and in some cases even greater.

Exhibit 1

Finding an optimum development level

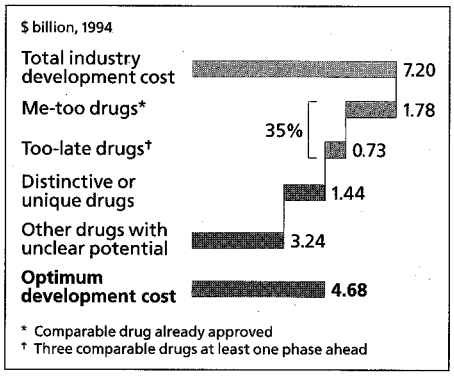
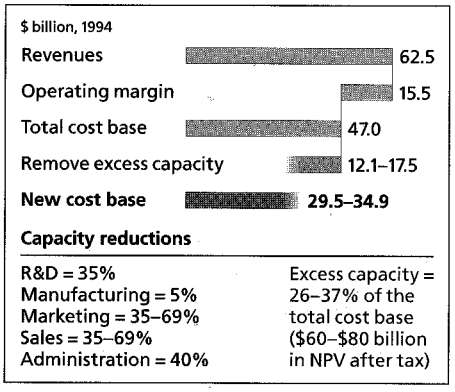


Exhibit 2

Industry value creation potential



Reexamining the premium paid

Even deals in which companies have paid large premiums for their acquisitions appear in a new light when their rationalization potential is examined. We reverse engineered the premium paid in five recent deals to identify what level and kind of excess capacity reductions would be needed to make the deal work. In almost every case, we found that if acquirers achieved cost reductions in line with industry-wide estimates of functional excess capacity, the deals would generate positive returns. In one large deal involving what was considered a huge premium, the companies had to reduce combined sales, goods, and administration and R&D costs by just over 1 percent for the acquisition to make sense, amounting to a reduction of 3,700 people. These synergies were achieved less than two years after the merger.

It is further proof that the value of a deal lies in how much cashflow it generates from combined sales and other synergies, and that only by knowing this value can the size of a premium be placed in perspective. Generalizations about a premium being too high are misleading; some deals in which no premium has been paid will destroy value, others will create value even if a 100 percent premium is paid.

Besides cutting costs, consolidation offers further benefits. These should be included in the valuation calculation, with the caveat that many are difficult to measure and as such are less likely to be realized. They are:

- Increased strength in specific therapeutic areas or disease states, enhancing the chance of a drug winning formulary approval. This also provides opportunities for "capitation offerings" (whereby a healthcare provider pays doctors a set amount per month to care for patients, regardless of demand) and "disease state management" (which is specialization in a given area of treatment).
- New opportunities for bundling, contract sales, and skill-based R&D synergies.
- Increased value from complementary geographic coverage, which may allow for large reductions in below-mass salesforces (which are salesforces that are not large enough to reach all of the major prescribing doctors for a given type of drug).
- The ability to fill time gaps between products by evening out the flow of product development and introduction.

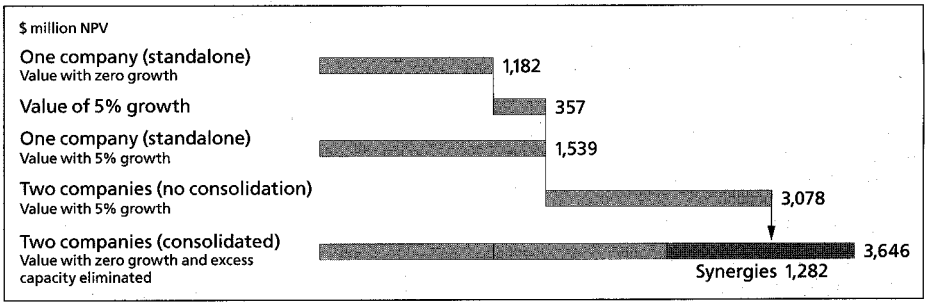
Who should do a deal?

Consider two $1 billion companies growing at 5 percent in real terms – a likely scenario for many pharmaceutical manufacturers. The NPV of each is $1.55 billion, assuming average industry margins. Of this amount, $357 million is the result of the 5 percent growth – or the growth that results from innovation (assuming no real price increases on the portfolio of existing drugs). If the two companies were to combine and reduce excess capacity in line with our optimum industry levels, they would achieve $1.3 billion in synergies. Thus the total value they could create *without growth* would be almost double the value they could create *with growth.* In other words, the value of horizontal integration exceeds that from innovation-related growth (Exhibit 3).

The implications are clear. To create maximum value, companies should seek out no-premium deals and move quickly to integrate and rationalize excess capacity. In place of a premium, shareholders of both companies would benefit from synergy savings and value creation. Why

Exhibit 3

Example of consolidating two $1 billion revenue companies



HAVE RECENT DEALS CREATED VALUE FROM CONSOLIDATION?

Even though many people felt Glaxo paid a large premium for Wellcome, there is already evidence that savings from consolidation will overcome the investment. Glaxo's own 1995 annual report summarizes the savings already being achieved from the merger and further economies that are planned. To cover the premium paid, and the present value of integration costs, Glaxo will need to save about £480 million a year. According to its report, Glaxo expects to achieve £700 million a year in savings by year three, well in excess of what is required to cover the premium.

Similarly, a reduction of about 3,700 people is required to overcome the premium that Roche paid for Syntex. From published company announcements, Roche has already reduced its headcount by 5,000, more than enough to offset the premium, in less than 18 months.

these deals do not occur more often is a mystery. They create the most value, and eliminate the need to justify huge premiums (which are only a guarantee of value creation to one group of shareholders and a delay of value creation to another). Some might point to management ego as the reason, or to the frequently deep-rooted belief that with luck or time, the problem will go away ("we know we will have the 10th ACE inhibitor on the market, but why should we be the ones to stop development?" or "our product really will be different and will capture 50 percent of the market").

The logic of consolidation applies not just to smaller and weaker players but to everyone. There is nothing to suggest that industry overcapacity is limited to smaller companies. In fact, larger ones may have additional opportunities to capture synergies and would thus have an extra incentive to consolidate.

None of this is meant to imply that horizontal integration is the key to long-term success in the pharmaceutical industry. For that, products and pipelines will remain the key requirements, followed by marketing skills and access to distribution channels. But horizontal integration can do a lot to create immediate value for companies, in a way that is relatively easier than pursuing traditional innovation. For some it will buy time until longer-term research bears fruit. For the industry as a whole it will help the process of restructuring around today's healthcare needs.

The time to do these deals is now. There is a window of opportunity that will not remain open for long, because after every merger, some of the potential to reduce industry capacity is lost. Companies should realistically assess their value creation potential for cost synergies *versus* innovation. Specifically, they should analyze a limited set of possible merger/acquisition candidates and determine how much value might be created. This must be done on a case-by-case basis since the synergistic value of each deal will differ, depending on the degree and type of overlap and how complementary the companies are. The analysis can form the basis not only for discussions with possible partners, but will put the value of the standalone company in perspective.

Companies may have little choice but to participate in horizontal integration. Even if they choose not to acquire or to initiate a merger, they

may not be able to choose not to be acquired. Acquired companies usually bear the brunt of cost reductions and changes. The message is clear: companies need to look for every possible way to create value in today's healthcare world. Horizontal integration is a tool with proven potential to increase shareholder value; its use should be considered by everyone in the industry. Q

Bill Pursche has been advising companies and senior executives for over 25 years. He has been involved in over 300 M&A and PMI efforts in a variety of industries and geographies, including numerous cross border deals. He is regarded as one of most knowledgeable experts in the world on synergies and Post Merger Integration.

Prior to his work with First Call Advisors, Bill was a Partner at McKinsey & Company, Inc. where he led McKinsey's worldwide Post Merger Management Group. While at McKinsey he also founded and led its Mergers and Acquisitions Group (M&A), and its Turnaround (Operational Profit Improvement) Group. His next book *Synergies: The Art and Science of Making 2+2=5* will be published in 2009.

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