

# What does it take to be a real super rep?

As the selling environment transforms for pharma, Dr Leandro Herrero imagines what might be required of the sales reps of the future



PARAPHRASING MARK TWAIN, reports of the death of the rep have been grossly exaggerated. Year after year we hear about the need for shrinking sales forces and more specialised selling.

Apocalyptic voices would lead you to believe that a combination of just-in-time multimedia, e-detailing and internet broadcasting would suppress the whole idea of the rep-and-bag soon. Don't hold your breath, or not yet. There is little doubt that the environment has changed and it is still changing. The stakeholders are moving around the theatre of the market place and acquiring different roles of varying importance. The plot is a moving target. Physician power is going down; that of the hospital pharmacist remains so-so; with purchasing people it is going up, centralised buyers up, formulary people up, etc. Patients, that is, you and me, are gaining ground but still have only minor roles in the script.

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monalities across Europe. Whatever the labels for the stakeholders, decision-making and buying power in healthcare are progressively shifting away from the physician in favour of the manager. All this is so well known it is hardly worth stating. It is also a bit old in countries such as the UK and the US and rather less so in the French hospital sector, for example. Despite these real, well known, continuous changes and shifts in power, sales forces in many companies are still in soul-searching mode trying to figure out how to allocate resources. It is clear it is no longer a simple question of redistribution of bodies, but of re-engineering skills and competencies. We may need fewer reps but we certainly need more super-reps. To work on sweeping generalisations is risky but I am willing to take the risk providing you remember I have warned you. Four sets of skills and competencies are emerging as conditions to win the super-rep race.

1. **Mastering negotiation.** Super-reps do not deliver information hoping that at the end of a skillful delivery of a rational and convincing story, the customer will buy. Super-reps negotiate the multiple variables around the selling exercise. Negotiation by definition entails trade-offs. Trade-offs entail flexibility. Tip: negotiators must have the freedom to negotiate. Therefore new sales management that includes super-reps needs to be willing to allocate a wide enough spectrum of possibilities so negotiation can happen. The interface with hospital administrators, budget holders, decision-making advisers, and so on, is a negotiating interface where information delivery is only the baseline. It is taken for granted that the information base will be good, professional, accurate and reliable. Hopefully! Despite the importance of negotiation, this competence is not prominent enough even in training curricula.

2. **Competing on collaboration.** Super-reps abandon the traditional individualistic approach to sales. Success is not possible unless other super-reps, sales management, marketing structures, medical advisers, and so on, join forces well beyond the traditional coordination of functions. Super-reps are not rewarded for possessing information; they are recognised and rewarded for sharing it. A super-rep compensation system requires equal weight to be accorded to sales targets and knowledge sharing. Given that the same stakeholder is often addressed by several company people or groups, the naïve solution of an ill-conceived Customer Relationship Management (CRM) system is to create a vast recipient of information that anybody can tap into. CRM, as 'the mother of all repositories', is still a model in many people's minds. CRM entails joint forces, collegial effort and uncompromising collaboration between everybody involved. The technology platforms in CRMs work as a vehicle for this but are not CRM per se. Super-reps can create true competitive advantage out of collaboration.

3. **50/50 science and economics proficiency.** Complaints of inaccuracy or insufficiency of the scientific story have been on the up for a while. The need to master the science and technology behind drugs has not gone away; on the contrary, it has become more prominent and complex. The use of qualified scientists or medics tries to address this aspect but it is neither new nor is it a solution per se. Super-reps go beyond the science of a drug's efficacy and safety and address the economics simultaneously. Whether in the form of cost-effectiveness data, if these exist, or the broader epidemiological and economic impact of a drug, super-reps are able to jump between the two camps – science and economics. They master a new and broader understanding of the product in terms of its multiple impact on several ecosystems, from the economics of the surgery to the national drug budget, from the individual impact in terms of quality of life to the 'cost of not treating' for a particular geographical jurisdiction or budget holder. The key component of this competence is not science; it is not economics. It is found in the 'and'.

4. **Solution selling.** The fourth competence of the super-rep is solution selling. And this is one where the average pharmaceutical rep scores very low compared with almost any other industry. The ethos, language, focus and DNA of the standard pharmaceutical company is one of product shelf life. CEOs talk about pipelines because new product launches play the stock market numerical game, and, let's face it, the industry has always employed sales forces with the idea of selling products. This is hardly a breakthrough idea. However, dealing with illness is not only a question of products. The management of a disease very often requires other non-pharmacological interventions. Product selling is often about selling an anti-inflammatory as a Pavlovian reaction to the words inflammation or pain. Solution selling is

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about providing the customer (the physician, for example) with answers to the question: how can I manage the pain and inflammation of Mr X? The problem for the physician is Mr X's expectations and any complaints that may arise. The answers to the problem may or may not be pharmacological, and a given company product may or may not be the only one suitable. The pharmaceutical industry is nowhere near solution selling, even if there are whole orchestras and choruses singing customer-driven and customer-centric anthems. In many companies, understanding customer needs is not about putting oneself in the customer shoes but accumulating as much knowledge as possible about the customer so they can sell more products or sell them more easily. Many customer-centric strategies are simply company-centric. Pharmaceutical super-reps may not be true and full solution sellers but they are further down that road in their ability to not only understand customer needs but to be able to provide holistic solutions, including one's drug.

## The fifth competence

A fifth competence of super-reps is the ability to navigate at different levels of engagement with the customer. Not all customers are at the same level of receptiveness to reps or super-reps. There is nothing new about this. However, traditional selling has understood this issue only through a rather old concept of segmentation and post-hoc benchmarking. Sales management can dedicate resources to the segments that contain the highest potential

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prescribers. Once the profitable segments have been identified (and the only way to do so is via retrospective analysis), the forces of information delivery and persuasion descend upon that segment. Less is known about the progression of the prescriber from hopeless to hopeful and on to high volume. Where it is knowing, the knowledge is again retrospective. Super-reps master the ability to understand and spot the progression even when there are no data. Super-reps sell with a conscious presence in mind of a step-wise model of sales effectiveness which has the following building blocks:

1. **Access.** Nothing will happen without access to the prescriber or budget holder. The progressive difficulty in obtaining an audience is well documented. The supply-and-demand mechanisms produce a situation, in which physicians may simply refuse to see reps. Where this is not the case, access may be limited. Interestingly, the strange mathematics in some corporate headquarters seems to solve the problem with an increase in the number of bodies available.
2. **Attention.** Many access-improvement campaigns seem to have access as an end in itself. Access is meaningless if there is no attention from the other side. The quality of the call should matter more than the number of calls, although the majority of performance management systems still have the numerical call rate as the key linkage with reward mechanisms. Advocates of the call-rate-management model say the frequency of call still correlates well with sales achievement. This is certainly a popular concept in general practice territory; I'll come back to this later.

3. **Permission.** Once access and some sort of attention have been gained, it seems logical to aim for permission to return. This will entail a minimal delivery of some value in the first place, enough to grant access and attention again. I am not suggesting this is an overt and articulated process all the time; in many cases it is implicit and invisible.
4. **Experience.** With access gained, attention dedicated and permission to return obtained, the next step is to convert the call into an experience. This represents a higher level status of the relationship that goes well beyond the cold delivery of information. It means, for example, that the time spent has worth and emotional attachment. A good experience is defined as being enjoyable, valuable or something someone looks forward to. The relationship in itself is now high on the weighting score. It is about personalising the interaction beyond the content of the information flow.
5. **Reputation.** This is the ultimate aim. This is the stage where doors are wide open and any information exchange is pre-conceived as valuable, whether this is true or not in reality. It would be a mistake, however, to assume that reputation is always associated with the firm. In many cases it is personalised at the rep level, although even if this is so, some of the effect inevitably attaches to the employer by default.

Many sales directors would not hesitate to state they are not in pursuit of anything but access and as much quality attention as possible. They would probably laugh at the idea of 'creating an experience' from a three-minute call, and say that reputation creation is not on their agenda. In secondary care, the picture would be more recognisable, although not necessarily embraced. Super-reps have the model in mind all the time. They allocate their customers to these phases of call effectiveness. They progressively master the behavioural recognition of the progression itself, that is, what it is that triggers jumps in the curve and how to spot behaviours that predict that jump. Super-reps would not hesitate to build reputation at the expense of modifying the dynamics of the interaction in the 'experience' phase, if necessary. That may mean a temporary downplay of the product-information focus in favour of language and an approach closer to 'solution selling'. The same would apply down the scale. Once permission is present, a focus on experience may mean a stronger emphasis on a more personalised approach to the prescriber,

less focus on the product, and gaining ground on making it distinguishable from the competition. And this is a challenge since there are plenty of data to suggest that the average physician in the UK, for example, can't distinguish between a rep from company A, company B or company C. Physicians are unable to recognise any distinctive features, characteristics, styles, or experiences between companies, in other words.

The concept used in professional services (and super-reps in the path to solution selling are one) is that 'you-are-the-brand'; that is, you bring all the weight of the company reputation, image and style with you. It is alien in pharmaceuticals. It may be talked about at incestuous sales conferences but disappears quickly once quotas take over from any other aims, objectives and conditions for the pay cheque. Super-reps are managers of an adoption curve that has more weight in the relationship itself than in the delivery of product information. Super-reps have no role in companies that don't care about relationships as long as sales targets are met, at any cost, with the involvement of as many machine guns as possible. Although I have described most of the above with the language of the customer as prescriber, similar model applies to other budget holders, adoption bodies or hospital administrators.

Super-reps constitute on the whole a different league. Skills and competency sets are concrete and well defined. I'll let you make up your own mind as to whether these people are or need to be smarter, better educated or more senior than we often see. In any case they are probably more expensive. Assuming that all these characteristics I have described are right, dare I say we also need another kind of manager or leader who is able to support (acquire, develop) a broader spectrum of skills including being able to deal with complex situations. Surely, the expectation of obtaining better results by applying old, similar ways of working, is lethal. The temptation is often to play with organisation charts and labels without thinking too deeply as to the skill set for the new selling. In that respect, the discovery by the industry and its subsequent falling in love with the concept of key account management is often incredibly naïve in following what is little more than a simple re-labelling process. But this is a story for another day. In any case, the super-reps have landed, and, believe me, you want to have them in your courtyard. ■

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