

The virtues of implementing a benchmarking database in medical education and the perils of obtaining acceptance for using the database

As the pharmaceutical industry faces greater financial pressure, the \$2.5-3B spent annually on medical education (Med Ed) programs comes under increased scrutiny. The practice of benchmarking, which has resulted in 5-10% savings in Med Ed programs, is gaining attention among bottom line-conscious senior managers. For a top five pharmaceutical company spending about \$200-300M a year on MedEd, benchmarking can offer up front savings of \$10-30M--a number that could make or break a quarter on Wall Street.

But while its arithmetic looks great, factoring in the high human costs associated with applying benchmarking procedures to Med Ed programs can tip the overall balance and keep those big savings tantalizingly out of reach. Benchmarking's tendency to introduce a strain into the relationship between product managers and outside vendors is the chief human cost and deterrent to its implementation. This article describes how benchmarking has and can be made to work in Med Ed. It presents the advantages of benchmarking, describes how senior management can apply it to boost their bottom line, suggests a methodology for developing a benchmarking database and details a process to obtain acceptance within the organization.

There are several ways to benchmark, and at least two of these methods have shown dramatic potential savings in Med Ed applications. The first is called the top down approach and compares cost ratios. An example of a ratio would be to compare overall costs per physician per meeting in similar programs. Another method, the bottom up approach, focuses on specific line items from a Med Ed program including airfares, meals, hotel expenses and shipping rates. Both methods enable management to compare programs and analyze why certain programs are more expensive than others. Both methods have enabled management to identify savings of between 5-40% and startlingly varying costs for the same services in Med Ed programs.

For example, one pharmaceutical company used benchmarking to compare similar advisory boards in different therapeutic areas. The benchmarking showed that the same vendor was charging different therapeutic areas varying rates for services provided. Hourly management fees for strategy and editorial development were \$150 for one therapeutic area and \$125 per hour for another therapeutic area of the same company.

Similar differences were discovered in a benchmarking comparison of advisory boards organized by one Med Ed vendor over the time span of three years. The same pharmaceutical company compared management fees of advisory boards by plotting total costs per physician and size of the program (number of physicians). One would expect that management fees are largely fixed, and that therefore the cost per physician per program would decrease as the size of the program increases. The actual data showed an insignificant correlation between the data. The cost per physician per meeting varied a remarkable 174%, from a low of \$302 per physician to a high of \$830.

In addition, the team discovered that the vendor was charging widely different rates for pass through expenses. When asked to explain the differences, the vendor's reply was, "We have to make our money somewhere." Med Ed vendors sometimes mark up their pass through expenses to compensate for the competitive management fee they have quoted on a

program to win the business. Line item pass through expenses--which have little if anything to do with program quality--are sometimes billed at 10-15% higher than their proposed costs.

Obviously not all Med Ed vendors provide the same level of quality, resulting in companies paying "top dollar" if they think doing so will secure access to a vendor who can ensure the success of a particularly important program. But does spending more money on MedEd programs necessarily improve its quality? Benchmarking enables the product manager to measure and quantify the trade-offs between one Med Ed vendor and another and allows the product managers to make better informed decisions about where best to put their Med Ed funding going forward.

A good place to begin the process of adopting benchmarking is to apply it in the evaluation of Med Ed program proposals submitted by vendors to the pharmaceutical company. Benchmarking data must be collected consistently over time and that data must be comparable -- "apples to apples". Therefore, the first step in benchmarking is to require all Med Ed vendors to submit all program bids in the same standard spreadsheet proposal template. The next step is to enter the proposal templates in a database and provide benchmarks and comparisons that provide product managers fast and easy results.

The acceptance of the new process relies on the feedback and buy-in of product managers and product directors. The benchmarking process is typically supported by departments such as Strategic Sourcing (because they know it will lead to lower costs and the selection of the best vendors), Health Care Compliance (who are interested in Fair Market Value of fees paid to advisors and speakers), and Finance (since they know it will lead to greater efficiency and lower costs). The support of these departments is important, but a strong case must be made to the actual users of the benchmarking data--the product managers.

There are two reasons why product managers are typically resistant to benchmarking. First, they see it as a cumbersome process. Product managers tend to shy away from the analysis and additional work involved in benchmarking. Also, they know they will get push back from the Med Ed vendors. A product manager's success in their job is largely determined by his ability to successfully select and work with the best teams the vendors can provide, so an interdependence between the two naturally develops. Vendors do not like the process of benchmarking because it forces them to be explicit in their assumptions and reveal information about their cost structure. As one vendor put it, "the less information I give my client, the easier it is to negotiate a higher fee for my services." Med Ed vendors have been known to threaten to increase their fees for having to fill out proposal templates and the additional work that is involved in properly pricing out a project using the spreadsheet required by the pharmaceutical company.

The financial benefits of benchmarking for senior management are clear. But would they be willing to impose a new process on product managers who are typically in a 2-3 year rotational position—especially as whose jobs are typically highly demanding and intensive already? And what about the Med Ed vendors who are an integral part of all Med Ed operations? How will they react to strictures imposed upon them after so many years of operating without them?

One more benefit of benchmarking is that, through the process of demystifying Med Ed vendor practices and making them more transparent, it makes it easier to see which vendors offer the most for the money. Because of this, the more efficient vendors eventually come to

accept and welcome benchmarking. For instance, proposal templates quickly reveal a stronger vendor's knowledge of the industry, understanding of the program, and fairness in pricing in comparison to a weaker vendor. Better vendors know that benchmarking actually gives them a competitive advantage over inferior ones. They also know they will benefit from the faster and more consistent process. It will improve vendor flexibility, increase their margins, and enable them to obtain sign offs on proposals and invoices more quickly.

For the product managers and the brand teams the answer is that they are in fact beneficiaries of a more efficient, better-designed process for managing vendors. They will quickly recoup the initial time investment that benchmarking requires in ways more varied and even greater than the expenditure savings windfall that their senior managers will receive. Product managers also gain because the efficient process will allow them to plan more meetings for the same budget, and by obtaining additional information about the programs execution, enable them to better manage the vendor. Senior gains management by savings costs, developing a consistent process across all franchises, and a higher lever of Health Care Compliance proposed by the OIG and PhRMA. In the end, benchmarking can make winners out of everyone seated at the Med Ed table.

In a separate box:

The "black belts" take benchmarking to the next level:

The "black belts" in benchmarking have learned that the success of benchmarking depends on the data in the database. They do not use proposal templates to populate the benchmarking database, but rather obtain more reliable data by requiring vendors to reconcile programs. Reconciliation is the process of matching actual expenses and receipts with proposed expenses. Using actual expenses from past projects provides the pharmaceutical company with a better footing to negotiate better fees for future projects.

Reconciliation has some added benefits. While the practice of requiring vendors to reconcile all management fees and pass through expenses before getting paid is relatively new idea for pharmaceutical companies (though common in other industries), it has already yielded some examples that are making the rounds in senior management circles. Recently a product manager who reconciled \$450k in billed expenses for an advisory board received a \$143k credit (32% of the total) for a future program when the vendor found they were unable to back up all of their expense billing. Another reconciliation revealed that a meeting planning company was billing a flat \$75 fee for recruiting physicians even though the product manager's sales reps were doing most of that work. In this case, the pharmaceutical company was reimbursed over \$300k. Reconciling expenses can yield an additional 5-10% on top of the benchmark savings.

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