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CASE STUDY WITH COMMENTARIES

The Urge to Merge in the Pharmaceutical Industry

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This Case Study focuses on the giant Glaxo Wellcome and SmithKline Beecham merger to form Glaxo SmithKline. There is a general background of evidence to show that mergers frequently destroy shareholder values. The pharmaceutical sector is no exception, even though companies are in the early stages of healthy growth and not seeking consolidation because they are mature. The urge to merge is stimulated essentially by intense competitive pressures in pharmaceuticals. Chief Executive Jean-Pierre Garnier faced many challenges in early 2000, primarily how to deliver the promise of the merger. The case study analyses the growth of the pharmaceutical industry, its business system and value chain, and the steps to merge between Glaxo Wellcome and SmithKline Beecham. The case is followed by commentaries from experts in the field which help to form opinion on whether the merger will succeed. © **2001 Elsevier Science Ltd. All rights reserved.**

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Introduction

In January 2000 Jean-Pierre Garnier became Chief Executive-elect of the new pharmaceutical giant Glaxo SmithKline. Born from the merger of Glaxo Wellcome and SmithKline Beecham, the new company had $25bn in sales, a market value of around $180bn and an industry-leading market share of 7.3 per cent.

Garnier faced one of the biggest challenges yet faced by a pharmaceutical Chief Executive: to create additional value for shareholders, to steer a path through the scientific, market and competitive turbulence of the new century and to confound the many critics of big mergers. Criticism of big mergers were many, and some uncomfortably close to home. For example, Glaxo's acquisition of Wellcome in 1995 produced only short-term savings but no long-term growth (*Economist*, 2000a). Glaxo Wellcome and SmithKline Beecham had attempted a merger in 1998 with their shareholders' agreement, but the deal collapsed in a squabble over which Chief Executive should run the merged company. Warnings about the difficulty of post-merger integration had a special meaning for Garnier.

Various research studies provided evidence that most mergers did not create shareholder value and that many destroyed it. Some observers saw big mergers as the product of an Anglo-Saxon preference for deals as vehicles of change, or as exercises in self-aggrandisement by senior executives at shareholders' expense. Robert Baldock in, *The Last Days of the Giants*, saw the big merger as the death spasm of doomed dinosaur-like companies of the twentieth century in the face of new competitive dynamics and the organisational forms of the 'new economy'. From his point of view, Glaxo SmithKline might have unique competencies in R&D and manufacturing but its other activities would be better performed by specialists in a network of alliances, held together by e-commerce technologies and connected to final customers through new agents such as drugstore.com.

Nonetheless, Garnier was undaunted: 'Before, drug companies were forced together because they were

weak. This is a merger between the strong and the strong' (ibid). He believed that a fundamental shift was taking place in the scientific and research base of the industry. It was moving from a tradition of 'blue skies' research and serendipity to so-called 'rational drug design'. The latter was based on systematic investigation starting with understanding the genetic causes of disease through new disciplines such as genomics, and then identifying and patenting biological targets that could be modified by a new drug. SmithKline Beecham had filed 300 patents on potential new drug targets between 1993 and 1999 while the whole industry had worked on only 450 targets in the whole century (ibid).

Tachi Yamada, Chairman of R&D at Glaxo SmithKline saw a once-in-a-lifetime opportunity. 'There is only one human genome. Once it is sequenced, that is it. It will be a race to see who gets to claim the intellectual property' (ibid). However, Sergio Traversa, an analyst at Mehta Partners noted that the torrent of genetic information generated by the large firms might be of more help to small firms by breaking patient populations into genetically distinct cohorts. If each cohort responds to different drugs for the same illness then a multitude of niche markets suited to small firms could be created (ibid). Indeed, Jonathan Knowles, president of Global research at Roche reflected that 'if you look around a number of organisations and ask, "where was this drug actually discovered?", the proportion of important drugs found in smaller sites away from corporate headquarters is larger than it should be' (*Financial Times*, 1999).

Yet Garnier knew that a critical element of the merger strategy was a bet on scale in R&D. Richard Sykes, CEO of the former Glaxo Wellcome, had been a strong advocate of that vision. Putting more dollars into research now would reap rewards for years to come through profiting from the once-off leap in biological knowledge represented by genomics he argued trenchantly (ibid). And for just that task Garnier now had an R&D budget of $4bn.

As Garnier surveyed an industry landscape in turmoil, crossed by a new wave of 'mega-mergers', he wondered how he would deliver on the promise of the merger. How would he integrate the two companies? How would he achieve the promised cost savings? How would he exploit the promised economies of scale and the critical mass in R&D? How would he exploit the promise of genetic science and genomics? How would he grow the new company and create additional shareholder value? How would he prove that mergers, and especially big mergers, could work?

A Dynamic Industry

Various forecasts predicted healthy growth for the pharmaceutical industry. According to the *Economist*,[1] the industry is worth $350bn, and is exhibiting annual growth of 10 per cent and margins of over 35 per cent. IMS Health predicted a 7 per cent compound average growth to December 2003, reaching $435bn.[2] Total sales of the 14 pharmaceutical firms in the *Fortune* 2000 Global 500 list were $245.4bn with profits of $36.1bn, a healthy 14.7 per cent return on sales. Other industries such as airlines exhibited a mere 3.7 per cent return on sales, and motor vehicle and parts companies a vexing 2.1 per cent, showing the effects of ruthless competition and thinning margins (*Fortune*, 2000).

Global drug sales through retail pharmacies (over the counter segment — OTC) for selected regions in the year to Oct 2000 reached $221.3bn, exhibiting an 11% growth rate during the year. The five best-selling categories during this period were cardiovascular drugs ($42.9bn), central nervous system drugs ($34.7bn), alimentary/metabolic drugs ($33.9bn), anti-infectives ($22.1bn) and respiratory drugs ($20.4bn). Table 1 shows regional growth rates in over the counter drug sales at constant exchange, for the two-year period ending October 2000.

The emerging area of genetic medicine promised the ability to develop targeted therapies for groups of individuals, based on discovering the particular genes involved in a disease and developing medicines targeted at those genes — a process known as pharmacogenomics. By giving drug companies the ability to test patients for adverse reactions before they receive the drugs, genetic technologies could save drugs that would otherwise be delayed, scrapped or prompt multi-million dollar litigation because of adverse side-effects on small parts of the population. Pharmacogenomics can also reduce the time and money it takes to develop new drugs. Whereas it typically takes about 13.5 years, thousands of participants and about $250m on investigating the effects of a promising drug and moving it up to the approval stage, pharmacogenomics can potentially lead to savings of up to $85m and significantly shorten the length of trials by reducing the number of compounds tested, testing only the compounds that are targeted for a particular ailment and by reducing the number of patients participating in testing due to genetic pre-screening (Bhandari *et al.*, 1999).

Tailor-made drugs can then be targeted at genetically well-defined groups of patients that are most likely to respond positively to a particular treatment, and can potentially be sold at premium prices. Industry insiders, however, believed that meaningful results based on genetic technologies would only be achieved in the medium term, by around 2005.

Table 1 Drug Retail Sales for 1998/2000 $USbn

	12 mos to Oct 2000	12 mos to Oct 1999	% growth at constant exchange
North America	101.3	87.8	15
Europe	51.8	54.3	8
Japan	52	45.5	5
Latin America	13.4	12.4	8
Australia/New Zealand	2.9	2.8	12
Total	221.3	202.7	11

Source: Adapted from IMS Health 'Drug Monitor'

The Pharmaceutical Business System

The value chain of the industry is long and complex. Research and Development is the intellectual source of the industry and of new products. It can account for over 20 per cent of manufacturers' sales (vs 12 per cent in 1980). Many believed that a spend of at least $1.5 — $2bn was required to remain a research-led major pharmaceutical company. The traditional product development cycle begins with the search for, and discovery of, a new compound. This process typically takes one year to find one pharmacologically viable new chemical entity (NCE). An NCE then moves into pre-clinical testing for about 2 years and generally one in 20 NCEs survived this stage. Approval is then sought from the appropriate regulatory authority — for example, the Food & Drug Administration (FDA) in the Unites States — to proceed to clinical trials. Clinical testing involves three phases of testing on human subjects. Typically, a year is spent on Phase I safety assessment. A further two years are spent on assessing effectiveness, dosage and side effects in Phase II. Finally, safety in long-term use in large samples of patients is assessed over a period of three years. For every five new drugs entering Phase I, 1.65 typically completed Phase III successfully. On successful completion of clinical trials, a new drug application is filed. It is then reviewed by a regulatory authority. The FDA, for example, may take a further year and a half to complete their review. Between 1990 and 1995 it took, on average, 15.3 years for the total development cycle. One in every 5000 compounds at the discovery stage typically survived to become a new approved drug. Over two thirds of the total R&D cost of a successful new drug was spent on clinical trials (Harvard Business School, 1995).

Patent protection traditionally lasts 17–20 years from filing of a new chemical entity (NCE) and provides a monopoly on an approved drug for about 10 years. In 1994, the GATT extended new patents for 20 years from the NDA application date. Nonetheless, new 'rational drug design' approaches now allowed 'fast-follower' products to be produced very quickly that were therapeutically similar to a novel drug but different enough chemically not to infringe patents. As a result, new drugs often enjoyed no more that a year or less of market monopoly before being attacked by a competitive entry (Harvard Business School, 1998).

The principal raw materials of the industry are the 'active ingredients' for drugs and come from the fine chemicals industry. Manufacturing was traditionally something of a Cinderella activity in the big pharmaceutical firms, often running at 60 per cent capacity and with long lead times. Marketing, sales and promotion were major expense items, accounting for as much as 30 per cent of manufacturers' cost. Seventy five percent of this was attributable to the cost of sophisticated salesforces calling on medical practitioners.

Distribution was effected through a variety of channels — retail pharmacies, hospital pharmacies, mail order, health management organisations/managed care organisations and new Internet pharmacies. The whole system is driven by the illnesses of individuals and the efforts of their physicians to treat or to prevent the occurrence of these illnesses by prescribing suitable drug treatment. In most countries, the economics of the traditional value chain are deeply influenced by method of payment. Many patients do not pay directly, as the cost of the drugs they use is paid by a national public health system, by a health insurance scheme to which they subscribe or by a corporate health scheme. In such circumstances the patient does not worry unduly about the cost of treatment and the physician is concerned with effectiveness. Price is not of greatest concern. However, as the cost of drug treatment rose steadily in the post war years, it became a major source of friction between the ultimate payers and the pharmaceutical industry. Governments, and later managed care organisations, made drug prices a focus of contentious negotiation and the exercise of accumulating buying power.

The downstream end of the business system was transformed by the entry of several new forms of health organisations in the USA in the last decades of the twentieth century. Managed Care Organisations (MCOs) including Health Maintenance Organisations (HMOs) emerged as powerful purchasing groups, providing health services to members who paid an annual fee — in effect health insurance schemes. As they grew they used their purchasing power to nego-

tiate contracts and discounts with providers of health care. With a very real economic incentive, they worked to contain costs through purchasing discounts, emphasis on preventive medicine, primary care, outpatient treatment, the use of formularies and avoidance of hospitalisation and surgery where possible. The latter are the most expensive forms of health care. A formulary lists all the drugs approved by an MCO, an insurer or a public health authority for use for specific medical conditions. It constrains the physician's discretion in prescribing to the more economical options and often indicates the use of a generic substitute rather than a branded ethical drug. By 1996, it was estimated that 86 per cent of MCOs regularly substituted generics for patented drugs where possible (ibid). Changes in US legislation in the 1980s had made it possible to accelerate the approval process for generic drugs. Generic manufacturers had to prove that their products were chemically and biologically equivalent to the original patented drug but they did not have to repeat the clinical trials. As a result, a generic alternative could be launched as soon as a patent expired. Corporations encouraged membership of MCOs. By 1993, 80 per cent of the US population was covered by managed care and MCOs accounted for 75 per cent of drug purchases (ibid). The impact of all these changes in the USA was not lost on European governments and regulators. Since all developed countries faced a huge and growing bill for health care, options for cost containment were always investigated eagerly. In Europe, governments traditionally carried much of a nation's health care cost through public health provision, funded through the tax system. As the nineties progressed they placed more pressure on prices, became more discriminating in relation to what would be reimbursed, introduced the equivalent of formularies and encouraged generic substitution.

Value added through the business system can vary considerably but an example can give a general impression of the economics of the system. A successful blood pressure treatment drug introduced in the late 80s sold at a pharmacy for approximately $665 for a year's supply. The pharmacist typically paid $300 for this and the cost of manufacture was about $50 (op. cit, p. 10). Of the $300 manufacturer's selling price, 30 per cent was attributable to Sales & Marketing; 20 per cent to Manufacturing, 15 per cent to R&D, 20 per cent to Administration, and 15 per cent to profit.[3] As much as half the manufacturing cost could be for raw materials.

Coping with Change

In response to the changing pressures on the industry, companies positioned and repositioned themselves in a variety of ways. Some firms made big bets on scale and scope through mergers and acquisitions. Some bet on new science emerging from genetics, molecular biology and biochemistry. Some invested to exploit new techniques such as 'rational drug design' or combinatorial chemistry which allows chemists to produce several thousand new compounds a year compared to a hundred or so in the past. 'High throughput screening' allowed large libraries of molecules (prized assets) to be screened very quickly. Pharmacoeconomics was deployed to study and quantify the costs and benefits of drugs and compare them with alternative treatment approaches, leading to considerable evidence that certain drug regimes, despite their cost, were far more economical than alternative hospitalisation treatment.

Companies integrated forward into distribution and health care to chase the downstream value added and patient information. They began to outsource traditionally integrated activities including research, clinical trials and manufacturing and specialist companies grew to provide these services. Reaching forward to the patient, companies began to advertise directly to the consumer to generate primary demand and preferences. Traditional research based companies began to produce generics themselves rather than leave this sector of demand to the non-ethical pharmaceutical firms. And they began to plan and introduce 'switches'. 'Switches' were modified formulations of prescription drugs that could be placed on the over-the-counter (OTC) market in pharmacies and general retail outlets for use as self-medication. A successful 'switch' could greatly increase a product's cash flows and prolong its life-cycle.

A Wave of Consolidation

The late nineties saw a quickening in the pace of industry consolidation. In 1988 the top 10 pharmaceutical companies commanded a 25 per cent market share, by 1998 this had risen to almost 40 per cent.[4]

In January 2000, Glaxo Wellcome and SmithKline Beecham announced their $76bn proposed merger, expected to give the combined company a global market share of 7.3 per cent and an R&D budget of $4bn. In February 2000, Pfizer succeeded in its hostile bid for Warner-Lambert, in a deal worth $90bn, to create the second-largest global pharmaceutical company, with an estimated global share of 6.5 per cent and an R&D budget of $4.7bn. Following in terms of market share were AstraZeneca and Merck, with 4.4 per cent market share each, and Aventis, with 4.2 per cent.[5]

Even though this industry was still relatively fragmented, with the largest competitor having a 7 per cent share of the global market, regulatory authorities such as the US Federal Trade Commission still had concerns regarding anti-competitive practices. According to a spokesman:

Clearly if the FTC is assigned (to the case) then we would have to look into whether there are any anti-competitive concerns … We're looking out for potential problems that could result in anti-competitive practices to ensure that transactions, whatever the size, do not hinder competition in a way that's going to hurt consumers, or other businesses.[6]

The FTC may require companies engaged in mergers to sell some of their drugs to competitors if the merged entity controls a significant market share for that particular drug category. The proposed Glaxo SmithKline merger, for example, raised such concerns with the US Federal Trade Commission because of significant product overlaps in antidepressants and antiviral treatments.

Why Merge?

Nothing keeps pharmaceuticals executives awake at night like the prospect of cheap generic substitutes flooding their most profitable niches. (*Fortune*, 1998)

Given promising future prospects and a growing market, what prompted firms to look for partners in a hurry? It was argued that drug companies were facing trends that could raise costs as well as compromise future earnings.

First, R&D investment was rising. An increasing proportion of sales was spent on R&D, which had risen from about $20bn annually in the early 1990s to about $35bn in 1999.[7] AstraZeneca, for example, spent 19.8 per cent of its 1998 sales on R&D, Hoffmann-La Roche 19.1 per cent, and Eli Lilly 18.8 per cent.[8] Whereas pharmaceutical companies had been able to enjoy years of effective patent protection from imitators, in some cases rivals could now study patent applications and apply new methods to come up with similar drugs which didn't violate the patent — often less than a year after the original drug was launched. Screening-speed was crucial, as only one out of 7 million compounds screened made it to market (*Fortune*, 1998).

Investments in R&D and particularly the emerging area of genetic medicine have a long and uncertain payback period and drug firms believed that larger size could help their ability to invest the vast sums required.

Many patents would expire early in the new century, compromising those drugs' profitability, as generic versions appeared. A patent expiry can reduce the innovator's sales by as much as 80 per cent. For example, during 1999–2005, patents on 10 of Merck's products accounting for $6.8bn in sales would expire; nine patents held by Bristol Myers Squib accounting for $6.1bn of sales; and six patents held by Pfizer, accounting for $4.7bn in sales. In total, between 1999 and 2005, US patents would expire on 178 drugs worth about $60bn.[9] During the three year period 2001–3 inclusive, drugs with annual revenues of $44bn will lose their patent protection.[10] It was argued that merging research laboratories and product pipelines could give firms added knowledge from which potential blockbuster drugs could emerge.

Marketing costs were rising too, in terms of salespeople employed and in terms of the rise of new direct-to-consumer advertising as opposed to only marketing to physicians. From fewer than 40,000 salespeople employed by US drug firms in 1995, the number was about 65,000 in 2000 and rising.[11] Direct-to-consumer marketing emerged after the US Food and Drug Administration issued new guidelines 1997 allowing drug companies to specify the uses of prescription drugs in advertising. Whereas in 1995 direct-to-consumer advertising spending was $313m, in 1998 it rose to $1,172m, and was projected to double in 2000, to about $2300m (Aitken and Holt, 2000). It was argued that larger size enabled merged firms to pool their marketing and financial resources to respond to the scale of sales and promotional demands.

In addition to mergers and acquisitions, pharmaceutical companies had formed elaborate webs of strategic alliances. Ten large pharmaceutical companies, for example, formed a $45m joint research consortium to study human DNA (*Economist*, 1999), and AstraZeneca had set up more than 600 collaborations with biotechnology companies and university labs. Some analysts believed that more specialization would develop between the functions of 'Research' and 'Development', with smaller organisations doing more of the research and larger ones doing more of the development. According to the CEO of Vertex:

This is an industry where 97 out of 100 attempts to make a product fail … In a rapidly changing technology picture, the small organisation has an advantage. (*Business Week*, 1999b)

Have Mergers Delivered?

Of the dozen or so larger mergers and acquisitions over the past 30 years, not a single one has increased the combined market share of the companies involved … The profitability of merged firms has suffered too. The return over and above the invested capital appears to fall after mergers. In the largest deals of the past decade, the returns achieved by the firms involved had on average fallen from over 12 per cent to 4 per cent three years after they were completed. (*Economist*, 1998)

In virtually all pharmaceutical mergers except one (Bristol-Myers Squibb), the merged entities had lower market share in the years after the merger than they had separately before the merger. For example, Hoechst Roussel's market share declined by over 50 per cent after the merger, Ciba-Geigy's market share declined by over 20 per cent, and Glaxo Wellcome's

market share by over 15 per cent. In contrast, during the 1990–98 period, Pfizer's market share had risen by over 80 per cent as a stand-alone entity, Abbott's by over 70 per cent and Schering-Plough's by over 40 per cent. None of these firms had engaged in merger activity during this period (*Economist*, 2000a).

Even though pharmaceutical CEOs would not agree that short-term cost cutting was the primary objective of merging, industry observers such as the president of Cambridge Pharma Consultancy believed that 'those savings have largely driven deals to date' (*Business Week*, 1999a). Analysts cited examples such as Ciba-Geigy and Sandoz that merged to form Novartis in 1996. By 1998, the combined entity had cut $1.2bn in costs and so achieved growth in profits of 16 per cent even though sales increased by only 2 per cent. A 1996 McKinsey article explicitly urged pharmaceutical companies to merge in order to achieve cost synergies 'to create immediate value for companies, in a way that is relatively easier than pursuing traditional innovation' (Pursche, 1996).

A study by the Boston Consulting Group that looked at 40 pharmaceutical and biotechnology companies between 1992 and 1997 found that, on average, large companies were not more innovative than smaller ones, and that size does not make a company more innovative. In fact, pharmaceutical companies were spending more money on licensing innovations from smaller biotechnology firms and were facing more competition from each other to win the license for promising new drugs. A 1999 survey of large pharmaceutical firms by McKinsey consultants found that whereas 5 years earlier 90 per cent of large pharmaceutical companies spent less than 10 per cent of their R&D budget on licensing drugs from other companies, in 1999 only 40 per cent spent less than 10 per cent; 30 per cent of companies spent between 10 and 20 per cent of their budget, and 30 per cent of companies spent over 20 per cent of their budget. Five years earlier 67 per cent of respondents faced less than three competitors for a given licensing deal. In 1999 no one faced less than three competitors; 56 per cent faced 3–5 competitors; and 44 per cent faced 6–8 competitors. Out of 55 blockbuster drugs with revenues of over $500m in 1998, 14 were licensed from outside organisations (Aitken *et al*., 2000).

The difficulty of post-acquisition integration was hard to ignore. Marrying two diverse corporate cultures and merging two large-scale research teams was not an easy task. Sometimes mergers were called off because CEOs could not even agree who would be in charge, such as the failed Glaxo SmithKline Beecham merger of February 1998. The former Chief Operating Officer, Sean Lance remarked that:

> They've made a right real cock-up of the negotiations Megalomania seems to be the driving force of these mergers. Egos are taking precedence over future strategies. (*Fortune*, n.d.)

Some analysts questioned the prospects of the Glaxo SmithKline merger and called it:

> a marriage of convenience — with lots of tough issues to be worked out … SmithKline is wedding itself to a slow-moving company with a lacklustre pipeline of new drugs coming to market. (*Barron's*, 2000)

In 1999, Pfizer had denied any merger rumours, and had managed to fill its drug pipeline on its own more effectively than merged rivals — both internally and through strategic alliances (*Fortune*, 1998). In addition to its effective innovations, Pfizer was also aided, at least once, by 'smart luck'. The popular Viagra drug was discovered when in clinical tests aimed at testing Viagra's heart treatment capabilities, it was found to have unexpected effects and was swiftly developed as an impotence treatment. Pfizer arranged in 1997 to jointly market the blockbuster cholesterol-lowering agent Lipitor developed by Warner-Lambert. Lipitor's 1999 sales were $3.73bn. Analysts believed that Pfizer's hostile bid for Warner-Lambert in 2000, that wrestled the company away from its former suitor, American Home Products, was really aimed at gaining full control of Lipitor as opposed to achieving any of the purported merger benefits and objectives cited by firms planning to merge.[12]

In the meantime, consumer groups were concerned with the wave of consolidation in the industry, believing that previous consolidation had provided no benefits to consumers. According to the legislative director of the Consumer Federation of America:

> What we have pointed out is that we often hear promises of greater resources devoted to R&D (as a result of a merger), but there is absolutely no proof that in the mergers over the last three to five years that that has occurred.[13]

Creating Value

Following the merger announcement in January 2000, Sir Richard Sykes, CEO of Glaxo Wellcome was upbeat:

> With this merger we are bringing together two world-class organisations with complementary technologies and scientific knowledge. The new organisation, led by one of the sector's most talented and experienced management teams, will be at the forefront of an industry which will continue to undergo rapid scientific and economic change.

Glaxo Wellcome shareholders would receive 58.75 per cent of the merged company, and SmithKline Beecham's shareholders 41.25 per cent. Projected cost savings were around $1.8 a year, to be comprised of combining their R&D operations, manufacturing consolidation and substantial headcount reductions (Gopal, 2000).

At the end of August 2000 shareholders approved the

merger of the two companies by a 99 per cent majority. Garnier was granted share options which would be worth about UK£15m if Glaxo SmithKline shares doubled in price in three years. The merger was expected to be completed in the Autumn following approval by the US Federal Trade Commission and the UK High Court (*Financial Times*, 2000). Whereas the European Union approved the merger in May, and required SmithKline to divest three drugs (sold for $2.86bn), scrutiny by the US Federal Trade Commission had been more exacting than expected, focussing on drugs in development in addition to simply drugs on the market. The merger was delayed till the end of the year, and resulted in the divestment of further drugs in order to preserve market competition. Finally, on December 27th 2000, the merged company was officially born after the FTC's approval.[14]

Analysts noted that in order to meet significant growth targets, big pharmaceutical companies would have to innovate blockbuster medicines, which was no easy task. The market was so fragmented that without blockbuster drugs, a company could not achieve substantial increases in market share. In 1998, for example, the top 20 drugs accounted for 13 per cent of the global market, and the top 100 drugs for 31.1 per cent. Whereas Glaxo Wellcome launched only two drugs (out of 18) worth over $1bn or more in sales during 1995–1999, SmithKline Beecham launched none in this bracket of revenues (out of eight drugs launched). Given the long development cycles and research commitments under way, it was argued that the merger would not substantially influence Glaxo's prospects (Ansell, 2000).

Further, the difficulties of implementation were noted. According to Mara Goldstein of CIBC World Markets,[15]

> You just can't put aside that these companies have been rivals for many years; at some point, you will get a stronger entity than either company is on its own, but execution is key … Glaxo Wellcome has been able to get a number of products out the door, but none of them has really had the oomph that they needed.

Whereas Glaxo Wellcome is highly decentralised allowing high autonomy to its divisions, SmithKline Beecham is the opposite, exerting tight control. Whereas GW prefers to enter new markets and to dominate them with several products, SB tends to move into mature markets and gain market share through intensive marketing. Add to these old rivalries between the two companies, and integration may not be an easy task (*Economist*, 2000b).

Given such adverse predictions and concerns, and aiming to beat the odds of the sad history of large mergers not only in his own but in most industries, Jean-Pierre Garnier settled down to the task for which he would be held fully accountable: making the merger work and increasing shareholder value.

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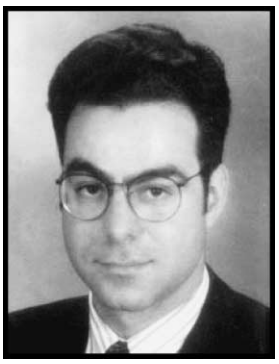

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