Fractal Force

The Complete Guide On “Who Owns the Customer Journey?”

Operating Models for HCP Engagement in Life Sciences

Insights from Senior Leaders Across Global, Regional & Local Pharma

Paper Structure

This white paper is organised as follows:

- **Section 1** establishes that the HCP engagement crisis stems from organisational ambiguity about journey ownership, not technology gaps, and that resolving this question is the prerequisite for all downstream engagement success.

- **Section 2** introduces the three operating model archetypes identified through our research, providing detailed descriptions of governance structures, decision rights, advantages, disadvantages, and optimal use cases for each.

- **Section 3** addresses the global-regional-local coordination challenge, including the "glocal" model tension, the emerging "blueprint market" pattern, and best-practice RACI frameworks.

- **Section 4** examines Medical Affairs integration and how leading organisations build "compliant gates" in the regulatory firewall to enable scientific-commercial collaboration.

- **Section 5** explores field force integration, contrasting the legacy "rep as orchestrator" model with the emerging "rep as channel" paradigm and examining hybrid implementations.

- **Section 6** provides diagnostic frameworks and migration roadmaps, enabling readers to assess their current state and chart an evolution path aligned to organisational maturity and strategic priorities.

- **Section 7** concludes with key takeaways and a critical bridge to our next White Paper: even optimised operating models fail without addressing three foundational bottlenecks (data architecture, content velocity, and measurement systems).

Executive Summary

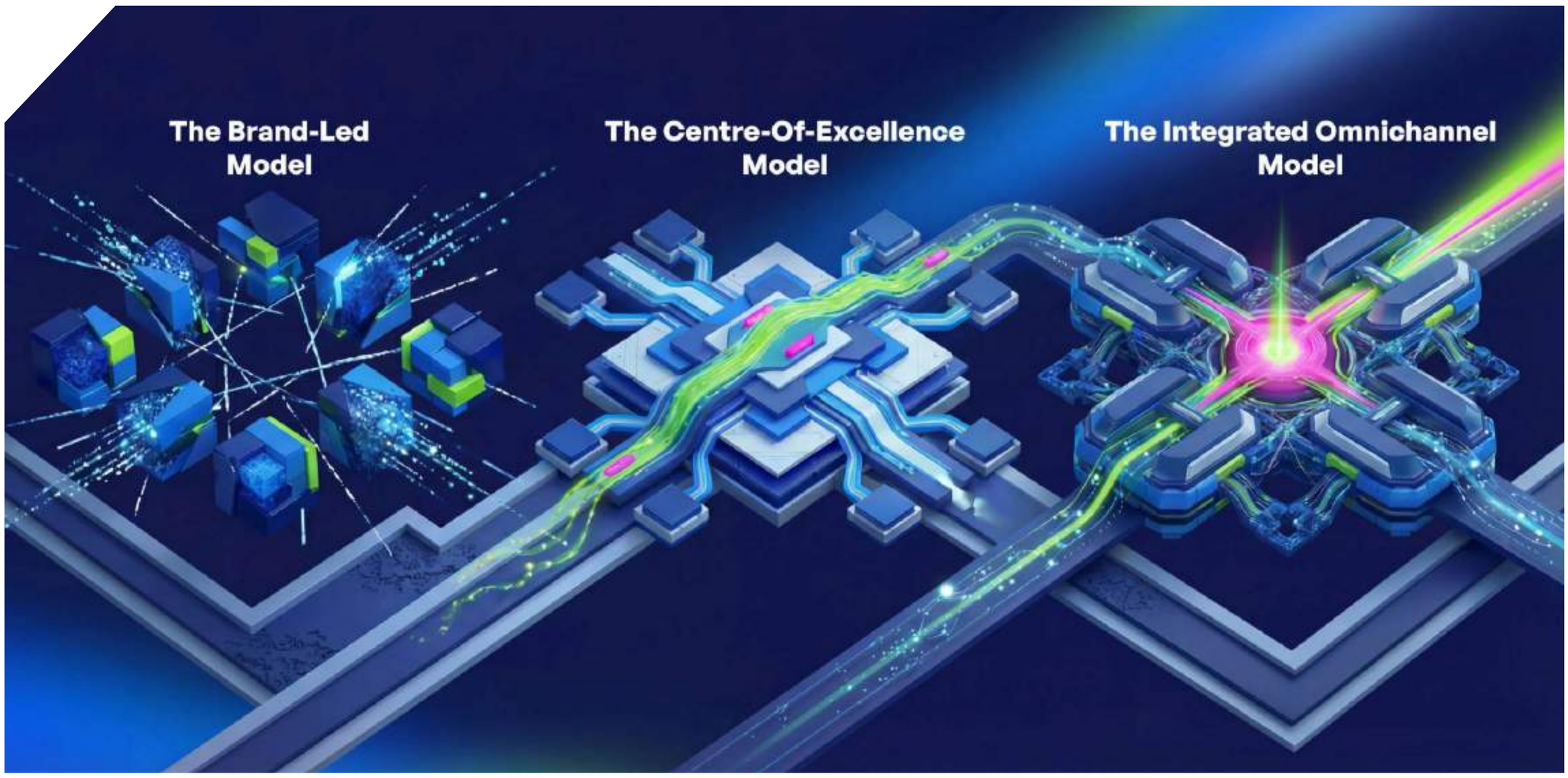
The life sciences industry is at a pivotal point in how it engages with HCPs. Despite billions invested in CRM systems, CDPs, AI, and marketing automation tools over the past decade, HCP engagement remains fragmented, inconsistent, and frustratingly ineffective. A clear perception gap highlights this crisis: The IQVIA Institute for Human Data Science reported in 2024 that while 82% of life sciences executives are satisfied with their current customer engagement strategies, only 28% of HCPs believe pharmaceutical companies meet their needs.

This white paper, based on in-depth interviews with more than 12 senior leaders spanning global headquarters, regional commercial excellence functions, and local market operations across both large and mid-size pharmaceutical companies, addresses a fundamental question that has eluded the industry: Who owns the customer journey?

Our research reveals that the root cause of HCP engagement fragmentation has a dual organisational dimension. The first is clarity: ambiguity about which function holds authority for journey design, how decision rights flow between global, regional, and local teams, and how cross-functional coordination is architected. The second is structural agility: the degree to which organisational design enables responsive execution. Global centralisation of infrastructural support (technology platforms, AI tools, content systems, data architecture,...) often creates dependencies that, regardless of decision-rights clarity, limit the velocity required for iterative, market-responsive engagement. Customer-facing chaos emerges not just from unclear authority but from structures that prevent those with authority from executing quickly.

Three Operating Model Archetypes

Through systematic analysis of interview data, we identified three distinct operating model archetypes that pharmaceutical companies employ to govern HCP engagement:



The Brand-Led Model (Decentralised)	The Centre of Excellence-Led Model (Centralised/Hybrid)	The Integrated Omnichannel Model (Customer-Centric)
Prevalence: Approximately 60-70% of organisations	**Prevalence:** Approximately 25-30% of organisations	**Prevalence:** Approximately 5-10% of organisations
Characteristics: Individual brand teams operate as semi-autonomous business units with full P&L responsibility and authority over journey design, content creation, and execution	**Characteristics:** A central Centre of Excellence (e.g. Omnichannel/Digital Excellence) function provides shared platforms, standardised processes, and enterprise capabilities; brand teams retain strategic authority	**Characteristics:** Cross-functional "journey pods" organised around HCP segments (not brands) with devolved authority for test-and-learn cycles
Primary Advantage: Speed, agility, and deep therapeutic area expertise	**Primary Advantage:** Efficiency, consistency, and the ability to build enterprise-level capabilities (data science, advanced analytics)	**Primary Advantage:** Purpose-built for seamless customer experience and breaks down functional silos by design
Primary Disadvantage: Can create HCP-facing fragmentation as multiple brands from the same company contact the same physician with sometimes uncoordinated messages	**Primary Disadvantage:** Can stifle brand agility and create "one-size-fits-all" solutions that don't fit specialised brands or unique markets	**Primary Disadvantage:** Requires massive transformation investment, high digital maturity, and cultural change

Key Findings

Our research surfaced five critical insights :

1 Operating Model Ambiguity and Structural Constraints Drive Fragmentation

Organisational clarity about decision rights is essential, but clarity alone is insufficient. Companies that attempt to layer sophisticated marketing automation or AI-powered personalisation onto unclear decision-rights structures inevitably fail. However, even organisations with explicit RACI frameworks struggle when global centralisation of infrastructural support creates dependencies that limit local execution velocity. Technology investments cannot compensate for this dual organisational challenge: ambiguity about who decides, and structural constraints that prevent those with authority from executing quickly.

2 The "Glocal" Model Creates Hidden Friction

The universal "global strategy, local execution" approach sounds elegant in theory, but it leads to ongoing negotiations about what is "core" (non-negotiable) versus "adaptive" (local discretion). Leading organisations adopt explicit three-tier models with "blueprint markets" that connect global and local. However, the dependency on global infrastructural support for technology, content, and data remains a significant barrier to the agility required for responsive local execution.

3 Medical-Commercial Integration Remains Elusive

Despite universal acknowledgement that HCPs demand scientific depth, the regulatory firewall between Medical Affairs and Commercial functions continues to create customer-facing fragmentation. Only one interviewed organisation reported genuinely shared KPIs across these functions.

4 The "Rep as Orchestrator" Model is Breaking

The traditional field-force-centric model is increasingly unable to incorporate digital engagement at scale. The emerging "rep as channel" paradigm, where marketing orchestrates and representatives deliver high-value face-to-face touchpoints within an integrated journey, offers superior customer experience and efficiency. However, this shift challenges the DNA of pharmaceutical commercial operations, built over 100+ years around the rep as the centre of gravity. Organisations face not just sales leadership resistance, but fundamental questions of identity, power, budgets, and incentive systems. Success demands mindset transformation at the most senior levels.

5 No Universal "Best" Model Exists

Operating model choice must be contingent on six factors: company size, portfolio complexity, market heterogeneity, digital maturity, regulatory environment, and competitive intensity. Organisations that blindly copy competitors' structures without considering their own context inevitably fail.

A Critical Warning: Operating Models Are Necessary, But Not Sufficient

Even organisations that successfully diagnose and optimise their operating model discover a sobering reality: **three foundational bottlenecks prevent execution.** Our interviews revealed near-universal frustration with:

1. **Data Architecture** → Fragmented customer data across systems prevents the unified HCP view required for orchestration
2. **Content Velocity** → MLR approval cycles of 3-9 months render journey iteration impossible
3. **Measurement Systems** → Inability to link engagement activities to prescription behaviour undermines credibility and budget defense

These three bottlenecks will be addressed systematically in our next White Paper: "Breaking the Bottlenecks: Data, Content, and Measurement Foundations."

Section 1 - Introduction | The Orchestration Crisis

The Omnichannel Promise vs. Reality

For more than a decade, the life sciences industry has pursued an ambitious “omnichannel” vision: seamless, personalised, value-driven engagement with HCPs across all touchpoints: face-to-face meetings, virtual calls, approved emails, HCP portals, social channels, medical affairs interactions, scientific congresses, and beyond. Consultants and technology vendors promised that the convergence of CRM systems, marketing automation platforms, and AI would finally enable pharmaceutical companies to deliver the "right message, to the right HCP, through the right channel, at the right time."

According to Accenture’s 2023 report Digital Transformation in Pharma Commercial Models, the global pharmaceutical industry invested approximately $12.8 billion in digital marketing and customer engagement technologies between 2020 and 2023. Major pharmaceutical companies deployed sophisticated technology stacks: enterprise CRM systems (predominantly Veeva), marketing automation platforms (Salesforce Marketing Cloud, Adobe Marketo), content management systems, event management platforms, and increasingly, Customer Data Platforms designed to unify customer data across all touchpoints.

Yet despite these massive investments, a profound disconnect persists between the industry's self-assessment and customer reality. A 2024 study by IQVIA found that while 82% of pharmaceutical executives expressed satisfaction with their customer engagement strategies, only 28% of HCPs reported that pharmaceutical companies adequately meet their information needs. This 54-percentage-point perception gap represents not a communication problem, but a systemic failure.
The gap manifests in HCP experiences that one of our interview subjects acknowledged with remarkable candour:

> *"As you very likely agree, we've got to have a unified voice to the customer. It doesn't make any sense that medical does something, brand does something, commercial excellence does something."*

HCPs report receiving:

- Uncoordinated emails from multiple brands within the same company promoting different products for the same therapeutic indication
- Sales representative visits that ignore or contradict the digital content the HCP recently consumed
- Medical Science Liaison outreach that duplicates or conflicts with commercial messaging
- Congress invitations from three different teams within the same organisation

The omnichannel dream has become, for many HCPs, an omnichannel nightmare: more touchpoints delivering more noise, not more value.

Why Technology Alone Doesn't Solve the Problem

The industry's instinctive response to engagement challenges has been technological. If the current CRM isn't delivering orchestration, buy a CDP. If the CDP isn't generating insights, add an AI-powered Next-Best-Action engine. If NBA recommendations aren't driving adoption, implement a more sophisticated personalisation platform.

Multiple interviewees described this "shiny object" cycle: "Technology vendors sell us vision; we buy tools we're not ready to use."

The cycle typically follows this pattern:

1. Executive mandate: CEO reads article about AI tools and mandates "AI strategy"

2. Technology procurement: Team purchases Next-Best-Action engine with promising vendor demos

3. Pilot launch: Field force receives recommendations

4. Field force rejection: Representatives ignore recommendations: "This doctor retired three years ago" or "Why are you telling me to promote Product A when I just detailed Product B last week?"

5. Project shelved: Initiative quietly abandoned and technology sits unused

6. Next mandate: Process repeats with the next technology trend

The root cause is not technological inadequacy. The platforms themselves are often advanced and capable. Instead, the issue is **organisational.** Technology amplifies existing processes and structures. When those structures are siloed, unclear, or misaligned, technology reinforces the silos rather than dismantling them.

A particularly revealing debate emerged in our interviews around the technology architecture itself. This is how someone described the fundamental tension:

> *"This whole big battle is going on between Salesforce and Veeva CRM. I don't think that Veeva can continue to be the centre of gravity. It's going to be through what you call CDP. You're ending up in a Customer 360 view."*

Another leader made the point more forcefully:

> *"We've been led by Veeva in a very field force-focused world, while we shouldn't. We should actually turn it around. It should be the industry from a customer perspective leading the design of the software infrastructure."*

This debate about Veeva versus Salesforce versus CDP is actually a proxy for a deeper organisational question: **Who sits at the centre? Is it the sales representative or the customer?** Technology vendors each promote their platform as the "system of record," but the real question is: **What organisational structure should determine the technology architecture, not vice versa?**

Organisations that allow technology vendors to dictate their operating model inevitably find themselves in what one interviewee called "an incentive model". Veeva's business model depends on field force seat licenses, so naturally, their architecture puts the rep at the centre. Salesforce's model emphasises marketing automation, so their architecture centres on the marketing function. Neither may be wrong, but neither should be the starting point.

→ The starting point must be: **Who in our organisation should own the customer journey?**

The Real Question: Who Owns the Journey?

The question "Who owns the customer journey?" manifests in three forms, each revealing a different dimension of organisational ambiguity:

Question 1: Which Function Leads?

- Does the Brand team design journeys (with marketing, medical, and sales as executors)?
- Does Commercial Excellence own journey design (with brands as clients)?
- Does an Omnichannel Centre of Excellence orchestrate (with functions as channel owners)?
- Does Medical Affairs co-own (given HCPs demand scientific depth)?
- Does an Executive Steering Committee govern (with execution delegated)?

Question 2: What Decisions Live Where?

The global-regional-local dimension adds complexity:

- Does Global HQ define the journey strategy with local execution?
- Do Regional teams design operational journeys with global providing frameworks?
- Do Local markets build their own journeys with global content as input?
- Who decides: content sequencing, channel mix, budget allocation, technology choices, performance metrics?

Question 3: Who Resolves Conflicts?

When the brand team wants one message sequence, medical affairs insists on different content, sales leadership demands rep control, and digital teams advocate marketing automation. Who decides?

Our research revealed that these questions remain unanswered or ambiguously answered in the majority of organisations. One interviewee described the local ownership pattern at their organisation:

> *"Who takes the lead on designing the customer journeys? It's local. That's local markets. Global designs high-level key messages, brand guidelines, key message platform. Then local comes in and designs their customer journeys based on what global decided."*

Yet another leader at a different organisation described precisely the opposite pattern:

> *"For global initiatives, it's the Global Omnichannel Lead. He's really the one who sits down with marketing and their agencies to define what that customer journey looks like."*

Both patterns can work. However, the ambiguity about which pattern applies creates organisational paralysis, duplicated effort, and ultimately, the fragmented HCP experience.

Another interviewee with a regional function summarised the orchestrator ambiguity elegantly:

> *"The real orchestrator for me is not the rep, it's marketing."*

Yet in many organisations, sales leadership would vehemently disagree, insisting that the sales rep, as the owner of the HCP relationship, must be the orchestrator. The lack of resolution to this debate manifests as technology architecture battles (CRM-centric vs. marketing-automation-centric), budget allocation conflicts (field force investment vs. digital investment), and ultimately, unorchestrated customer experiences.

The thesis of this white paper is simple → Organisational clarity about journey ownership is the prerequisite for HCP engagement success.

Technology, data, content, and measurement capabilities are all essential. But without first resolving the organisational question, those investments deliver disappointing returns.

Research Methodology & Paper Structure

This white paper is grounded in primary research: in-depth interviews with more than 12 senior leaders spanning global headquarters, regional commercial functions, and local market operations across multiple pharmaceutical companies. We complemented these insights with our extensive experience and expertise, gained through our work with various life sciences companies at global, regional, and local levels. To ensure candour and confidentiality, the quotes have been anonymised.

Geographic Level	Function	Company	Name
Global	Omnichannel Head Emerging Markets	GSK	Marc Koolen
Regional	Omnichannel Strategy Director	Kyowa Kirin	Mark Wheeler
Global	Global Omnichannel Experience Standards Lead	MSD	Yazan Iwidat
Local	Customer Experience Lead	MSD	Ara Cabeza Llata
Global	Global Field Excellence Lead	Astellas	Michael Van Hauwermeiren
Regional	Business & Customer Excellence Director	Ipsen	Rick Hollis
Global	Senior Consultant	Independent	Salma Esseghir
Global	Senior Consultant	Independent	Yacin Marzouki
Global	World Operations Digital Lead	Servier	Laetitia Huret
Local	Associate Director Customer Experience	Lilly	Stan Bilinski
Regional	Omnichannel Lead GenMed North Europe	Sanofi	Matteo Roset

Geographic Coverage:

United States, Europe, and references to Asia-Pacific operations

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Interview Protocol:

Duration: 45-60 minutes per interview

Structure: Standardised questionnaire covering eight domains:

1. Organisational context and maturity
2. Team leadership and ownership
3. Decision-making and governance
4. Cross-functional coordination
5. Technology and tools
6. Journey complexity and design
7. Content creation and management
8. Performance and learnings

Coding Methodology: Thematic analysis using Fractal Force's Five Foundation Pillars framework:

1. Data & Analytics Architecture
2. Segmentation
3. Engagement Journey Design
4. Agile Operating Models
5. Impact Measurement Frameworks

Anonymisation Commitment: All quotes in this white paper have been verified against interview transcripts. Where necessary to preserve anonymity, minor details have been generalised without altering substantive content.

Secion 2 -The Three Operating Model Archetypes

Through systematic analysis of interview data, organisational charts, and decision-flow descriptions, we identified three dominant operating model archetypes in HCP engagement. Each archetype reflects fundamentally different choices about **centralisation versus decentralisation, decision rights allocation, and functional accountability.**

Understanding your organisation's current archetype and whether it aligns with your strategic context is the crucial first step towards organisational clarity. Attempting to implement "best practice" processes from a different archetype without first addressing structural misalignment inevitably results in failure.

Archetype 1: The Brand-Led Model (Decentralised)

The Brand-Led model has been the historical default for pharmaceutical companies, particularly those that grew through brand-building rather than platform technologies. In this archetype, individual brand teams operate as semi-autonomous business units, each responsible for driving the entire commercialisation process for a specific product or franchise.

Core Structural Characteristics:

→ Decision Rights
Brand teams, typically led by a Brand Director, Global Brand Lead, or Franchise Head, hold full P&L responsibility and corresponding authority over all aspects of customer engagement. This includes journey design, content creation, budget allocation, channel selection, agency relationships, and performance metrics.

→ Organisational Structure
Each brand team is cross-functional within itself, often including dedicated or matrixed resources from marketing, sales (dedicated representatives or overlay model), medical affairs, and market access. Global brand teams set overall strategy, while regional and local brand teams retain significant autonomy to adapt tactics to market-specific dynamics.

→ Coordination Mechanism
Cross-brand coordination is typically voluntary or facilitated through informal networks rather than mandatory governance structures. Global headquarters may provide high-level playbooks, brand guidelines, or best-practice sharing forums, but enforcement is limited.

→ Technology Architecture
In pure Brand-Led models, individual brands sometimes procure their own analytics tools, content management solutions, and manage agency relationships. CRM systems are shared, but usage patterns, data standards, and reporting vary by brand.

Real-World Manifestations:

An interviewee at a large pharmaceutical company described the brand-led coordination pattern at their organisation:

> *"For now, it's still split really by portfolio, brand. At least the key stakeholders, marketing, medical, and commercial, are working together with the same plan for the brand or the portfolio."*

Another leader described the customer-facing consequence of this model:

> *"There are a lot of stakeholders and a lot of points of contact, and potentially high overlap toward the same customer in terms of speciality. We have portfolios that cross each other on some specific specialities within the HCPs."*

This overlap is the natural consequence of brand autonomy: when three brand teams independently target the same oncologist with three different messaging strategies, coordination depends on voluntary alignment rather than structural mandate.

Advantages of the Brand-Led Model

Speed and Agility

Brand teams can react swiftly to competitive moves, emerging clinical data, or market opportunities without navigating bureaucratic approval layers. When a competitor launches a new product, the brand team can pivot messaging and reallocate budget within days or weeks, not months.

Deep Therapeutic Area Expertise

Concentrated focus allows brand teams to develop a profound understanding of their therapeutic area, disease pathophysiology, competitor landscape, and HCP prescribing behaviours. This depth is particularly valuable in complex speciality areas (oncology, immunology, rare diseases) where scientific nuance matters.

Clear Accountability

Success or failure rests clearly with the brand team. P&L responsibility creates strong incentives for performance and enables rapid decision-making without diffusion of accountability across functions.

Market Responsiveness

Local brand teams can adapt strategies to market-specific dynamics (e.g., different healthcare systems, formulary requirements, HCP preferences, or regulatory constraints) without seeking global approval for every tactical variation.

When the Brand-Led Model Works:

Despite its limitations, the Brand-Led model remains optimal in specific contexts

- **Small-to-mid-size pharmaceutical companies** with focused portfolios (2-5 brands) where duplication costs are manageable, and coordination overhead would exceed efficiency gains
- **Speciality pharmaceutical companies** where each brand targets distinct HCP segments with minimal overlap (e.g., a rare epilepsy drug targeting 200 pediatric neurologists, a haemophilia drug targeting 150 haematologists, an orphan oncology drug targeting 300 oncologists, with no cross-targeting)
- **Highly competitive therapeutic areas** requiring rapid tactical response where agility trumps consistency (e.g., PD-1 inhibitor market, where competitive positioning shifts monthly based on new trial data)
- **Markets requiring** significant local customisation (Japan, China), where global standardisation would be culturally or regulatorily inappropriate

Disadvantages of the Brand-Led Model

HCP-Facing Fragmentation (The Critical Flaw)

From the HCP's perspective, the company does not present as a unified entity. Instead, they experience:

- Multiple sales representatives from the same company (each representing a different brand) requesting meetings
- Uncoordinated emails promoting overlapping or contradictory solutions
- Duplicate invitations to advisory boards or congress events
- Medical Science Liaisons and sales representatives providing inconsistent information

A leader described the recognition of this problem and the attempted solution:

> *"We engage by speciality toward HCPs and not by product. So we have a cross-communication: for cardiologists, teams work together sending and contacting one target instead of having maybe three, four teams contacting the same target with four topics."*

However, implementing this coordination in a Brand-Led structure requires voluntary cross-brand collaboration. Achieving this is challenging when brand teams have competing incentives and priorities.

Resource Duplication and Inefficiency

Each brand builds redundant capabilities:

- Separate analytics teams analysing the same HCP universe
- Multiple agencies creating content in similar formats
- Duplicate technology procurements (journey orchestration tools, personalisation engines)
- Parallel training programs for sales forces

One interviewee noted the historical pattern

> *"Every team needed to have their own separate setup, their own budget allocations."*

In a company with 10-15 major brands, this duplication represents tens of millions in unnecessary spending.

Data Silos and Hoarding

Brand teams naturally view HCP data as proprietary competitive intelligence. Sharing data with other brands might reveal strategic insights or HCP preferences that could benefit a competing franchise. This creates fragmented customer data: the same physician appears as separate records in each brand's systems, preventing enterprise-level segmentation or orchestration.

Inability to Build Enterprise Capabilities

Advanced capabilities like Customer Data Platforms, AI/machine learning models, sophisticated attribution analytics require scale, investment, and specialised expertise. Individual brand teams lack the budget, headcount, or technical sophistication to build these capabilities. The Brand-Led model structurally prevents the consolidation required for next-generation capabilities

Archetype 2: The Centre Of Excellence-Led Model (Centralised/Hybrid)

The Centre Of Excellence model typically emerges as a direct organisational response to the manifest inefficiencies and customer-facing failures of the purely decentralised Brand-Led approach.

This archetype establishes a central function (often named Commercial Excellence, Commercial Operations, Digital Excellence, or Omnichannel Centre of Excellence) tasked with providing shared services, building enterprise-wide capabilities, and standardising processes that would be too costly or inefficient to replicate within each brand silo.

Core Structural Characteristics:

→ Decision Rights (Bifurcated)
This model's defining feature is the bifurcation of authority:

- **Brand teams** retain control over the strategic "what": brand positioning, core messaging, scientific narrative, target segment prioritisation

- **Centre of Excellence** controls the operational "how": standardised platforms, processes, templates, tools, and enabling infrastructure

For example, the Brand team decides on the campaign message and target HCP segment, but the Centre of Excellence team defines the email template, deployment process, and the marketing automation platform through which execution occurs.

→ Organisational Structure
A central Centre of Excellence function (typically 10-50+ FTEs depending on company size) owns:

- Technology stack (enterprise CRM, marketing automation, analytics platforms, content management)

- Data governance and master data management

- Sales force effectiveness (SFE), training, and performance management

- Omnichannel orchestration and journey templates

- Analytics, reporting, and business intelligence

Brand teams continue to exist and hold budget authority but must utilise centrally-provided infrastructure.

→ Coordination Mechanism
Mandatory compliance with central standards, reinforced through:

- Required use of enterprise platforms (cannot procure separate tools)

- Centralised budget approval for technology and agencies

- Governance committees (monthly or quarterly) with brand and CE representation

- Service-level agreements defining CE's obligations to brands (e.g., "journey template requests delivered within 6 weeks")

→ Technology Architecture
Consolidated enterprise stack with a single instance of Veeva CRM (or Salesforce Health Cloud), single marketing automation platform (Salesforce Marketing Cloud or Adobe Marketo), unified data warehouse, and enterprise analytics tools. Integration across platforms is architected and maintained centrally.

→ Real-World Manifestations:
An interviewee described the hybrid collaboration model at their organisation:

> *"We have a digital lead, omnichannel expert. They're the guys that know their way around the systems, when we should use Veeva versus Salesforce Marketing Cloud. They'll be working in collaboration with the marketing leads for either that country or cluster."*

A leader at another organisation described the centralised content factory approach:

> *"Everything is done centrally: central cookies, central everything you can imagine. We call this the content factory. The content factory supports local entities to create their own local initiatives digitally or take the global content and localise it."*

This centralisation delivers efficiency but also creates the tension that multiple interviewees described.

Advantages of the Brand-Led Model

Efficiency and Cost Reduction

By eliminating redundant systems, tools, and headcount across brands, organisations typically realise 20-40% cost savings in technology and operations:

- Single CRM contract (not 10 separate Veeva instances)
- Consolidated marketing automation platform (one contract, one implementation)
- Shared data science team (not separate analysts per brand)
- Centralised content production (economies of scale)

According to a 2023 Deloitte study of commercial model optimisation in pharma, companies transitioning from Brand-Led to Centre of Excellence-Led models reported average technology cost reductions of 35% over three years.

Consistency and Customer Experience

Standardised processes mitigate (though don't eliminate) the fragmentation problem:

- Common email templates and brand guidelines ensure visual consistency
- Centralised CRM data enables (in theory) visibility into cross-brand HCP interactions
- Standardised journey templates provide repeatable patterns
- Enterprise consent management prevents regulatory violations

Enterprise Capability Building

The central function can recruit specialised expertise that individual brands cannot afford:

- Data scientists and machine learning engineers
- Omnichannel strategists and journey architects
- Technology integration specialists
- Advanced analytics and attribution modelling experts

Scalability

Once processes and platforms are standardised, onboarding new brands or entering new markets becomes significantly faster and cheaper. The enterprise infrastructure scales horizontally.

When the Brand-Led Model Works:

The COE-Led model is optimal in specific contexts:

- **Large pharmaceutical companies** (top-10 to top-20) with broad portfolios (10+ major brands) where efficiency gains from consolidation outweigh agility losses
- **Organisations scaling** from pilot to enterprise omnichannel: the COE provides the infrastructure and standards that enable consistent scale
- **Highly regulated markets (Germany, France)** requiring strict compliance processes where standardisation reduces regulatory risk
- **Companies with significant field forces** (500-2,000+ representatives) requiring sophisticated SFE infrastructure, training platforms, and CRM capabilities that brands cannot build individually
- **Post-merger integration scenarios** where multiple legacy operating models must be harmonised

Disadvantages of the Centre of Excellence-Led Model

Slower Decision-Making and Bureaucracy

Brand teams must navigate approval processes, central priorities, and queue management:

- "I need a new journey template" → "Your request is in the queue; 8-week delivery timeline"
- "Can we pilot this new technology?" → "That tool isn't on our approved vendor list; submit a business case for steering committee review"

Someone acknowledged the frustration:

> *"The issue that most of your peers still have is that you have a commercial excellence-heavy organisation where that team only thinks around the engagement journey with HCPs based on their own channels. Then you have brand digital or other teams trying to organise themselves around other, mostly digital channels, and trying to match those two."*

The central COE establishes structural dependencies: brands and local markets must depend on global teams for technology provision, content creation, and data analytics. Even when decision rights are well-defined, the speed of execution relies on the capacity and prioritisation of the central COE, leading to bottlenecks regardless of organisational clarity.

One-Size-Fits-All Risk

Central solutions optimise for the average use case, potentially under-serving specialised brands:

- A rare disease brand targeting 300 HCPs globally has very different needs than a primary care brand targeting 50,000 physicians
- An oncology brand requires sophisticated scientific content capabilities that a consumer health brand does not
- Fast-moving competitive markets (immunology) require agility that centralised processes may not support

Brand Frustration and Shadow Operations

When centralised services don't meet brand needs, brands create workarounds:

- Hiring external agencies for "brand-specific" content (by passing central factory)
- Using unapproved analytics tools (spreadsheets, Tableau instances)
- Building local-market capabilities that duplicate central functions

One interviewee candidly described the local need:

> "We need speed and flexibility; central processes are too slow."

Ambiguous Accountability

When a journey or campaign fails, attribution becomes difficult:

- Brand: "The central team's template was too rigid and the technology didn't work"
- CE: "The brand's strategy was flawed; we executed what they asked for"

This "blame diffusion" can create organisational paralysis.

Archetype 3: The Integrated Omnichannel Model (Customer-Centric)

The Integrated Omnichannel model represents the most advanced and transformative archetype, and also the rarest. This model fundamentally reorients the commercial organisation around customer segments rather than internal product P&Ls or functional departments.

In its purest form, work is organised into persistent, cross-functional "journey teams" or "customer pods" focused on understanding and serving specific HCP personas or segments across the entire product portfolio.

Core Structural Characteristics:

→ Decision Rights (Devolved to Teams)
Journey teams (not brand leaders or central functions) hold primary authority for designing, executing, and optimising engagement strategies for their assigned HCP segment. These teams operate with significant autonomy for test-and-learn cycles, with leadership's role shifting from command-and-control to enablement: setting overall vision, defining shared customer-centric KPIs, and removing organisational barriers.

→ Organisational Structure
Persistent, cross-functional pods typically include:

- Pod Lead (Omnichannel Manager or Customer Segment Owner)
- Marketing representative (content, campaigns)
- Sales representative or sales ops liaison (field engagement)
- Medical Affairs representative (scientific strategy)
- Market Access specialist (payer and formulary strategy)
- Data analyst (segmentation, measurement)

Each pod is assigned a specific HCP segment (e.g., "Academic Medical Centre Oncologists," "Community-Based Cardiologists,"

"Endocrinologists in Diabetes Centres of Excellence") and is accountable for engagement outcomes across all brands relevant to that segment.

→ Coordination Mechanism
Cross-pod coordination occurs through:

- Shared Customer Data Platform providing unified HCP profiles
- Regular "customer review" meetings (replacing brand review meetings), analysing segment-level performance
- Enabling functions (Data, Content, Analytics) operating as shared services supporting all pods
- Governance focused on journey performance metrics (HCP progression velocity, satisfaction scores, lifetime value) rather than brand-specific KPIs

→ Technology Architecture
Fully integrated, real-time data architecture:

- CDP as the single source of truth, ingesting data from CRM, marketing automation, websites, events, third-party sources
- API-driven real-time integration (not batch uploads)
- Journey orchestration platform enabling dynamic, personalised multi-channel campaigns

Advanced analytics layer (AI/ML for Next-Best-Action, propensity scoring, attribution modelling)

→ Real-World Manifestations
While full implementations of this model remain rare, several interviewees described elements of the journey-pod structure. A leader described their omnichannel execution team:

> *"We have an omnichannel execution team. The person executing user journeys is also responsible for orchestration. It's one function that is doing the orchestration, the experience design and journey orchestrator."*

Another interviewee described the most sophisticated end-to-end model we encountered:

> *"My team is called the campaign planning and tagging team, responsible for four pillars: strategic campaign design, creative design, execution and orchestration design, and measurement and optimisation design. We look at the marketer's journey from strategy setting into customer knowledge, then campaign planning, content building, activation, and finally measurement."*

This end-to-end ownership, from strategy through measurement, organised around the customer journey rather than internal functions, exemplifies the Integrated Omnichannel philosophy.

Advantages of the Brand-Led Model

Seamless, Coherent Customer Experience

The model is purpose-built for customer-centricity:

- HCPs experience a single, unified relationship with the company (not multiple brand contacts)
- All touchpoints (rep visits, emails, website, congress) are orchestrated to tell a coherent story
- Hand-offs between channels (digital nurturing → rep visit → MSL scientific deep-dive) are choreographed, not accidental

Breaks Down Functional Silos by Design

Cross-functional collaboration is structurally mandated, not aspirational:

- Marketing, Sales, and Medical representatives sit together daily, literally (in-office) or virtually
- Shared pod KPIs align incentives: no one "wins" unless the customer journey succeeds
- Information flows naturally within pods; no need for elaborate knowledge-sharing forums

Agility and Continuous Optimisation

Journey teams are empowered to run rapid test-and-learn cycles:

- A/B test content variations → Analyse results → Iterate (weekly or bi-weekly cycles)
- No need for steering committee approval to adjust journey trigger rules
- Real-time data enables in-flight course correction

A study by Forrester in 2024 on Customer Journey Maturity found that organisations with journey-based team structures achieved 2.5× faster time-to-market for new engagement campaigns compared to functionally-siloed structures.

Optimises for Customer Lifetime Value

By focusing on long-term HCP relationships rather than quarterly brand sales, the model aligns commercial activities with sustainable value creation:

- Invest in educational content that builds trust (even if it doesn't drive immediate prescriptions)
- Nurture HCPs through multi-year adoption curves (awareness → consideration → trial → loyalty)
- Cross-sell and portfolio management become natural (one pod owns the cardiologist relationship across all cardiovascular brands)

Disadvantages of the Integrated Omnichannel Model:

Massive Transformation Investment and Disruption

Transitioning to this model requires:

- Organisational restructuring (reassigning hundreds of employees)
- New roles that don't exist in traditional structures (Omnichannel Pod Leads, Journey Architects)
- New career paths and talent development frameworks (how does one get promoted in a pod structure?)
- Cultural change management (resistance from brand leaders losing authority, sales leaders losing field force control)

High Digital and Data Maturity Prerequisites

The model cannot function without:

- **Unified Customer Data Platform:** Must aggregate data from all sources in real-time
- **Clean Master Data Management:** HCP golden records must be accurate and de-duplicated
- **Advanced Analytics Capabilities:** Need predictive models, propensity scoring, attribution, not just descriptive dashboards
- **Marketing Automation Sophistication:** Journey orchestration platform capable of complex, multi-step, multi-channel campaigns with dynamic branching

One interviewee acknowledged their organisation's early-stage status:

> *"We're very early stage, I think, for us [on orchestration]. We do measure percentage reached and percentage engaged [for journeys], but that's very basic."*

Organisations lacking these foundational capabilities cannot operate an Integrated Omnichannel model successfully as the teams would lack the data and tools required to orchestrate.

Complexity and Operational Overhead

A global leader described the scaling challenge candidly:

> *"It's really about breaking it down, because otherwise you make it way too complex. In the life sciences industry, we always see these examples of omnichannel. HCP registers through a form, and then, magically, I know who he is; he gets an engagement score, and I take action. But at the scale I'm operating at, we don't have five content pieces to follow up on. It's really every time just one content piece, maximum two."*

The vision of hyper-personalisation (dynamic content assembly, real-time Next-Best-Action) requires content libraries, metadata tagging, and AI capabilities that most organisations don't possess.

Accountability and Performance Management Challenges

Traditional performance management frameworks don't map to pod structures:

- How do you measure an individual marketer's contribution when they're part of a 6-person pod?
- How do you allocate brand P&L when one pod manages 5 brands targeting the same segment?
- What's the career path for someone who's been a "Pod Lead" for 3 years?

These are solvable problems, but they require entirely new HR frameworks.

When the Integrated Omnichannel Model Works:

Despite its challenges, this model is optimal in specific contexts:

- **Digital-native or "future-ready"** organisations with executive mandate for customer-centricity and appetite for transformation (rare in traditional pharma, more common in biotech)
- **Speciality pharmaceutical companies with concentrated HCP segments.** For example, a rare disease company targeting 500 global treaters can justify organising around those 500 relationships rather than around 3-4 product brands
- **Organisations with strong data foundations** that have already implemented CDP, MDM, and unified analytics (prerequisite capability)
- **Therapeutic areas with stable, long-cycle sales** (not launch-intensive) where long-term HCP relationship value justifies investment in orchestration. For example, diabetes management, where endocrinologists prescribe for decades
- **Companies with overlapping brand portfolios** where multiple products target the same HCPs (oncology, cardiovascular) and fragmentation pain is acute

Comparative Framework: Choosing Your Archetype

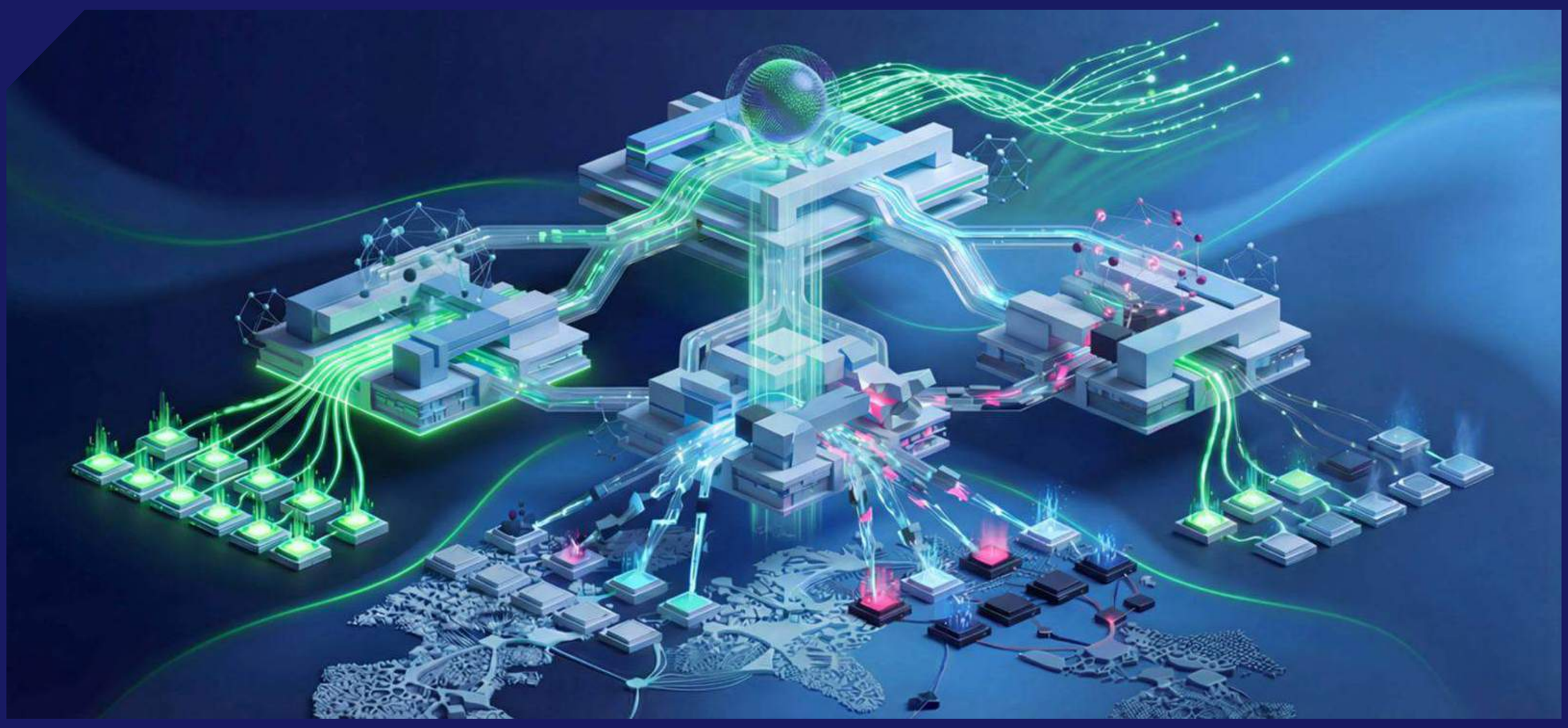
The table below synthesises the three archetypes across critical dimensions:

Dimension	Brand-Led (Decentralised)	COE-Led (Centralised/Hybrid)	Integrated Omnichannel (Customer-Centric)
Primary Decision-Maker	Brand Lead (P&L owner)	Bifurcated: Brand (strategy) + COE (execution)	Journey Pod (cross-functional team)
Coordination Mechanism	Voluntary / Informal networks	Mandatory governance committees + SLAs	Embedded in structure (pods)
Technology Architecture	Fragmented (per brand)	Consolidated enterprise stack	Fully integrated real-time (CDP-centric)
Primary Advantage	Speed, agility, TA expertise	Efficiency, consistency, scale	Seamless CX, breaks silos, customer LTV
Primary Disadvantage	HCP fragmentation, duplication	Slower decisions, one-size-fits-all	Massive transformation, high maturity needed
Data Architecture	Siloed by brand	Shared CRM, emerging data integration	Unified CDP, real-time, 360-degree HCP view
Typical Prevalence	60-70% of pharma	25-30% of pharma	5-10% of pharma (pioneers)
Best Fit Context	Small/mid-size, focused portfolio, speciality	Large pharma, broad portfolio, scaling omnichannel	Digital-native, concentrated segments, overlapping brands
Maturity Requirement	Low (can operate with basic CRM)	Medium (requires consolidated tech)	High (requires CDP, advanced analytics, cultural readiness)
Timeline to Implement	N/A (existing state)	12-18 months (consolidation project)	24-36 months (full transformation)

Section 3 - The Global Regional-Local Coordination Challenge

The operating model choice is further complicated by the geographic dimension. Even within a single archetype (Brand-Led, COE-Led, or Integrated Omnichannel), the distribution of decision rights and workflows across global headquarters, regional clusters, and local markets determines whether organisational friction or executional velocity is created.

Our interviews revealed near-universal adoption of what the industry calls the "glocal" model ("think global, act local") but with different implementations of that philosophy. Some organisations have architected explicit, tiered decision frameworks that work effectively. Many have not, resulting in constant negotiation, content waste, and local frustration.



The "Glocal" Model: Intent vs. Reality

The standard articulation of the glocal model sounds elegant in theory:

- **Global HQ develops brand strategy,** core messaging, positioning, and scientific narrative
- **Regional clusters** (EMEA, Americas, APAC) adapt strategy for multi-market dynamics and provide coordination
- **Local markets** execute campaigns and localise content to country-specific requirements (language, regulatory, cultural, formulary)

The theory assumes clear boundaries: global provides "guardrails" (non-negotiable strategy, approved claims, brand guidelines), and local has freedom within those boundaries to optimise tactics. The reality, as our interviews revealed, is far messier. Someone described the intent:

> *"Global is responsible for strategy setting, customer knowledge, segmentation, journey mapping. Then my part is campaign planning. Then content building. Then activation (channel activation). Then finally measurement and optimisation."*

This end-to-end view presumes a clean hand-off at each stage. But another leader described the ground-level complexity:

> *"Global designs high-level key messages, creative concepts, brand guidelines. Local comes in and looks at these key message platforms and can design their customer journeys based on what global decided. Then the rest of the world takes these as blueprints and localises to their requirements."*

The word "blueprints" is instructive. It implies local teams have significant interpretative freedom. Yet this creates the central tension:

→ When is localisation "adapting a blueprint" versus "ignoring global strategy"?

The tension manifests in content utilisation, or lack thereof. Someone described the reality with stark honesty:

> *"We also really take away a lot of the workloads from the markets. But in all transparency, different levels of success. With some markets, we really have that visibility. With others, the penetration is not as high as I would hope for."*

Translation: Global creates content, some local markets use it, many don't. Gartner Research estimated in its 2023 white paper "Content Utilisation in Global Marketing" that 60-80% of globally-created content goes unused by local markets. This represents massive waste: millions invested in creating materials that sit on servers, never reaching HCPs.

The root causes of this waste are structural:

- **Global doesn't understand local constraints:** A 60-page brand book created in the US doesn't account for Germany's strict regulatory environment or Japan's cultural communication preferences
- **Local doesn't trust global's relevance:** Local teams believe (sometimes correctly) that global content was designed for US/UK markets and won't resonate in their context
- **Local doesn't trust global's relevance:** Local teams believe (sometimes correctly) that global content was designed for US/UK markets and won't resonate in their context
- **Lack of feedback loops:** Global rarely learns why local didn't use content, so problems repeat

Blueprint Markets vs. Localisation Markets: A Three-Tier Solution

The most sophisticated organisations we studied have moved beyond the simple "global to local" dichotomy to implement a three-tier model that inserts a critical intermediate layer: blueprint markets (also called early-launch markets or lead markets).

Tier 1: Global Headquarters

Role: Strategic architect and core asset creator

Key Outputs:

- Brand strategy and positioning
- Key message platforms (claims hierarchy, scientific narrative)
- Customer journey maps (outside-in, from HCP perspective, not execution plans)
- Core asset library (modular content components, not finished campaigns)
- Segmentation framework and persona definitions

Critical Decisions:

- What to say (approved claims based on clinical data)
- Who to target (priority segments)
- Strategic sequencing (awareness → consideration → adoption messaging flow)

Does NOT Produce:

- Finished campaigns (emails, detail aids, landing pages)
- Operational journey definitions (trigger rules, channel sequences)
- Market-specific tactics

Tier 2: Blueprint/Early-Launch Markets

Role: Operational translator, builds executable templates from global strategy

Which Markets: Typically US, Germany, UK, France (markets with faster regulatory approval, higher digital maturity, larger budgets)

Key Outputs:

- Actual finished content (detail aids, email templates, landing pages, webinar decks)
- Operational journey definitions (trigger rules: "If HCP opens email but doesn't click, send follow-up in 3 days")
- Tested playbooks with performance data ("This email subject line achieved 32% open rate")
- Technology implementation (marketing automation workflows, CRM call flows)

Critical Decisions:

- How to say it (creative execution, visual design, copy tone)
- Which channels to use (email, web, rep visit, congress, MSL)
- What works (A/B test results, optimisation learnings)

Why These Markets? They typically have:

- Earlier regulatory approval (reimbursement 6-12 months ahead of other markets)
- Higher commercial sophistication and digital infrastructure
- Larger budgets enabling experimentation
- Talent density (agencies, technology vendors, digital expertise)

Value to Enterprise: Blueprint markets absorb the cost and risk of experimentation. Their learnings become templates for Tier

Tier 3: Localisation Markets

Role: Localisers and executors, configure templates to market requirements

Which Markets: All other markets (typically 80-90% of global markets by number, 30-50% by revenue)

Key Inputs: Blueprint market templates (finished content, operational journeys)

Key Outputs:

- Localised versions (translation, cultural adaptation, local regulatory approval)
- Market-specific prioritisation (given budget constraints, which journeys to deploy first?)
- Local execution (agency management, rep training, KPI tracking)

Critical Decisions:

- What to keep versus adapt (how much localisation is required?)
- Prioritisation given budget (deploy journey A, B, or C first?)
- Local channel mix (if WhatsApp isn't available, substitute SMS?)

Does NOT Do:

- Recreate content from scratch (expensive, slow)
- Redesign journeys (unless blueprint fundamentally doesn't fit market)

A leader described this three-tier model in action:

> *"These early-launch markets collaborate with the global team to localise messages and build an ideal omnichannel customer journey. Then the rest of the world takes the US omnichannel customer journey as a blueprint and localises that customer journey to their requirements."*

Another leader explained the practical adaptation:

> *"The US invests heavily in paid media. Outside the US, we can't invest heavily in paid media due to different regulations. But then they start playing with this blueprint and adapting it to their local regulations."*

Why This Model Works:

1. Reduces Global-Local Friction: Global isn't dictating finished execution; blueprint markets do that based on real-world testing

2. Prevents Reinvention: Localisation markets don't waste budget recreating content that blueprints already built

3. Enables Learning Loops: Blueprint markets test, learn, and refine, then share proven templates

4. Realistic About Resources: Acknowledges that most markets lack budget/capability for full journey design

5. Faster Time-to-Market: Localisation is 3-6x faster than creation from scratch

When It Works:

- Product launches (blueprint markets launch first, others follow with proven playbooks)
- Global brands with consistent positioning (not highly localised products like vaccines with country-specific schedules)
- Organisations with significant digital maturity gaps between markets

Decision Rights: The RACI Framework

Even with a three-tier geographic model, ambiguity persists unless explicit RACI mapping defines who makes which decisions at which level. RACI (Responsible, Accountable, Consulted, Informed) is a decision-rights framework that specifies:

- **Responsible:** Who does the work?
- **Accountable:** Who has final approval authority and owns the outcome?
- **Consulted:** Who provides input before decisions are made?
- **Informed:** Who is notified after decisions are made?

Below, we present a best-practice RACI matrix for the eight critical decision types governing HCP journey design and execution, mapped across Global, Regional (Blueprint Markets), and Local levels.

RACI Matrix for Journey Decisions (Best Practice Pattern)

Decision Type	Global HQ	Regional / Blueprint Local Markets	Local Markets
Brand Strategy & Positioning	A/R	C	I
Customer Segmentation Framework	A/R	C	C
Customer Journey Mapping (HCP perspective)	A/R	C	C
Core Message Platform & Claims	A/R	C	I
Core Asset Creation (modular components)	A	R	I
Operational Journey Design (triggers, sequences	C	A/R	C
Finished Content Creation (emails, detail aids)	I	A/R	C
Content Localisation & Translation	I	C	A/R
Maturity Requirement	C	A	R
Technology Platform Selection (CRM, CDP)	A/R	C	I
Local Execution & Deployment	I	C	A/R
Budget Allocation (by geography)	A	R	R
Performance Measurement & KPIs	A	R	R

Key Patterns from Best-Practice RACI:

Global HQ is Accountable for:

- Strategy (brand positioning, segmentation framework, journey maps)
- Core content (message platforms, modular assets)
- Enterprise technology (platform selection, data governance)
- Measurement frameworks (KPI definitions, attribution methodology)

Global HQ is NOT Accountable for:

- Finished content creation (too far from market reality)
- Operational journey design (lacks execution visibility)
- Local execution (cannot manage 50+ markets)

Regional/Blueprint Markets are Accountable for:

- Operational journey design (translating strategy into executable workflows)
- Finished content creation (detail aids, emails, landing pages)
- Channel selection (email vs. web vs. rep vs. congress)
- Testing and learning (A/B tests, optimisation)

Local Markets are Accountable for:

- Localisation and translation
- Local execution and deployment
- Market-specific prioritisation (given budget constraints)

Local Markets are Consulted on:

- Segmentation frameworks (provide input on local HCP preferences)
- Journey design (flag what won't work in local context)

Managing the "Lost in Translation" Problem

Content and strategy degradation is inevitable at each geographic handoff. A common pattern:

- Global creates comprehensive 100-page brand book with scientific rationale, messaging architecture, customer insights
- Regional distills to 20-page playbook highlighting execution priorities
- Local reads 5-page summary (or PowerPoint deck) for quick orientation
- Execution reflects 10-20% of original strategic intent

This "lost in translation" problem has multiple root causes:

Information Overload

Local teams lack time to digest 100-page documents. They want actionable guidance: "What should I do next week?"

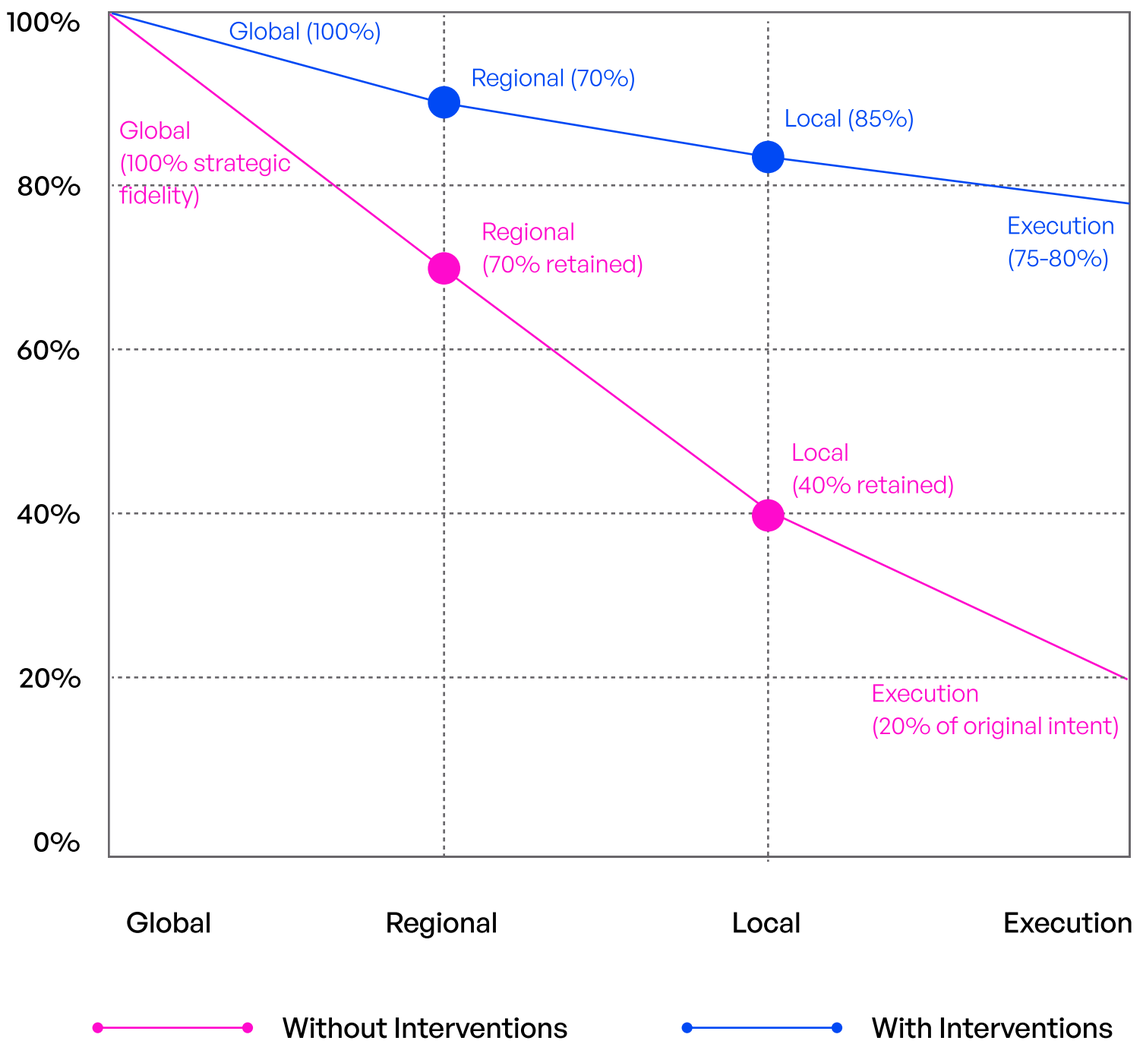
Context Loss

Global's strategic rationale (why this positioning? why this segment?) doesn't transfer. Local teams see the "what" without understanding the "why," making adaptation difficult.

"Not Invented Here" Syndrome

Local teams naturally distrust templates created by people who don't work in their market. They believe (sometimes correctly) that global doesn't understand local HCP preferences, regulatory constraints, or competitive dynamics.

Figure 3.1: Information Fidelity Across Geographic Layers



Solutions from Leading Organisations:

Solution 1: Direct Global-Local Collaboration (Skip the Middle)

An interviewee described their content factory model:

> *"We call this the content factory. That content factory either supports local entities to create their own local initiatives digitally, or takes the global content and localises it. What that allows us to do is actually also have analytics and measurement of what content was localised and what content was not localised."*

By enabling direct collaboration between the global content factory and local digital leads, this model:

- Reduces handoff layers (global → local, not global → regional → local)
- Provides real-time support ("I'm creating content now; can you help me adapt that global module?")
- Enables measurement (which content gets used? which doesn't? why?)

Solution 2: Modular Content Architecture

Rather than handing off finished assets (which require reinterpretation), global creates certified modular components:

- Individual claims (pre-approved by MLR)
- Data visualisations (efficacy charts, safety profiles)
- Video clips
- Case study vignettes

Local teams assemble content from these modules rather than re-creating. This:

- Preserves strategic fidelity (claims are pre-approved, can't be misinterpreted)
- Enables local flexibility (assemble different combinations for different audiences)
- Reduces MLR cycle time at local level (modules already approved, only assembly needs review)

We will explore modular content architecture in depth in our next White Paper II

Solution 3: Reverse Feedback Loops

A leader described their accompaniment model:

> *"We accompany the global teams from the moment they set their strategy and build these segments and customer journeys, to the moment that it goes to a local team, and actually they activate the campaign and optimise it in the market. We accompany them with standard guidelines, standard ways of working, technologies that would help them automate, simplify."*

This "accompaniment" includes:

- Regular touchpoints (not just hand-off and disappear)
- Learning capture (what worked? what didn't? why?)
- Iteration (global updates templates based on local feedback)

The key insight: **Glocal coordination is not a one-time hand-off; it's a continuous dialogue.**

Section 4 - Medical Affairs Integration | Building Compliant Gates In The Firewall

One of the most challenging dimensions of operating model design is the relationship between Commercial functions (Sales and Marketing) and Medical Affairs. These two functions are intentionally separated by regulatory firewalls designed to prevent improper influence and off-label promotion. Yet modern HCPs increasingly demand the deep scientific credibility that only Medical Affairs can provide, creating pressure to integrate what regulation mandates be kept separate.

The organisations that excel at HCP engagement have learned to architect "compliant gates" in the firewall: formal mechanisms that enable strategic alignment and tactical coordination while respecting the distinct, non-promotional role of Medical Affairs.

The Firewall Paradox

The Regulatory Mandate:

In virtually all major markets (US, EU, Japan), pharmaceutical companies must maintain clear separation between:

- **Commercial (Sales and Marketing):** Promotes approved products for approved indications; activities are inherently promotional
- **Medical Affairs:** Provides balanced, scientifically rigorous, non-promotional medical information; responds to unsolicited requests; engages in scientific exchange

This separation is enforced through:

- **Distinct reporting lines** (Medical Affairs often reports to Chief Medical Officer, not Chief Commercial Officer)
- **Separate budgets** and headcount
- **Strict protocols governing** when MSLs can engage versus when sales representatives engage
- **Compliance training** emphasising the distinction

The HCP Reality:

Modern HCPs, particularly specialists in complex therapeutic areas, are sophisticated consumers of scientific information. They report that:

- Promotional messages alone don't drive prescribing decisions (they need deep scientific evidence)
- Sales representative expertise is insufficient for complex clinical questions
- They value interactions with MSLs more highly than sales rep visits (for scientific credibility)
- They want seamless access to scientific expertise when questions arise

The Convergence:

Medical Affairs' value proposition (scientific depth, credibility, balanced information) is increasingly central to commercial success.

The challenge → How do you align Commercial and Medical to deliver a unified HCP experience without violating the regulatory firewall or compromising Medical's non-promotional role?

An interviewee captured the tension candidly

> *"Medical and commercial already live in their own 'we're more important.' So they all have an equal say. From an omnichannel point of view, we also support our medical initiatives because medical is very important."*

Another leader articulated the aspiration:

> *"Brand team is medical, marketing, omnichannel, three working as one, period. It's not commercial drives, medical drives. Brand team is those three, period."*

The question is: How do you make "three working as one" operational while maintaining compliance?

Coordination Mechanisms That Work

Leading organisations implement coordination across three layers: Governance (steering committees), Process (joint journey mapping), and Metrics (shared KPIs).

Layer 1: Cross-Functional Governance Committees

The foundational coordination mechanism is a formal governance structure that brings together Commercial, Medical Affairs, and Compliance leadership on a regular cadence (typically monthly or quarterly).

Committee Composition:

- **Commercial:** Brand Leads, Marketing Directors, Sales Leadership
- **Medical Affairs**: Medical Directors, MSL Leadership, Publications Lead
- **Compliance:** Regulatory Affairs, Legal
- **Optional:** Market Access, Health Economics & Outcomes Research (HEOR)

Real-World Evidence

A local leader described the annual coordination at their organisation:

> "On a yearly brand planning cycle level, you have that collaboration between the cross-functional teams: medical and commercial. They all work together with a same plan for the brand or the portfolio."

This annual planning cycle represents the minimum baseline. More mature organisations conduct monthly or quarterly reviews to maintain alignment throughout the year.

Committee Purposes:

Strategic Alignment

Ensure all functions operate from a shared understanding of:

- Brand strategy and positioning
- Target HCP segments and priorities
- Customer insights (what questions are HCPs asking?)
- Annual objectives and success metrics

Insight Sharing

Create a formal venue for each function to share intelligence:

- **Commercial:** Digital engagement patterns (which content drives conversions?), sales force feedback, competitive intelligence
- **Medical:** Scientific queries logged by MSLs, congress insights, KOL perspectives, emerging clinical data
- **Market Access:** Payer priorities, formulary dynamics, health economics evidence gaps

Conflict Resolution

Provide a mechanism for addressing potential overlaps proactively:

- **Example:** Both Commercial and Medical want to sponsor the same HCP at an upcoming congress: who pays? How is engagement sequenced?
- **Example:** Commercial wants to promote new indication; Medical identifies safety signal requiring discussion with KOLs: how do we coordinate?

Defining "Rules of Engagement"

Establish clear protocols:

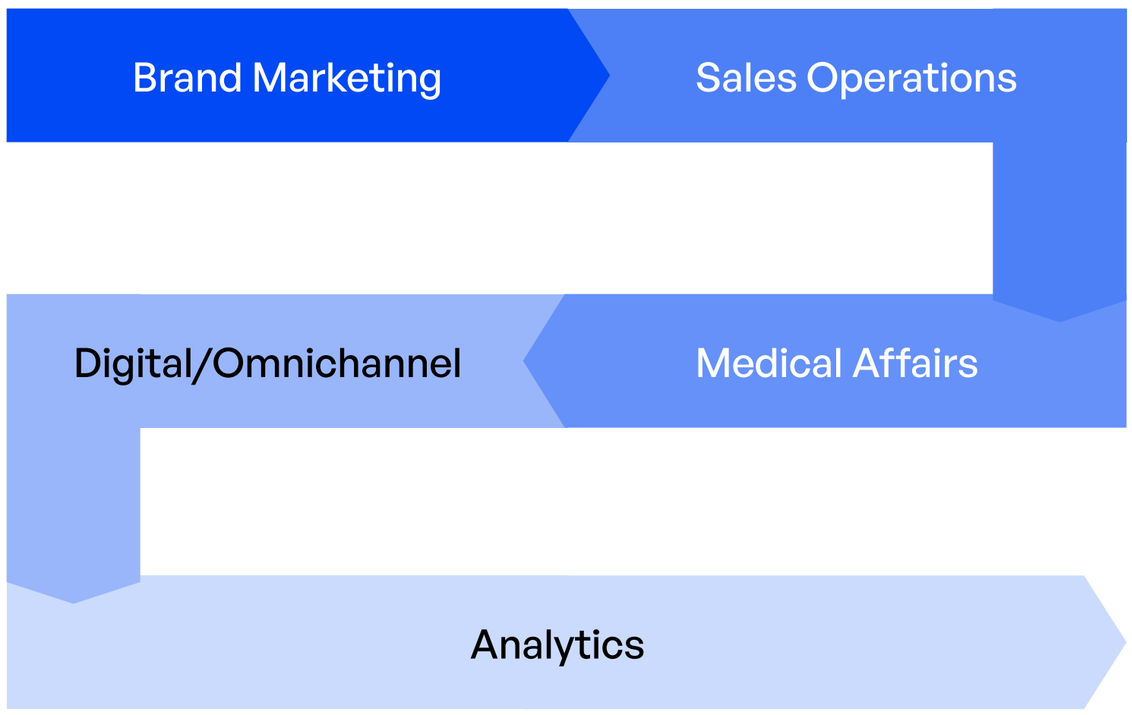
- **When does an HCP interaction** require MSL engagement versus sales rep?
- **How are unsolicited medical information** requests handled? (sales rep logs in CRM → auto-triggers MSL follow-up)
- **What content is promotional** (Commercial) versus educational (Medical)?
- **How are KOL relationships managed?** (Medical identifies and engages; Commercial may sponsor activities, but Medical leads relationship)

Layer 2: Joint Journey Mapping Process

The most powerful integration mechanism is requiring Commercial and Medical to jointly map the HCP journey from the HCP's perspective (not from internal functional perspectives).

Process

Cross-functional workshops (typically 1-2 days) bringing together representatives from:



Benefits

This joint process forces functions to see the journey through the HCP's eyes rather than their internal operational view. It reveals:

- Gaps (moments when HCP has unmet need, but no function is engaging)
- Overlaps (both Commercial and Medical contacting HCP about same topic)
- Sequencing opportunities (Medical builds scientific credibility → Commercial leverages for conversion)

The output becomes a shared roadmap that all functions reference throughout the year.

Typical Workshop Outputs:

HCP Journey Map

Visual representation of the HCP's experience from awareness to adoption, mapped across stages like:

- Awareness (HCP first learns about disease/treatment option)
- Consideration (HCP evaluates evidence, seeks information)
- Trial (HCP prescribes to first patient, monitors outcomes)
- Adoption (HCP prescribes regularly, becomes confident)
- Advocacy (HCP recommends to peers, may become KOL)

Touchpoint Inventory

All interactions the HCP experiences, categorised:

- Commercial touchpoints: Sales rep visits, promotional emails, brand websites, sponsored congress booths,...
- Medical touchpoints: MSL interactions, publications, medical education programs, advisory boards,...
- Self-directed touchpoints: HCP searches brand website, attends non-sponsored CME, reads peer-reviewed publications,...

Hand-Off Identification

Critical moments when engagement should transfer between functions

- Example: HCP responds to promotional email with complex clinical question → Sales rep cannot answer → Hand-off to MSL
- Example: MSL engages HCP during pre-launch phase, builds scientific relationship → Product launches → Hand-off to Sales Rep for commercial discussions
- Example: HCP prescribes product, then experiences adverse event with patient → Hand-off to Medical for safety follow-up

Content Strategy

Unified plan showing:

- Which content is delivered when (sequencing)
- Which function owns each content type (promotional vs. educational)
- How content reinforces across touchpoints (scientific publication mentioned by MSL → Sales rep provides summary → HCP accesses full text on medical portal)

Layer 3: Shared KPIs (Aspiration > Current Reality)

The ultimate integration mechanism is measuring Commercial and Medical against shared, customer-centric KPIs rather than siloed functional metrics.

Current State (Typical):

- **Commercial measured on:** Emails sent, sales calls completed, prescriptions (Rx) written, market share
- **Medical Affairs measured on:** MSL interactions completed, HCPs engaged, publications authored, advisory boards conducted
- **Result:** Functions optimise for their own metrics, even when it sub-optimises the overall HCP experience

Future State (Best Practice):

Functions share accountability for customer journey outcomes:

Customer-Centric KPIs:

- **HCP Satisfaction Scores (NPS or CSAT):** Survey HCPs: "How likely are you to recommend [Company X] as a scientific partner to your colleagues?"
- **HCP Engagement Quality Score:** Composite metric tracking depth and breadth of engagement (not just activity count)
- **Journey Progression Velocity:** % of HCPs moving from Awareness → Consideration → Adoption within defined timeframes
- **Scientific Credibility Index: Survey question:** "To what extent do you trust [Company X] to provide balanced, rigorous scientific information?"
- **Business Outcome Metrics:** Ultimately, both functions measured on downstream Rx growth, new patient starts, market share

The Power of Shared KPIs:

When Medical Affairs and Commercial are both measured on "HCP Satisfaction" and "Journey Progression Velocity," collaboration becomes the natural path of least resistance. Neither function "wins" unless the HCP journey succeeds

A particularly sophisticated approach is to design mutual dependencies:

"What medical outcomes (e.g., increase in scientific knowledge scores among HCPs) can we measure that will pave the way for future commercial success?

Conversely, which commercial KPIs (e.g., a high volume of product-related questions logged by sales reps) could signal a need for further educational intervention by the medical team?"

- **Medical → Commercial dependency:** Medical Affairs' success in building scientific credibility (measured via surveys) predicts Commercial's conversion rates (HCPs who rate company highly on scientific credibility are more likely to prescribe)
- **Commercial → Medical dependency:** Commercial's success in driving awareness (measured via aided recall) predicts Medical's ability to engage in scientific exchange (HCPs who are aware of the product proactively ask MSLs questions)

This mutual dependency transforms the measurement system from a scorecard into a dynamic alignment engine.

Reality Check:

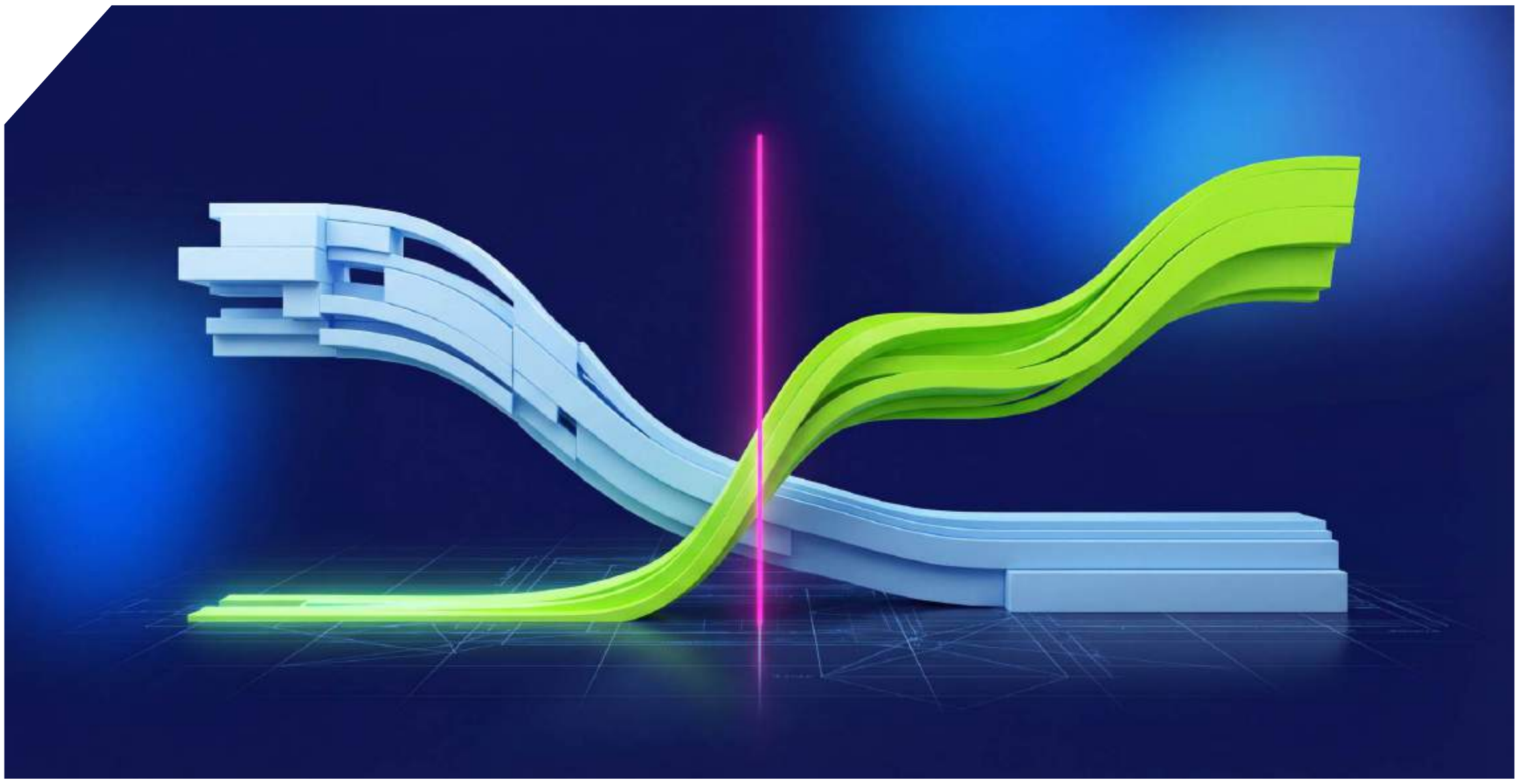
Among our interview subjects, only one organisation reported actually implementing shared KPIs. The remainder acknowledged it as an aspiration but cited barriers:

- HR/compensation systems aren't designed for cross-functional accountability
- Medical Affairs leadership resists being measured on commercial outcomes (fears it compromises independence)
- Difficulty defining metrics that genuinely reflect both functions' contributions

Despite these barriers, the organisations that achieve shared KPIs report dramatically improved collaboration and customer experience.

Pre-Launch vs. Commercial Phase Dynamics

The Medical-Commercial relationship is not static. It shifts significantly across the product lifecycle, particularly between pre-launch and commercial phases.



Pre-Launch Phase: Medical Affairs Leads

During the period between Phase III trial read-outs and regulatory approval/launch, Medical Affairs operates in a "safe harbour" with unique authorities:

What Medical Affairs Can Do:

- Engage KOLs in scientific exchange about investigational products
- Present unpublished clinical trial data at scientific congresses
- Conduct advisory boards to gather scientific input
- Discuss potential treatment paradigms in disease areas
- Build relationships with HCPs who will be early adopters

What Commercial Cannot Do:

- Promote unapproved products (illegal in all major markets)
- Discuss potential pricing or market positioning
- Request HCPs to prescribe (no product to prescribe yet)
- Engage the sales force in product discussions

Commercial Phase: Authority Shifts

Once the product receives regulatory approval and launches commercially, authority shifts:

- Market intelligence gathering (understanding competitive landscape, payer dynamics)
- Planning activities (preparing launch materials, training sales force) without customer engagement
- Supporting Medical Affairs' efforts (funding advisory boards, congress sponsorships, but Medical leads content)

What Medical Affairs Can Do Now:

- Promote approved indications through sales force
- Execute marketing campaigns (digital, congress booths, brand advertising where allowed)
- Discuss pricing, patient access programs, formulary positioning
- Drive prescription volume through traditional commercial activities

What Medical Affairs Continues to do (But in Supporting Role):

- Respond to unsolicited medical information requests
- Engage HCPs with questions beyond the promotional label
- Conduct medical education (non-promotional)
- Manage publication strategy and KOL relationships
- Monitor safety signals and adverse events

Operating Model Implication

During pre-launch, Medical Affairs has full authority. The governance structure places Medical in the driver's seat. Commercial's role is limited to:

- Market intelligence gathering (understanding competitive landscape, payer dynamics)
- Planning activities (preparing launch materials, training sales force) without customer engagement
- Supporting Medical Affairs' efforts (funding advisory boards, congress sponsorships, but Medical leads content)

This pre-launch phase is critical for seeding awareness and building KOL advocacy. Organisations that fail to leverage Medical Affairs aggressively during this window find themselves at a significant disadvantage at launch.

Solution: Visibility and Sequencing

The CRM system (or CDP) must provide cross-functional visibility:

- Medical Affairs sees Commercial's engagement calendar (sales call history, email sends, congress invitations)
- Commercial sees Medical Affairs' engagement calendar (MSL interactions, advisory board participation)
- But: Medical's detailed interaction notes remain confidential (protected from Commercial) to maintain regulatory separation

Trigger rules enable hand-offs:

- Sales rep logs scientific question in CRM → Auto-generates task for MSL to follow up
- MSL completes scientific engagement → CRM alerts sales rep "Okay to schedule commercial follow-up in 2 weeks"

One interviewee emphasised the importance of medical integration:

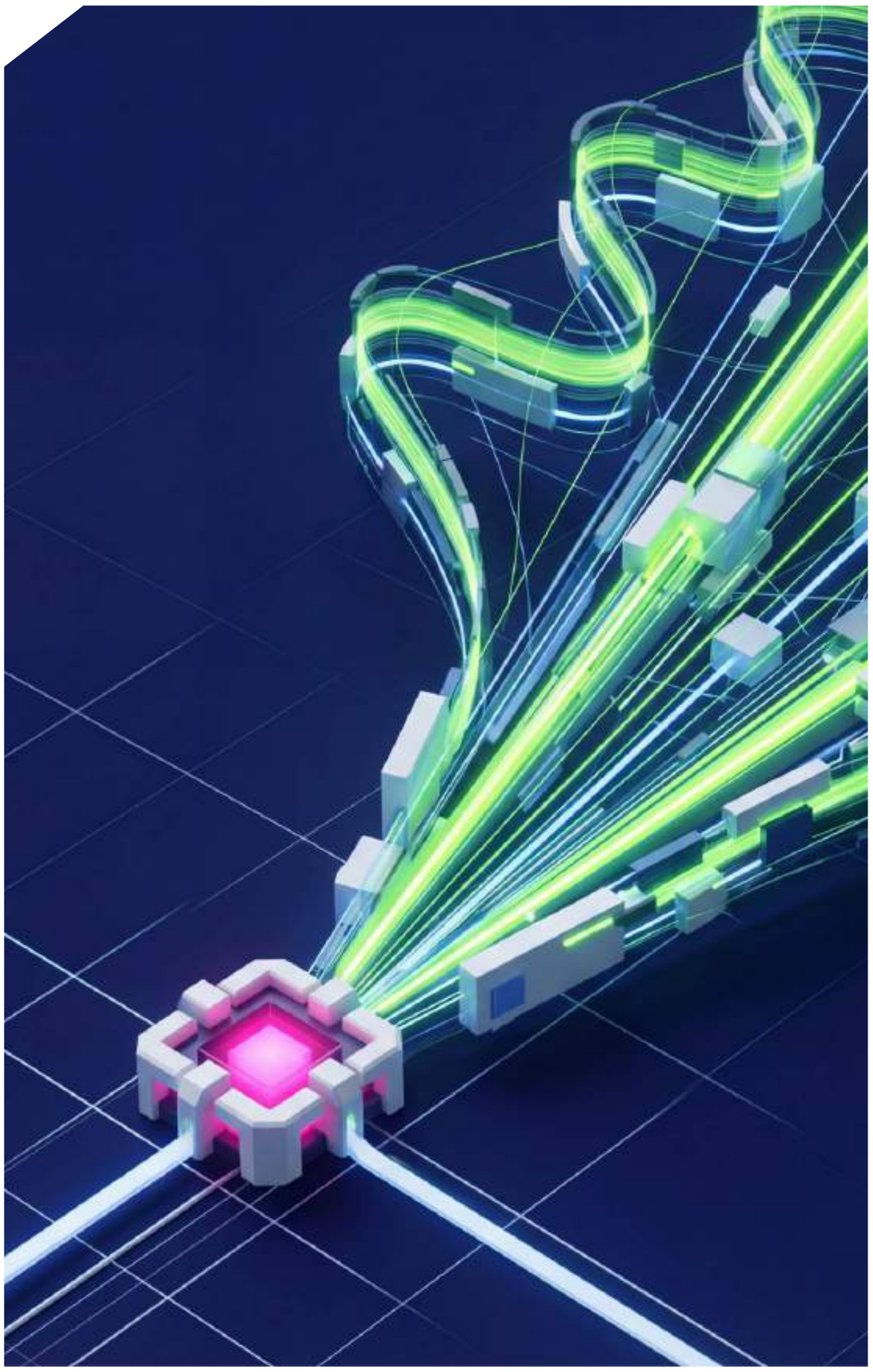
> *"Medical is very important. There's a lot of things I would do differently. I would redesign brand plans to involve omnichannel thinking in them, because otherwise the brand plan usually is a list of activities – launch this, then speak about safety – but without a how."*

This "how" (the operational integration of Medical and Commercial in the journey) is what separates leading organisations from the rest.

Coordination Challenge:

Post-launch, both functions engage the same HCPs. Without coordination:

- HCP receives sales rep visit (promotional message), same week as MSL visit (scientific exchange) → Confusing or contradictory
- MSL engages HCP on an off-label scientific question, then the sales rep follows up, trying to "close" → Inappropriate and potentially illegal
- Both functions invite HCP to the same events/congresses → Wasteful and irritating to HCP

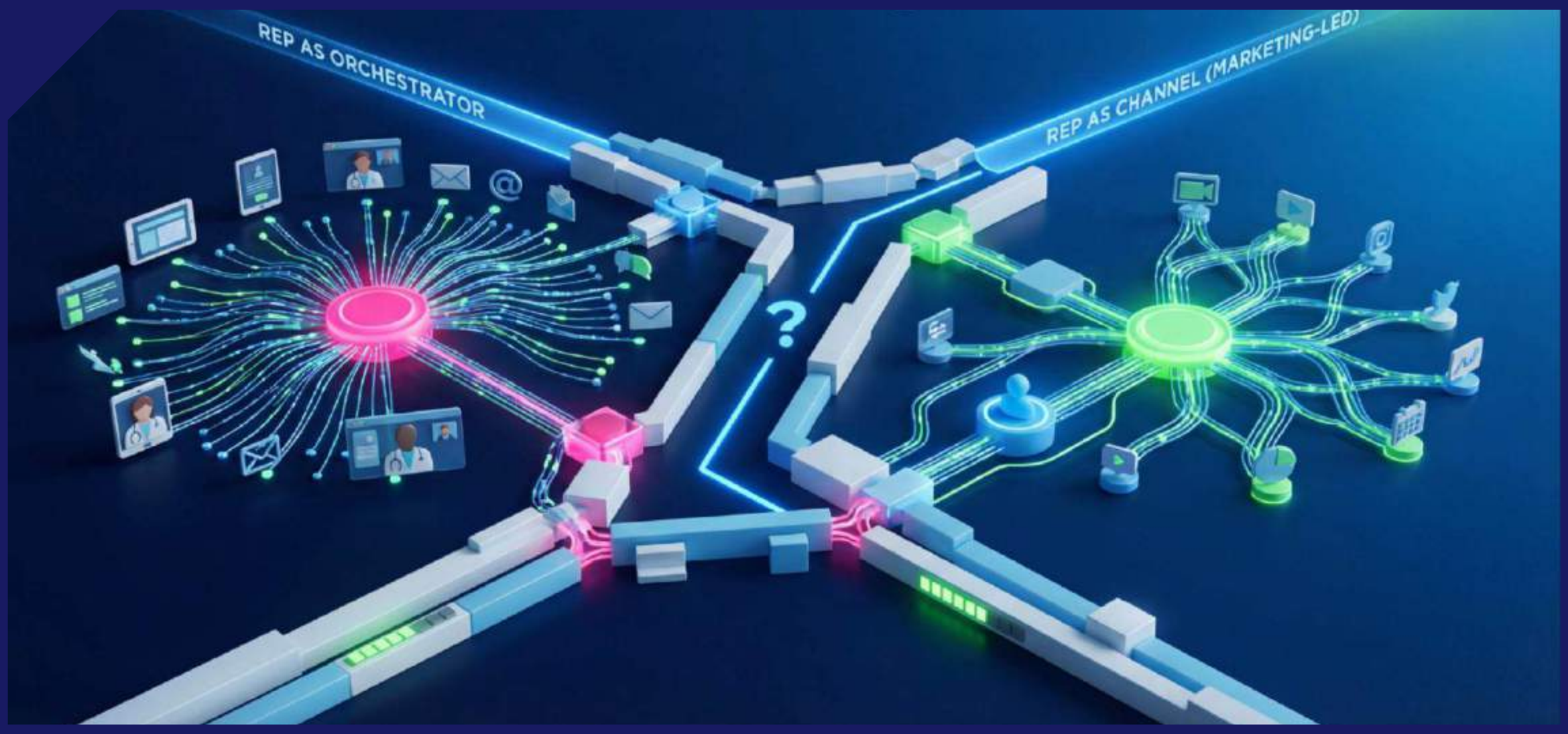


Section 5 - Field Force Integration | Orchestrator Or Channel?

Perhaps no debate in pharmaceutical commercial model design generates more heat than the role of the sales representative. This debate is not merely philosophical: it has profound implications for technology architecture, budget allocation, organisational power structures, and ultimately, customer experience

The central question:

→ Is the sales representative the orchestrator of all HCP touchpoints, with digital serving the rep? Or is the rep one of the (important) channels within a marketing-led orchestration?



The "Rep as Orchestrator" Model (Legacy Paradigm)

The field force-centric model dominated pharmaceutical commercial operations for decades. In this paradigm:

Core Assumptions:

- The representative owns the HCP relationship
- The rep is best positioned to understand HCP needs and preferences (through face-to-face interaction)
- All touchpoints (digital, medical, events) should serve the rep, providing tools, content, and follow-up that the rep directs
- The CRM system is the "centre of gravity", all customer data, orchestration logic, and reporting flows through the CRM

Operational Model:

- **When to engage:** Rep decides when to schedule face-to-face meetings based on call frequency targets and HCP accessibility
- **What content to share:** Rep selects detail aid slides, leaves behind materials, determines which clinical messages to emphasise
- **What digital to trigger:** Rep determines whether to send follow-up emails, invite to webinars, or schedule dinner programs
- **Who else engages:** Rep coordinates with MSLs (requesting scientific support) or event managers (inviting HCPs to congress)

Technology Architecture:

In this model, Veeva CRM is often the system of record:

- All HCP master data lives in Veeva
- All activity tracking (calls, emails, events) logs in Veeva
- Digital channels are "extensions" of Veeva (Veeva CRM Approved Email, Veeva CRM Events)
- Reporting and analytics are CRM-centric (call dashboards, reach and frequency)

Real-World Description:

A leader described their current hybrid model, which still centres on the field force:

> *"We have a digital lead, omnichannel expert. They're the guys that know their way around the systems, when we should use Veeva versus Salesforce Marketing Cloud. They'll be working in collaboration with the marketing leads for either that country or region."*

The telling phrase: "when we should use Veeva versus Salesforce Marketing Cloud." In many organisations, this is an either/or choice, not an integrated architecture.

Why This Model Persists

Despite its limitations (which we'll explore), the rep-centric model remains dominant for several reasons:

Sales Leadership Power

In most pharmaceutical companies, sales leadership holds significant organisational influence. The field force represents 40-60% of commercial budgets and historically drives the majority of revenue.

Veeva's Market Dominance

Veeva CRM has become the de facto standard, with an estimated 65-70% market share among top-20 pharma companies according to Gartner’s market share analysis. Veeva's architecture is built around field force workflows.

Cultural Tradition

"Pharma is a sales-driven industry" is conventional wisdom reinforced by decades of success with the representative-led model.

Intuitive Logic

It feels right that the person with face-to-face HCP relationships should orchestrate. Reps argue (not unreasonably): "I know my doctors better than a marketing automation algorithm does."

Digital Blindness

Sales representatives do not always see HCP digital behaviour unless it's synced to CRM:

HCP visits website, spends 12 minutes reading efficacy data
→ Rep has no visibility

HCP opens email, clicks link, downloads safety brochure
→ Rep doesn't know

HCP attends webinar, asks questions in chat
→ Rep unaware

Without this visibility, reps cannot truly orchestrate. They're flying blind on 50%+ of HCP touchpoints.

No-See/Low-See HCP Challenge

Each sales representative manages 200-400 HCPs (depending on speciality). Even with perfect tools, reps cannot:

- Not accessible for face-to-face → Rep can't engage
- Digital-only engagement → Rep doesn't orchestrate digital
- Result: HCP receives generic, un-personalised digital content (or no content)

Without this visibility, reps cannot truly orchestrate. They're flying blind on 50%+ of HCP touchpoints.

Technology Architecture Constraints

Veeva CRM, while powerful for field force automation, was not designed for omnichannel orchestration:

- Batch data updates (not real-time)
- Limited marketing automation capabilities (bolted-on modules, not native)
- Rep-facing UX (not designed for marketers or data scientists)
- Channel biases (WhatsApp, chatbots, patient apps are not natural fits)

Despite its persistence, the rep-centric model increasingly struggles with modern engagement requirements:

Scale and Personalisation Limitations

Each sales representative manages 200-400 HCPs (depending on speciality). Even with perfect tools, reps cannot:

- Personalise content for 300 individual HCPs based on their unique needs
- Monitor and respond to digital signals in real-time (rep checks CRM daily or weekly, not continuously)
- Execute sophisticated multi-channel sequences (if HCP opens email but doesn't click, resend in 3 days → Rep cannot manually manage this logic at scale)

Without this visibility, reps cannot truly orchestrate. They're flying blind on 50%+ of HCP touchpoints.

The "Rep as Channel" Model (Emerging Paradigm)

The emerging alternative inverts the architecture: Marketing orchestrates, and the rep is one (important) channel within an integrated journey.

Core Assumptions:

- Marketing (or Omnichannel team) designs journeys based on HCP needs and behaviours across all channels
- The Customer Data Platform (CDP) is the centre of gravity as a unified HCP profile aggregating data from CRM + digital + events + third-party sources
- The rep is a high-value channel for complex discussions, relationship building, and closing, but not the only channel and not the orchestrator
- Orchestration logic lives in marketing automation (Salesforce Marketing Cloud, Adobe Marketo), triggered by HCP behaviour and data

Operational Model:

Marketing makes orchestration decisions:

- **Journey design:** Marketing maps the HCP journey, defines trigger rules (if HCP does X, then send Y through channel Z)
- **Content sequencing:** Marketing determines the optimal sequence (email → web → rep → congress → follow-up email)
- **Channel selection:** Marketing decides which channel is appropriate for each touchpoint based on HCP preferences, segment, and journey stage
- **Performance optimisation:** Marketing analyses journey performance, A/B tests content, reallocates budget

Technology Architecture:

In this model, the CDP + **Marketing Automation is the system of record**

- CDP aggregates all data: CRM (field interactions) + marketing automation (digital behaviour) + website analytics + event platforms + third-party data (prescriptions, affiliations)
- Marketing Automation executes journeys: Trigger rules, content s equences, A/B tests, campaign management
- CRM remains critical but is one input and one output in the ecosystem (not the centre)
- Integration is bidirectional: CRM pushes field interaction data to CDP → CDP enriches HCP profile → Marketing automation orchestrates next touchpoint → If next touchpoint is rep visit, CRM receives task

Rep's Role (Still Critical, But Redefined):

The rep remains essential but is integrated into the orchestrated journey:

- **Rep receives intelligence:** Before visiting HCP, rep reviews dashboard showing HCP's recent digital engagement (emails opened, content consumed, questions asked)
- **Rep executes high-value touchpoint:** Face-to-face discussion is personalised based on HCP's demonstrated interests
- **Rep logs interaction:** Call notes captured in CRM trigger next orchestration steps (e.g., if rep discussed safety, marketing automation sends safety deep-dive content 48 hours later)
- **Rep focuses on complexity:** Rep time is allocated to HCPs requiring complex, relationship-intensive engagement (top-tier KOLs, high prescribers), routine HCPs are managed digitally

Real-World Description:

Someone described their emerging architecture:

> *"The real orchestrator for me is not the rep, it's marketing. You can only do it when you provide your reps with a 360º view, which is not coming only from Veeva. All the other channels you are using, like webinars or WhatsApp (which are typical channels Veeva is not supporting), are coming from different sources. We have built a 360º dashboard giving a holistic customer view based upon all our data, not only coming from Veeva."*

Another leader described the operational reality:

> *"What you see in any local operating company is that we have a mix of marketing-led activities and sales-led activities, and of course, they are aligned through the marketing plan. In some cases, you don't even have reps as a channel."*

Why This Model is Gaining Traction:

Digital-First HCPs

McKinsey estimates that 30-40% of HCPs now prefer digital-first engagement. They want information on demand, consume content at their convenience (evenings, weekends), and view rep visits as interruptive. For these HCPs, marketing-led orchestration is natural.

Hybrid Efficiency

The optimal model for most HCPs is hybrid: digital nurturing (awareness, education) → Rep visit when HCP is "warm" and receptive → Digital reinforcement (case studies, peer videos). This requires marketing to orchestrate the digital layers, with rep as one touchpoint.

Personalisation at Scale

Marketing automation can execute sophisticated personalisation that reps cannot manually manage:

- If HCP opens email about efficacy → Send efficacy deep-dive 48 hours later
- If HCP doesn't open → Send different subject line via SMS 5 days later
- If HCP clicks safety content → Flag for rep "HCP has safety concerns, address in next call"

This dynamic, behaviour-driven orchestration requires automation, not manual rep effort.

Data Richness Enables AI

Customer Data Platforms unify data that enables AI/machine learning:

- Predictive models: Which HCPs are likely to adopt? (Train model on historical data)
- Next-Best-Action: Given this HCP's profile and recent behaviour, what's the optimal next touchpoint?
- Attribution: Which touchpoints actually drive prescription changes? (Requires multi-channel data)

These advanced capabilities require a CDP architecture, not a CRM-centric one.

Implementation Challenges:

Sales Force Resistance

Reps naturally perceive "rep as channel" as diminishment: "You're taking away my customer." Sales leadership often resists fiercely, arguing that marketing lacks the relationship knowledge to orchestrate.

Cultural Shift

The model requires pharmaceutical companies to think like consumer tech companies (marketing-led, data-driven, test-and-learn) rather than traditional pharma (relationship-led, sales-driven). This cultural shift is profound.

Technology Investment

Implementing CDP + Marketing Automation + real-time CRM integration requires significant investment ($2-10M+ depending on scale) and 12-24 month timelines.

Despite these challenges, the long-term trend clearly favours marketing-led orchestration, particularly as younger, digital-native HCPs enter the market and as AI capabilities mature.

The Hybrid Model in Practice: Rep-to-Digital Journeys

The most common practical implementation, and the bridge between the two paradigms, is the **"Rep-to-Digital" journey**, which blends both models.

How It Works:

Step 1: Rep Visit (High-Touch, Relationship Building)

- Sales representative visits HCP (face-to-face or virtual)
- Uses detail aid in Veeva, presents key messages (efficacy, safety, patient outcomes,..)
- Logs call in CRM, noting HCP interests, questions, and objections

Step 2: Trigger Logic (Automated Based on Rep Input)

- CRM data syncs to marketing automation platform
- Trigger rules analyse call: "Rep spent >2 minutes on efficacy slide → HCP interested in efficacy data"
- Business rules determine timing: Send follow-up in 3 days (not immediate, not too delayed)

Step 3: Automated Digital Follow-Up

Marketing automation sends personalised email:

- Subject: "Deep Dive into [Product] Efficacy Data"
- Content: Links to clinical trial publications, efficacy charts, peer testimonials
- CTA: "Download full study results" or "Register for efficacy webinar"

Step 4: Engagement Tracking

- HCP opens email → Event logged in marketing automation → Syncs to CRM
- HCP clicks link, downloads content → Higher intent signal → Alert generated for rep
- HCP doesn't open after 5 days → Send reminder via different channel

Step 5: Closed-Loop Back to Rep

- Rep's CRM dashboard shows: "HCP [Dr. Smith] engaged with efficacy email, downloaded 2 studies, viewed webinar → High Intent"
- Rep references this digital engagement in next face-to-face visit: "I saw you reviewed the efficacy data we sent last week. What questions can I answer?"

This ROI proof is critical for securing continued investment.

Why Rep-to-Digital Works:

1. Extends Rep Reach Without Requiring More Rep Time

The rep has a few minutes with the HCP; digital extends the conversation over days/weeks without additional rep effort.

2. Rep Remains "Relationship Owner" (Politically Palatable)

Sales leadership accepts this model because the rep is still central, they initiate, and digital supports. This is an easier cultural sell than "marketing orchestrates everything."

3. Digital Reinforces and Deepens Rep Message

Studies show HCPs need 5-7 exposures to a message before behaviour change. Rep provides 1-2 exposures; digital provides the remaining 4-5.

4. Measurable

The model enables clear measurement

- **Baseline:** Rep visits without digital follow-up → X% conversion to Rx
- **Test:** Rep visits WITH digital follow-up → Y% conversion to Rx
- **Incremental lift:** Y - X = impact of digital reinforcement

Section 6 - Conclusion | Operating Models Are Necessary, But Not Sufficient

Key Takeaways: Organisational Clarity as the Foundation

This white paper has explored the organisational structures, decision rights, and coordination mechanisms that govern HCP engagement in life sciences. Through analysis of 12+ in-depth interviews, our experience working across various companies, and synthesis with industry research, we identified five critical insights:

Insight 1 → Operating Model Ambiguity is the Root Cause of Omnichannel Fragmentation

The perception gap (remember that 82% of pharma executives are satisfied, while only 28% of HCPs are satisfied) is not primarily a failure of technology or content quality. It is a failure of organisational clarity. When it is unclear who owns the customer journey, how decision rights flow between global/regional/local levels, and how functions coordinate, the result is inevitably a fragmented, inconsistent, and suboptimal customer experience.

Technology investments (CRM, CDP, marketing automation, AI) cannot compensate for organisational misalignment. In fact, technology often amplifies existing organisational dysfunction rather than solving it.

Insight 2 → Three Archetypal Models Exist; Each Has Distinct Trade-Offs

The three operating models we identified – Brand-Led (Decentralised), Centre of Excellence-Led (Centralised/Hybrid), and Integrated Omnichannel (Customer-Centric) – are not "good" or "bad" in absolute terms. Each has strengths and weaknesses contingent on organisational context:

- Brand-Led optimises for speed and agility, but creates customer-facing fragmentation
- COE-Led optimises for efficiency and consistency, but can stifle brand responsiveness
- Integrated Omnichannel optimises for seamless customer experience, but requires massive transformation investment and high digital maturity

Our research and experience working with global, regional, and local clients indicate that approximately 60-70% of pharmaceutical companies operate under the Brand-Led model, 25-30% under the COE-Led model, and only 5-10% under the Integrated Omnichannel model.

Insight 3 → Geographic Coordination (Global-Regional-Local) is a Second-Order Challenge

Beyond choosing an archetype, organisations must architect how decision rights and workflows distribute across geographies. The "glocal" model, which combines global strategy with local execution, sounds elegant but creates hidden friction when boundaries are ambiguous.

Best-practice organisations implement three-tier models: Global HQ creates strategy and core assets, Blueprint Markets (US, UK, Germany, France) build executable templates and test, and Localisation Markets configure templates to local requirements. Explicit RACI mapping prevents constant negotiation and content waste.

Insight 4 → Medical-Commercial and Field-Digital Integration are Critical Success Factors

Two integration challenges cut across all archetypes:

Medical Affairs and Commercial: The regulatory firewall that separates these functions is necessary for compliance, but creates customer-facing fragmentation if not actively bridged. Leading organisations implement a three-layer coordination model: Governance (steering committees), Process (joint journey mapping), and Metrics (shared KPIs). However, only one interviewed organisation reported genuinely shared KPIs. Most remain aspirational.

Field Force and Digital: The debate about whether sales representatives are "orchestrators" or "one channel" reflects deeper organisational questions about power, technology architecture, and customer-centricity. The trend is clear: marketing-led orchestration (rep as channel) is gaining traction, particularly for digital-native HCPs. However, the Rep-to-Digital hybrid model offers a pragmatic bridge.

Insight 5 → Operating Model Choice Must Be Data-Driven, Not Imitative

There is no universal "best" operating model. Six contingency factors must drive choice:

1. Company size and portfolio breadth
2. HCP segment overlap
3. Geographic footprint
4. Data and technology maturity
5. Organisational culture
6. Launch intensity and market dynamism

Organisations that blindly copy competitors' models or follow consultant recommendations without assessing their own context inevitably fail. Use our diagnostic frameworks in the appendix (maturity assessment, contingency analysis) to make informed choices.

The Three Bottlenecks: Operating Models Are Necessary, But Not Sufficient

Even organisations that successfully diagnose their current archetype, chart an evolution path, and implement explicit decision rights discover a sobering reality: operating model clarity is necessary, but not sufficient.

Our interviews revealed three foundational bottlenecks that prevent even well-structured organisations from delivering an orchestrated customer-centric experience:

Bottleneck 1: Data Architecture → The Foundation is Missing

The most sophisticated operating model cannot function without unified, high-quality customer data. Yet most pharmaceutical companies operate with:

- **Fragmented data silos:** Customer data trapped in separate systems (CRM, marketing automation, website analytics, event platforms, third-party sources) with no unification
- **No Master Data Management (MDM):** The same HCP appears as 5-10 variants across systems; no "golden record"
- **No Customer Data Platform (CDP):** No 360-degree HCP profile; orchestration is impossible without unified data
- **Poor data quality:** Outdated addresses, incorrect specialities, missing consent records

When organisations attempt to deploy AI-powered Next-Best-Action engines or sophisticated personalisation on top of fragmented, low-quality data, the result is predictable: "garbage in, garbage out." Field force representatives reject recommendations because they're obviously wrong, trust erodes, and projects are shelved.

One interview subject captured the problem with stark clarity:

> *"AI on bad data is garbage in, garbage out. We need to build the house before the roof."*

The Implication: Even an Integrated Omnichannel operating model with journey pods, cross-functional teams, and devolved authority cannot function without a unified data foundation. Data architecture is the prerequisite for orchestration.

Bottleneck 2: Content Velocity → The Supply Chain is Broken

The second universal bottleneck: content creation and approval cycles are too slow to support iterative, adaptive journeys.
Our interviews revealed:

- MLR (Medical-Legal-Regulatory) cycle times of 3-9 months for global content, plus an additional 4-6 months for local adaptation and approval
- Content designed as monolithic assets (60-page detail aids, comprehensive email campaigns) rather than modular, reusable components
- 77% of globally-created content goes unused by local markets (either irrelevant, or local teams recreate rather than adapt)
- No modular content architecture: Content cannot be dynamically assembled; every variation requires full MLR review

One interviewee stated the problem unequivocally:

> *"Content approval, not creation, is the real bottleneck."*

When journey velocity requires weekly iteration cycles (test content, analyse results, optimise, relaunch), but content approval takes months, the journey vision collapses. Organisations either:

- Accept slow, un-optimised journeys (launching once per quarter, never iterating)
- Bypass MLR (creating compliance risk)
- Give up on personalisation (use generic content for all segments to minimize approval burden)

The Implication: Modular content architecture and MLR transformation are prerequisites for journey velocity. Without them, even optimal operating models deliver static campaigns, not dynamic journeys.

Bottleneck 3: Measurement Systems → Cannot Prove ROI

The third bottleneck: **inability to link engagement activities to business outcomes undermines** credibility and budget defense. This is what we call the Black Box problem.

Our interviews found that pharmaceutical companies universally rely on activity metrics:

- Emails sent, open rates, click rates
- Sales calls completed, call reach, frequency
- Website visits, page views, time on site
- MSL interactions, advisory boards conducted

Yet when executive leadership asks the essential question "Did our $50M digital investment increase prescriptions?" the industry cannot answer. The typical response: "Open rates improved 15%" is irrelevant to business outcomes.

One interviewee described the organisational incentive problem with brutal honesty:

> *"Being realistic doesn't get you promoted; vanity metrics do."*

The measurement gap has three layers:

No leading indicators: Industry doesn't measure adoption ladder progression (A→B shift: Awareness → Consideration → Regular → Loyal)

No attribution: Cannot isolate the impact of specific touchpoints (was it the rep visit, the email, the congress, or all three that drove prescription change?)

No shared KPIs: Commercial, Medical, and Market Access measured on functional metrics (leads, calls, MSL interactions), not customer outcomes (HCP satisfaction, journey progression, Rx lift)

The Implication: Without measurement systems that prove ROI, omnichannel and other investments remain vulnerable to budget cuts. Organisations cannot optimise what they cannot measure.

Bridge to our next white paper: "Breaking the Bottlenecks"

Organisational clarity, the focus of this white paper, is the essential foundation. However, addressing the three bottlenecks is the necessary next step.

In our forthcoming white paper, we will explore:

Part 1 | Data as the Foundation (Bottleneck 1)

- How to architect a modern data foundation: Master Data Management (MDM), Customer Data Platform (CDP), data governance
- The proper investment sequence: Why data must come before AI/analytics
- How to build the "single source of truth" that enables orchestration
- Technology vendor landscape: Choosing between CDP platforms (Salesforce, Adobe, Tealium, others)

Part 2 | Content for Journey Velocity (Bottleneck 2)

- Re-engineering the content supply chain: From monolithic assets to modular components
- Transforming MLR: From asset approval to module certification
- Global-to-local content flow: How blueprint markets create reusable templates
- The role of Generative AI: Content assembly and QA, not creation
- Metadata and taxonomy: The foundation for dynamic personalisation

Part 3 | Measurement for Proving ROI

- Beyond vanity metrics: Building leading-indicator frameworks
- Attribution modelling: From correlation to causation (control groups, propensity scoring, marketing mix models)
- Designing shared KPIs: Aligning Commercial, Medical, and Market Access around customer outcomes
- Technology enablers: Analytics architecture required for attribution
- CFO-ready business cases: How to defend omnichannel budgets with data

The Integration Thesis:

Operating models determine who decides and how teams coordinate. But even perfect coordination fails if:

- Teams coordinate around bad data (Bottleneck 1)
- Content supply chains prevent rapid iteration (Bottleneck 2)
- No one can prove what works (Bottleneck 3)

Our next white paper will provide the operational playbooks to systematically address these bottlenecks, completing the journey from organisational clarity to executional excellence.

Appendix

Appendix A | Interview Methodology

Research Design:

This white paper is based on qualitative research conducted between August and October 2025. The research employed semi-structured interviews with senior leaders across pharmaceutical companies, using a standardised questionnaire to enable cross-organisation comparison while allowing for contextual exploration.

Sample Characteristics:

Sample Size: 12+ interviews

Geographic Distribution:

- **North America:** United States
- **Europe:** Belgium, France, Turkey, United Kingdom
- **Asia-Pacific:** Referenced in several interviews Singapore-based operations)

Organisational Level:

- **Global Headquarters:** 5 interviewees
- **Regional (EMEA, Americas):** 4 interviewees
- **Local Market:** 3 interviewees

Functional Distribution:

- **Omnichannel/Digital Excellence:** 4 interviewees
- **Marketing Operations:** 2 interviewees
- **Commercial Excellence:** 3 interviewees
- **Brand Management:** 2 interviewees
- **Medical Affairs:** 1 interviewee

Company Scope:

- **Top-10 Global Pharmaceutical:** 6 interviewees
- **Mid-Size Global Pharmaceutical ($5-20B revenue):** 4 interviewees
- **Regional/Speciality Pharmaceutical:** 2 interviewees

Interview Protocol:

Each interview followed a standardised eight-section questionnaire:

1. Context & Background (5-8 minutes): Role description, organisational maturity assessment

2. Organisational Structure & Leadership (10-12 minutes): Who owns journey design? How do teams coordinate?

3. Collaboration & Information Sharing (8-10 minutes): Mechanisms for cross-functional alignment

4. Technology & Tools (8-10 minutes): Platforms, integration, gaps

5. Journey Complexity & Design (8-10 minutes): Journey characteristics, design process

6. Content Creation & Management (6-8 minutes): Content workflows, MLR, localisation

7. Performance & Learnings (8-10 minutes): What works, what doesn't, evolution over time

8. Closing Questions (3-5 minutes): Top recommendations, missing questions

Average interview duration: 50-60 minutes

Coding and Analysis:

Interview transcripts were coded using thematic analysis aligned to Fractal Force's Five Foundation Pillars:

1. Data & Analytics Architecture
2. Segmentation
3. Engagement Journey Design
4. Agile Operating Models
5. Impact Measurement Frameworks

Emergent themes (operating model archetypes, glocal tensions, content bottlenecks) were identified through iterative coding and cross-interview pattern recognition.

Anonymisation and Ethics:

1. All participating organisations and individuals have been de-identified
2. Quotes are verified against interview transcripts but anonymised in publication
3. Participants were informed of the research purposes and consented to anonymised quotation
4. Where necessary to preserve anonymity, minor contextual details (company size, specific therapeutic areas) have been generalised without altering substantive content

Limitations:

- **Sample size:** While 12+ interviews provide rich qualitative insights, findings may not be statistically representative of the entire pharmaceutical industry
- **Self-reported data:** Interviewees describe their organisations' stated processes; actual execution may vary
- **Snapshot in time:** Interviews conducted in Aug-Oct 2025; operating models are evolving rapidly
- **Selection bias:** Interviewees were senior leaders with omnichannel responsibilities; perspectives of field sales, medical affairs, or IT functions may differ

Appendix B
Choosing Your Operating Model | Diagnostic Framework

There is no universal "best" operating model for HCP engagement. The optimal choice depends on organisational maturity, market complexity, portfolio characteristics, and strategic priorities. Attempting to implement a model designed for a different organisational context inevitably leads to failure.

This section provides diagnostic frameworks to:

1. Assess your current operating model maturity
2. Identify contingency factors that should inform your model choice
3. Chart realistic migration pathways
4. Avoid common pitfalls

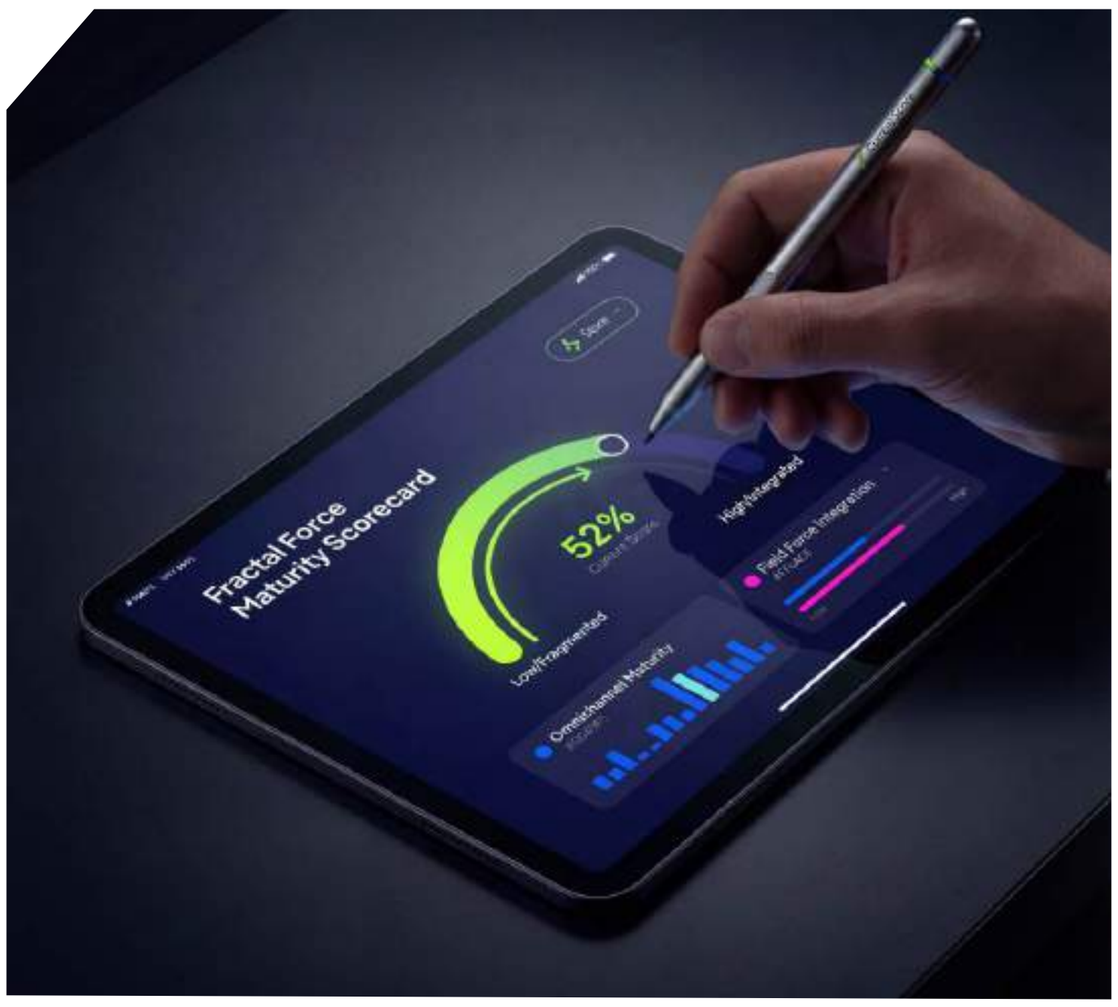
Maturity Assessment: Where Are You Today?

Current State Distribution:

Based on our interviews, our own experience working across various companies, and external research, we estimate the current distribution of pharmaceutical companies across the three archetypes:

- **Brand-Led (Decentralised):** ~60-70% of organisations
- **Commercial Excellence-Led (Hybrid):** ~25-30% of organisations
- **Integrated Omnichannel (Customer-Centric):** ~5-10% of organisations (pioneers only)

Most mid-size pharmaceutical companies and many large pharma remain in the Brand-Led model. Transition to COE-Led typically occurs after a "crisis" event (major duplication discovered, C-suite mandate for efficiency, post-merger integration requirement). The Integrated Omnichannel model remains aspirational for most, with only digital-native biotechs and a handful of top-10 pharma pilots truly implementing it.



Assessment Framework:

To diagnose your current operating model, assess your organisation across five dimensions:

Dimension 1: Decision Rights and Authority

Score your organisation (0-4 points):

0 points - Pure Brand-Led:
- Brand teams have full autonomy over journey design, content, budget, channel selection
- Cross-brand coordination is voluntary or non-existent
- No central function with authority over brand activities

2 points - Hybrid (Brand + Emerging COE):
- Brand teams retain strategy authority; central function provides platforms and shared services
- Mandatory use of some enterprise tools (CRM), but brands have freedom on content and agencies
- Governance committees exist but lack enforcement mechanisms

4 points - Integrated Omnichannel:
- Journey teams (pods) organised around HCP segments hold primary authority
- Cross-functional by design; marketing, sales, medical embedded in teams
- Central enabling functions provide data, analytics, content as shared services

Dimension 2: Data and Technology Architecture

0 points - Fragmented:
- Multiple CRM instances (different regions or brands use different systems)
- No Customer Data Platform; data siloed in separate tools
- Reporting is manual (Excel-based); no unified dashboards

2 points - Consolidated Enterprise Stack:
- Single enterprise CRM (one Veeva or Salesforce instance)
- Marketing automation platform deployed (Salesforce Marketing Cloud or Adobe)
- Data warehouse exists but batch-updated (daily or weekly, not real-time)

4 points - Integrated Omnichannel:
- Customer Data Platform implemented, ingesting data from all sources
- Real-time API integrations across systems
- 360-degree HCP profiles accessible to all functions
- Advanced analytics layer (AI/ML models for segmentation, NBA, attribution)

Dimension 3: Content Operations

0 points - Brand-Specific:

- Each brand team creates content independently (separate agencies, no templates)
- No content reuse across brands or markets
- MLR approval is per-brand, per-asset (no modular approach)

2 points - Centralised Content Factory (Emerging):

- Central team creates core content assets
- Templates exist but significant brand customization still occurs
- Some content reuse (global content localised, but variable adoption)

4 points - Modular Content Ecosystem:

- Content created as pre-approved modular components
- Metadata taxonomy enables dynamic assembly
- Global content factory supports local teams; high reuse rates (>60%)
- MLR approves modules and assembly rules (not final assets)

Dimension 4: Measurement and Analytics

0 points - Activity Metrics Only:

- KPIs are inputs: emails sent, calls made, website visits
- No measurement of customer progression (adoption ladder movement)
- No attribution (cannot link touchpoints to outcomes)

2 points - Engagement Scoring:

- Track customer engagement quality (not just quantity)
- Adoption ladder progression measured at aggregate level
- Basic multi-touch attribution (last-touch or first-touch models)

4 points - Impact Measurement and Attribution:

- Leading indicators tracked: A→B shift velocity, engagement quality scores
- Causal attribution models (control groups, propensity scoring, incrementality tests)
- Shared KPIs across Commercial, Medical, and Market Access
- Dashboards show journey performance, not just functional performance

Dimension 5: Coordination and Governance

0 points - Siloed:

- Functions (Marketing, Sales, Medical) operate independently
- Coordination is ad hoc or crisis-driven
- No formal governance structure; decisions escalate to senior leadership

2 points - Governance Committees:

- Regular cross-functional meetings (monthly or quarterly)
- Steering committees with brand, CE, and medical representation
- Processes exist for conflict resolution but are slow

4 points - Embedded Collaboration:

- Cross-functional teams (journey pods) work daily together
- Coordination is structural, not process-based
- Agile decision-making; teams empowered to test and learn

Scoring and Interpretation:

Total your score across five dimensions (maximum 20 points):

- **0-8 points:** Brand-Led Model (current state for most)
- **9-16 points:** Commercial Excellence-Led (transitioning or established hybrid)
- **17-20 points:** Integrated Omnichannel (mature, customer-centric)

Contingency Factors: What's Right for Your Context?

Operating model choice should be driven by six contingency factors. Use this framework to assess whether your current archetype aligns with your strategic context.

Factor 1: Company Size and Portfolio Breadth

If your organisation has:

2-5 brands, <$5B revenue → Brand-Led is likely optimal (coordination overhead exceeds efficiency gains)

6-15 brands, $5-20B revenue → COE-Led prevents duplication and enables scale

15+ brands, >$20B revenue OR concentrated speciality → Integrated Omnichannel may justify investment

Factor 2: HCP Segment Overlap

Assess: What percentage of your target HCPs are targeted by multiple brands

<20% overlap → Brand-Led acceptable (minimal fragmentation risk)

20-50% overlap → COE-Led mitigates some fragmentation through coordination

>50% overlap → Integrated Omnichannel required to prevent HCP fatigue (e.g., 3 oncology brands all targeting the same 2,000 oncologists)

Factor 3: Geographic Footprint

Single country or regional (2-5 markets) → Brand-Led manages complexity

Global with 20-50 markets → COE-Led provides economies of scale

Global with 50+ markets AND significant glocal tension → Three-tier model (global/blueprint/local) regardless of archetype

Factor 4: Data and Technology Maturity

Reality check: You cannot operate a model that exceeds your technology capability.

If you have: Fragmented CRMs, no CDP, manual reporting → **Stay Brand-Led;** don't pretend coordination exists

If you have: Enterprise CRM, marketing automation, data warehouse → **COE-Led** is accessible

If you have: CDP, real-time integration, advanced analytics → **Integrated Omnichannel** is technically feasible (but requires organisational readiness)

Factor 5: Organisational Culture and Readiness

Entrepreneurial, brand-driven culture (common in speciality pharma, biotech) → **Brand-Led aligns with DNA**

Process-oriented, efficiency-focused culture (common in large established pharma) → **COE-Led fits**

Innovation-driven, customer-obsessed culture (rare in pharma, more common in digital health) → **Integrated Omnichannel resonates**

Factor 6: Launch Intensity and Market Dynamism

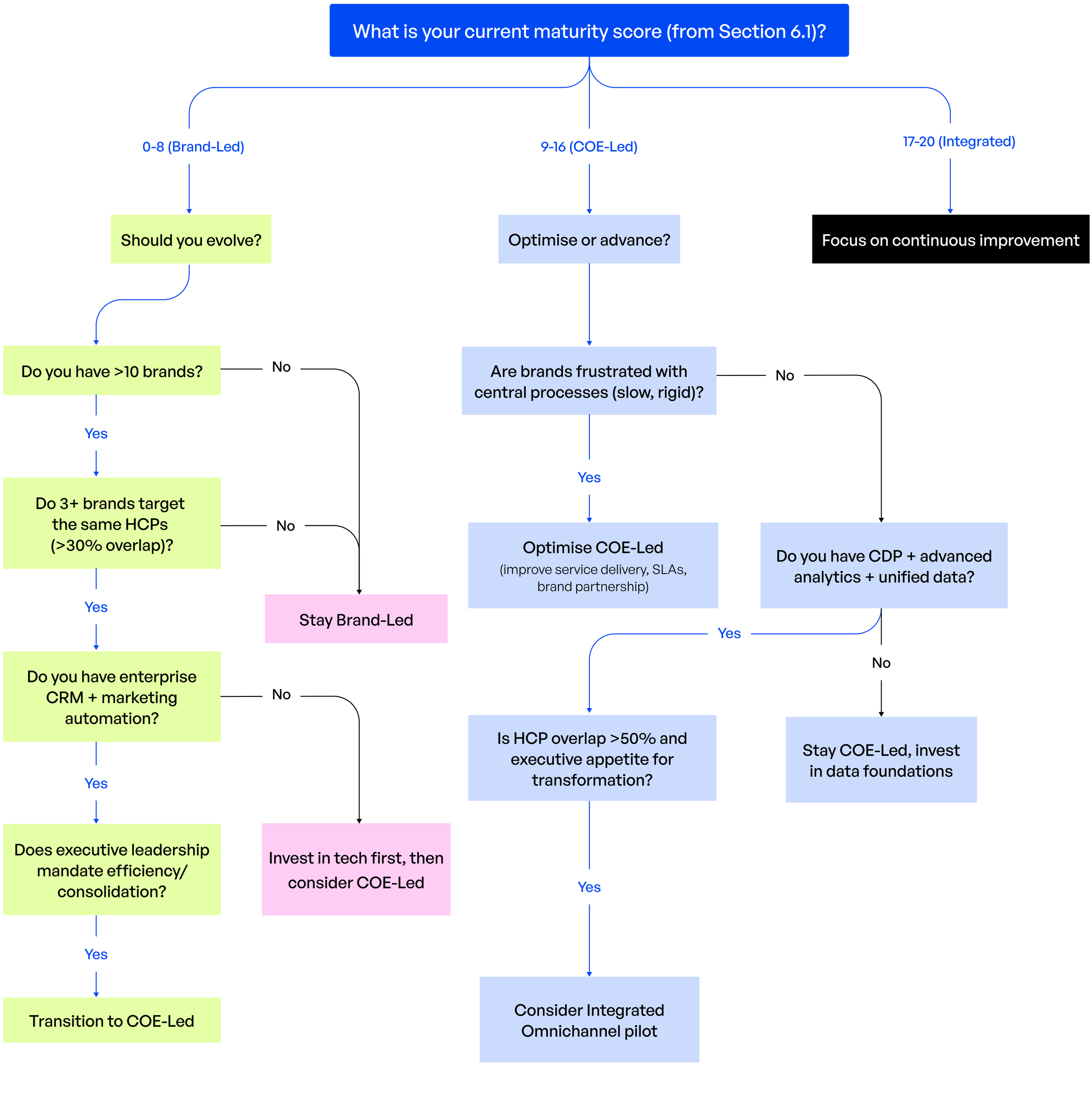
1-2 launches per year in stable markets → Integrated Omnichannel can absorb (long-term relationship building)

3-5 launches per year in competitive markets → COE-Led provides consistency without sacrificing too much speed

5+ launches per year in fast-moving markets → Brand-Led may be necessary for agility (accept some inefficiency as cost of speed)

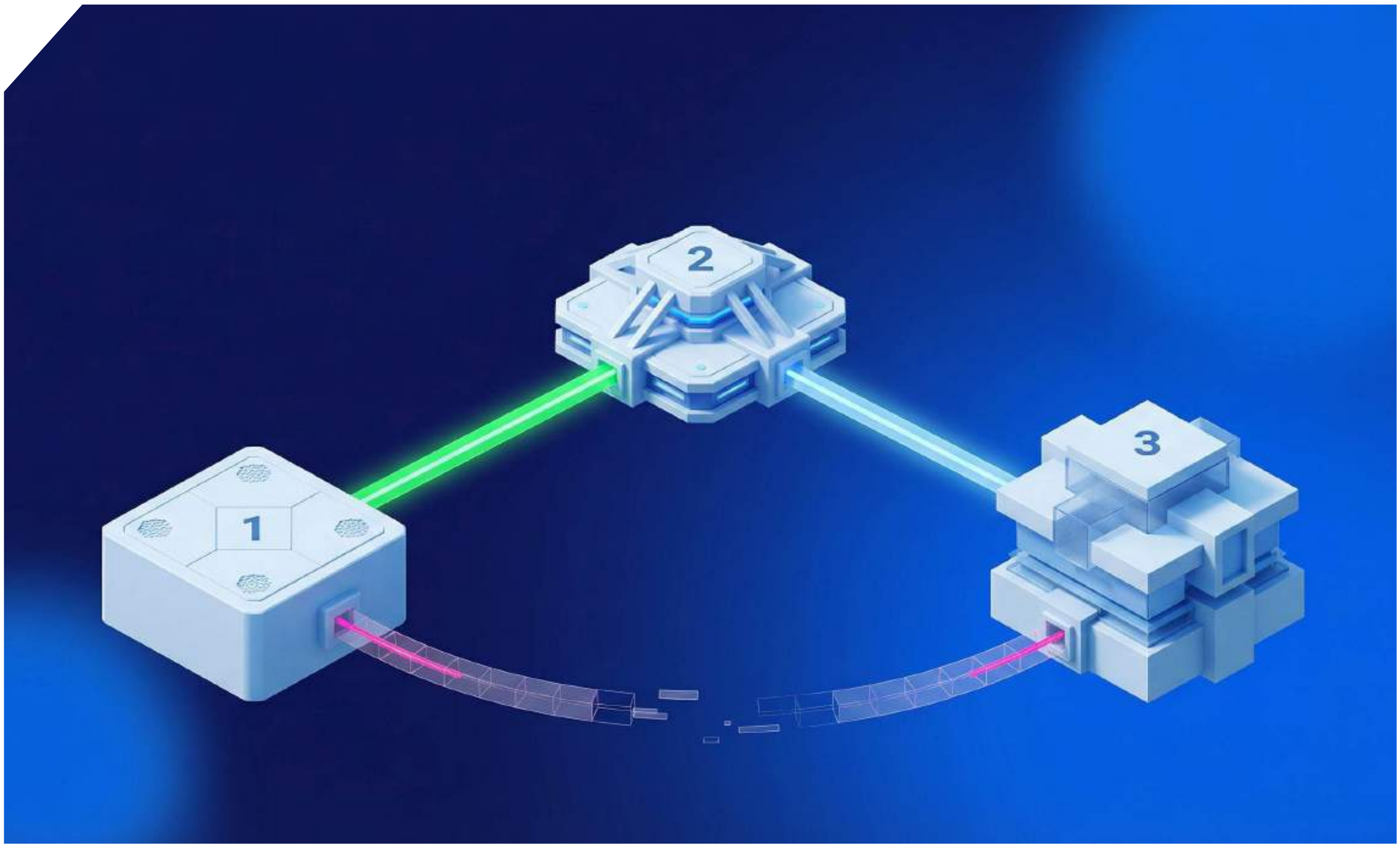
Forcing a model that conflicts with culture creates immense friction.

Decision Tree for Operating Model Selection



Migration Pathways: How to Evolve

Operating model evolution follows predictable paths. Attempting to "leapfrog" stages, particularly from Brand-Led directly to Integrated Omnichannel, fails without building intermediate capabilities.



Migration Path 1: Brand-Led → COE-Led (Most Common)

Operating model evolution follows predictable paths. Attempting to "leapfrog" stages, particularly from Brand-Led directly to Integrated Omnichannel, fails without building intermediate capabilities.

Trigger Events:

- C-suite discovers duplication costs (e.g., "We have 8 separate analytics teams?")
- Customer complaints about fragmentation reach executive level
- Post-merger integration creates urgency to harmonize operating models
- New Chief Commercial Officer with mandate to modernize

Prerequisites:

- Executive mandate and sponsorship (Chief Commercial Officer or CEO)
- Budget for central team (10-30 FTEs depending on company size; $5-15M investment)
- 18-24 month timeline expectation
- Willingness to accept short-term productivity dip during transition

Phase 1: Establish Central COE with Clear Mandate (Months 1-6)

Key Activities:

- Hire COE leadership (Director or VP of Commercial Excellence)
- Define COE charter: What does COE own? (platforms, data, SFE) What remains with brands? (strategy, content, budget)
- Establish governance structure: Steering committee with brand and COE representatives
- Conduct technology audit: What systems exist? What duplication? What should consolidate?

Communication:

- Emphasize to brands: "COE exists to serve you, not control you"
- Be explicit about what's changing and what's not
- Celebrate "we're investing in capabilities brands couldn't build alone"

Phase 2: Technology Consolidation (Months 6-18)

Key Activities:

- Consolidate CRM (if multiple Veeva instances exist, collapse to one)
- Implement or standardize marketing automation (select Salesforce Marketing Cloud OR Adobe Marketo; mandate usage)
- Build data warehouse or initial CDP (centralize reporting)
- Migrate content to centralised DAM (Digital Asset Management)

Risk: Brands resist giving up "their" systems Mitigation: Grandfather existing brand commitments (e.g., "Current campaigns run on your platform; all new campaigns use enterprise platform")

Phase 3: Process Standardisation (Months 12-24)

Key Activities:

- Develop journey templates (5-10 reusable patterns: launch journey, congress journey, rep-to-digital journey)
- Standardize content formats (email templates, detail aid structures)
- Create playbooks for common scenarios
- Pilot standardised journeys on 1-2 willing brands

Risk: One-size-fits-all doesn't fit specialised brands Mitigation: Offer "template + customization" model (80% standard, 20% brand-specific flexibility)

Phase 4: Scale and Optimise (Months 18-36)

Key Activities:

- Roll out standardised processes across all brands
- Train brand teams on new platforms and templates
- Measure efficiency gains (cost savings, faster time-to-market)
- Communicate wins to reinforce COE value

Success Metrics:

- Technology cost reduction: 25-35% (typically achieved)
- Time-to-market improvement: 30-40% faster campaign launches
- Brand satisfaction: Survey brands quarterly; target >70% satisfaction with COE services
- Consistency improvement: Measure HCP-facing consistency (e.g., brand compliance scores, visual identity adherence)

Interview Evidence:

One leader described their early-stage journey orchestration evolution:

> *"We've got a few people. The person executing user journeys is also the person orchestrating them. We installed these teams two years ago. At first, they relied mostly on rep-to-digital emails. But over the years, we have become increasingly advanced."*

Another described the progression:

> *"Are we at a super high level of complexity and sophistication yet? No, probably not. Are we still relying on agencies for the execution of these units? Yes, we are, but we are making progress there."*

This candor is important—evolution takes years, not months. Organisations should set realistic expectations.

Migration Path 2: COE-Led → Integrated Omnichannel (Rare, High-Risk)

Reality Check: This transformation is rare in pharmaceutical companies (5-10% attempting). It requires:

- Strong data foundation (CDP, MDM, unified analytics) → If this doesn't exist, do not attempt
- High digital maturity across organisation
- Executive appetite for disruption and transformation
- 24-36 month timeline and $10-30M+ investment

Trigger Events:

- Customer feedback/competitive pressure demands seamless experience
- New CEO or Chief Commercial Officer with mandate for customer-centricity
- Acquisition of digital-native biotech with different operating model creates pressure to modernize
- Board-level strategic imperative to differentiate on customer experience

Prerequisites (Non-Negotiable):

1. Customer Data Platform operational: Must have 360-degree HCP profiles, real-time data, unified across all sources

2. Advanced analytics capability: Data science team capable of building predictive models, attribution, NBA

3. Organisational readiness: Leadership willing to disrupt brand P&L structures, sales force reporting lines, career paths

4. Pilot-first mentality: Must prove ROI in small pilot before scaling

Phase 1: Pilot Journey Pod on High-Priority Segment (Months 1-12)

Select Pilot Segment:

- High strategic importance (large prescriber segment or critical KOL community)
- High HCP overlap (multiple brands target same HCPs → fragmentation pain is acute)
- Digital maturity (segment that is digitally engaged, not pure field-force access)
- Example: "Top 500 Academic Medical Centre Oncologists" or "Diabetes Endocrinologists in Major Metro Areas"

Design New KPIs (Customer-Centric):

- HCP satisfaction score (via survey)
- Journey progression velocity (% moving from awareness → adoption in 6 months)
- Engagement quality score (composite: depth of interaction, content consumption, channel diversity)
- Business outcomes: Prescription growth, new patient starts, market share in segment

Build Pilot Pod:

Pod Lead: Senior omnichannel manager with cross-functional credibility

Team Members (4-6 FTEs):

- Marketing representative (content, campaigns)
- Sales operations liaison (field engagement coordination)
- Medical Affairs representative (scientific strategy)
- Data analyst (segmentation, measurement, reporting)

Dedicated Budget: Transfer budget from brands for this segment to pod (create real P&L accountability)

Run Pilot:

- Design unified journey for segment (all brands integrated)
- Execute for 6-12 months
- Compare performance: Pod vs. control segment (similar HCPs managed via traditional model)

Success Criteria:

- HCP satisfaction +15-20 percentage points vs. control
- Journey progression velocity 30-50% faster
- Prescription growth 10-15% higher (controlling for other factors)

Phase 2: Scale to Additional Pods (Months 12-24)

If Pilot Succeeds:

- Launch 2-3 additional pods (different HCP segments)
- Refine pod structure based on learnings
- Develop pod playbook (how to set up, run, and measure a pod)
- Begin leadership development for pod leads (new career path)

Phase 3: Transformation (Months 24-36)

Restructure Organisation:

- Shift from brand-based to segment-based structure
- Dissolve or repurpose brand teams (brands become "product owners" providing scientific strategy, not full commercial teams)
- Enabling functions (Data, Content, Analytics, Medical, Sales Operations) become shared services supporting all pods
- Redefine performance management and compensation (how do we measure and reward pod performance?)

Risk: Organisational chaos, brand leadership resistance, sales force confusion

Mitigation

- Run new structure parallel to old structure for 6-12 months (don't "big bang" cutover)
- Over-communicate (town halls, FAQs, leadership roadshows)
- Create "change champions" network (mid-level leaders who evangelize new model)

Migration Path 3: Brand-Led → Integrated Omnichannel (NOT RECOMMENDED)

Why It Fails:

Attempting to jump from Brand-Led directly to Integrated Omnichannel skips the foundational capabilities required:

- **No consolidated technology:** Cannot orchestrate without CDP and enterprise platforms
- **No standardised processes**: Journey pods need playbooks, templates, governance—none exist in Brand-Led
- **No change management experience:** Brand-Led organisations haven't practiced organisational transformation; attempting the hardest transformation first is a recipe for failure

Exception (Rare):

Small speciality pharmaceutical companies (single therapeutic area, <5 brands, <500 employees) can jump directly to Integrated Omnichannel if:

- Digital-native from founding (no legacy field-force-centric culture)
- Leadership team has prior experience with customer-centric models (from consumer tech or digital health)
- Technology stack is modern from inception (cloud-native, API-first)

For traditional pharmaceutical companies (even mid-size), do not attempt. Build COE-Led capabilities first.

About Fractal Force

Architects of Customer-First Foundations for Life Sciences

We are HCP engagement architects, helping life sciences companies achieve customer-centricity by rebuilding foundations from brand-centric to customer-first. Rather than layer technology onto broken systems, we fix the underlying architecture first, ensuring your omnichannel, AI, and other digital investments truly deliver ROI.

The operating model challenges explored in this white paper are precisely the issues we address every day. The shift from brand-led to customer-led orchestration represents a fundamental transformation of over 100 years of pharmaceutical industry DNA, and we're built specifically to help you navigate it.

Our Approach: The Five Foundation Pillars

We address the entire ecosystem through five interconnected foundations that sit at the core of HCP engagement:

1. Data & Analytics Architecture: Data strategy, governance, integration, and advanced analytics that convert raw data into actionable insights.

2. Segmentation: Development of meaningful customer segments that drive personalisation and resource allocation.

3. Engagement Journey Design: Design and execution of cross-functional, integrated HCP engagement journeys.

4. Agile Operating Models: Streamlined planning processes, organisational structures, and governance to execute with speed and efficiency.

5. Impact Measurement Frameworks: KPIs and measurement models that shift focus from tracking activity to measuring true business impact.

Our Operating Model: A Network of Senior Experts

We orchestrate a growing global network of senior independent experts and technology partners. This plug-and-play model allows us to match precisely the right expertise to your unique challenges—no junior staff learning on your budget, no standardised solutions that don't fit your reality.

How We're Different

Global Talent Network → While traditional firms rely on finite in-house resources, we draw from a global network of vetted senior experts across commercial and medical excellence, omnichannel, digital transformation, change management, and technology architecture.

Flexibility & Agility → Our network brings deep and diverse expertise, allowing seamless integration of specialised talent to tackle your most complex challenges.

Cost-Effectiveness → Very limited overhead costs and no risk of bench-sitting consultants lead to competitive pricing while protecting your margins.

Senior Experts Only → Every engagement is staffed with vetted talent with extensive industry and advisory expertise. No "bait and switch."

Our Guiding Principles

Simplicity → We avoid intellectual gymnastics and adhere to the KISS principle.

Integration → We address the entire complexity, not just isolated parts.

Execution → We roll up our sleeves and iterate until we find the optimal way.

Impact → We instill an impact-focused mindset into every project.

Ready to Transform Your HCP Engagement Operating Model?

We start by mapping your unique situation through a rapid, targeted audit to assess your foundational maturity, then co-create a practical, prioritised roadmap for rebuilding your foundations.

Get in touch: info@fractal-force.com | www.fractal-force.com

Pieter Vanderbeeken & Mark Watson — *Co-founders, Fractal Force*

Fractal Force