GSK - A CASE STUDY ON THE STRATEGY OF "MERGER OF EQUALS" IN ETHICAL PHARMACEUTICALS

Bernardo Bátiz-Lazo

(*Open University Business School*)

ABSTRACT

This case summarises events leading to the creation of a global giant. The merger of Glaxo Wellcome and SmithKline Beecham had implications that went beyond the UK, where both companies were domiciled. The new company sought to take residence in the US but anti-trust authorities kept the companies formally apart for more than a year as they examined every aspect of the deal. The case invites readers to consider the process of integration as a general strategy, as well as the expectations, deliberations and motivation of managers and shareholders in doing so.

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This case is intended for class discussion and as an illustration of either good or bad management practice. Helpful comments from Gerry Johnson (Strathclyde), Sarah Holland (AstraZeneca), Steve Gorton (formerly at Glaxo) and Ana María Valdes

(formerly at SmithKline Beecham) are gratefully acknowledged. The usual caveats apply.

INTRODUCTION

Table 1 summarises how, during the 1990s Europe's pharmaceutical companies were locked in a high stakes multibillion dollar struggle with their US rivals to stay in business beyond the first decade of the twenty-first century. The frenzy of take-over activity resulted from companies seeking economies of scale to finance spiralling research and development budgets. However reassured companies could be of going alone, each new merger deal intensified pressure on rivals to either respond with matching amalgamations or risk falling behind in the race for market share. Merger activity during the 1990s took place while little evidence emerged to suggest bigger research programs were better (least of all after a merger) to replenish the '*pipeline*'. For instance, the amalgamation of Hoechst (Germany) and Rhône-Polenc (France) into Aventis reported a meagre 13% annual increase in profits between 1999 and 2000. Aventis' financial performance was amongst the lowest in the industry but typical for a drug company that had merged and had realised as much cost-saving as possible.

Table 1: Ethical drug sales after mergers are completed

(Sales in millions of dollars, 1998)

Company	Total Sales	US Sales	Rank	European Sales	Rank
Glaxo SmithKline	21,227	9,504	2	5,028	2
Pfizer (including Warner-Lambert)	17,834	11,435	1	3,170	6
Aventis	15,172	3,061	12	5,526	1
Merck	12,840	6,076	4	1,864	10
AstraZeneca	11,876	5,519	5	3,422	3
Bristol-Myers Squibb	10,368	8,393	3	2,926	5
Novartis	9,534	3,995	11	3,111	4
American Home Products	8,902	4,723	8	1,398	14
Eli Lilly	8,622	4,517	9	1,006	21
Johnson & Johnson	8,562	4,857	6	1,781	11

Source: Datamonitor, 2000

More representative of the industry norm were Pfizer and newly formed GlaxoSmithKline. Pfizer reported a 27% annual increase in profits between 1998 and 1999 after launching Viagra. In 2001 GlaxoSmithKline reported a 29% annual increase in profits from that achieved a year earlier by its originating companies. But while Pfizer's performance resulted directly from the successful launch of a new product, some questioned GlaxoSmithKline's ability to generate and sustain revenue growth. Deciding whether shareholders of GlaxoSmithKline should expect disappointing results in the medium term, however, was not so straight forward.

SMITHKLINE BEECHAM

The 1989 merger of Beecham and SmithKline Beckman lead to the creation of a transcontinental pharmaceutical and healthcare firm, and also sparked a wave of mergers between pharmaceutical companies that spanned over the following decade. Beecham and SmithKline Beckman were two '*also rans*', both running out of internal options: SmithKline had failed in its efforts to replace the income stream of its main '*blockbuster*' drug (Tagamet) but had an aggressive sales force in the US. Beecham was essentially a consumer goods company that had been successful in early research on antibiotics. Beecham had neither the mass nor the competencies to become a serious pharmaceutical player but it and SmithKline Beckman felt threatened as potential takeover targets.

Through amalgamation both Beecham and SmithKline Beckman were able to keep up with critical mass in R&D, as the combined research budget doubled, but total R&D expenditure still lagged behind the likes of top firms such as Glaxo, which were outspending them two to one. However, the amalgamation resulted in a meticulous power sharing agreement between the two management groups and brought about a new organisation with international marketing and sales presence.

People at SmithKline Beecham knew that the advantage of a friendly merger was allowing for '*equality of chances*' for those involved. A perception reinforced by Mr Bauman and his team investing substantial amount of time and effort to create a new culture (under the *Simply Better* initiative), which also transformed the way people were measured and rewarded. The amalgamation of Beecham and SmithKline Beckman was lengthy and relied

in a combination of benchmarking (i.e. continuous improvement efforts) and process re-engineering. But the fairly lengthy integration process resulted in great deal of uncertainty for the workforce as stringent demands were made on individual managers, who were not given their new responsibilities until after the integration plans and new organisation structures were approved.

Jan Leschly became chief executive in 1994 and was responsible for the continuing implementation of Bauman's vision. The key element of this vision was to create a *'fully integrated healthcare provider'* through, among other things, diversifying into managed care in the US. The intent was for the pharmaceutical company to match services already offered by insurance companies, hospitals and doctors, by offering complete healthcare packages for a flat, up-front fee. Merck had been the first to integrate vertically by acquiring a pharmacy benefit manager (PBM) called Medco in 1993. This move was followed by other major pharmaceutical companies in 1994 when SmithKline Beecham and Eli Lilly purchased DPS and PCS Health Systems, respectively.

Drug companies aimed to integrate vertically for several reasons. First, there was a potential threat in the success of the managed care model: in the US and elsewhere pharmaceuticals could be reduced to meagre suppliers of commodity products. A second reason involved the possibility of giving preference to SmithKline drugs in formulary lists managed by DPS and substitution for SmithKline's leading prescription drugs by DPS pharmacists. Yet a third reason was an expectation that synergies would emerge from SmithKline's Clinical Laboratories division and DPS, enabling the group to offer combined pharmaceutical and diagnostic testing services to large employers. Another potential benefit was having access to detailed patient records, which would improve drug discovery processes but also benefit direct-to-consumer marketing efforts.

Through the acquisition of DPS, SmithKline inherited a six year alliance with United Healthcare Corp., which owned several health management organisations (HMOs) with some 1.6 million members. The alliance would assure SmithKline exclusive rights among pharmaceutical and diagnostic companies, and to access medical outcome data from members of HMOs owned by United Healthcare. This would constitute a set of patient usage data, doctors' prescribing habits, and personal information that was more complete

than that accessible to Merck through Medco. The alliance, therefore, would provide a potential advantage in conducting outcome studies as well as actuarial studies on patient usage patterns.

However, the validity of the managed care model was questioned in 1998 when Ely Lilly sold PCS, at a substantial financial loss. The following year SmithKline divested DPS as well as the clinical laboratory business. For the industry the divestiture of PCS's was more significant than the associated financial losses. The strategic turn around of Eli Lilly and SmithKline Beecham signalled a failure to control distribution channels through formulary lists and the inability of established pharmaceutical companies to integrate proprietary outcome and patient information into new drug discovery.

GLAXO WELLCOME

In the mid-1970s, Glaxo was a small British firm with its origins in the dried milk business and most of its sales in antibiotics, respiratory drugs and nutritional supplements. During the 1980s Glaxo grew organically and rapidly thanks to its success in researching and developing innovative new medicines. By 1994 sales totalled £5,656 million or 3.6% of the world market with earnings emerging from a strong presence in Europe and the US.

The top industry position was secured in 1995 when the industry as a whole faced yet again climbing drug discovery costs. Glaxo managers effectively engineered a takeover of Wellcome, as the Wellcome Foundation (the largest non-profit medical institution in the UK) owned a 40% stake in Glaxo's Zantac and 39% of Wellcome's share capital. Zantac was an anti-ulcer '*blockbuster*' product and the world's best selling drug, commanding 35% of the antiulceran market and achieving record sales of £2.4 billion in 1994. Zantac had been launched at the beginning of the 1980s and contributed 43% of Glaxo's revenues, resulting in a large part of Glaxo's growth being based on Zantac's success. The problem was that Zantac's patent expired in 1997.

Wellcome was known for its *'academic'* approach to pharmaceuticals, with strong science but weak marketing. In 1996 and six months after the merger with Glaxo, managers already claimed that the newly created Glaxo Wellcome was fully integrated while its sales volume ranked world-wide first, it was the third largest company by market capitalisation in London

and the world's largest pharmaceutical research firm with 54,000 employees. But the reality was that a severe clash had occurred between Wellcome and Glaxo's hard-nose, commercial culture and things had worsened by the fact that few former Wellcome executives survived the takeover to serve the new Glaxo Wellcome. Organisational culture; problems were exacerbated by significant overlap between product portfolios and the geographic distribution of the sales force in key therapy classes.

Top managers thus endeavoured to rationalise the overall organisation and introduce economies of scale in R&D activities. However, executives had great difficulty holding the new company together. Russell Reynolds, a top recruitment consulting firm, was brought in to help re-organise world-wide operations. The aim was to create a levelled playing field so that few key individuals were lured away while, at the same time, the integration of different units was smooth and effective. In spite of this, there was increased middle-management turnover after coming together.

As part of its US operation, Glaxo Wellcome had developed presence in the managed care sector through a subsidiary called Wyeth-Ayerst Healthcare Systems. This company provided disease-management programs, patient/member materials, outcomes assessment, and support for managed care marketing efforts. The incursion into the managed care sector was cautious as management believed that research, development and marketing of drugs were Glaxo Wellcome's areas of expertise. Other areas of excellence included developing world-class operations in combinatorial chemistry and a late (although successful) involvement in the biotech industry. A joint venture with Warner-Lambert, called Lambert Wellcome, had given a foothold in the prescription-to-OTC switch market and thanks to this venture Glaxo Wellcome successfully managed competition from generics at the end of Zantac's patent in 1997.

At the time of the merger with Wellcome, the chief executive at Glaxo was Sir Richard Sykes. He had been holding that job since 1994, was a former (very successful) British academic and R&D director, as well as a firm believer in investing in R&D for company growth. One of the biggest setbacks of his career, at the top position in the new Glaxo Wellcome, was the UK government's decision in 1999 not to place Relenza, the company's new flu drug and the first real success of combinatorial chemistry research, on the National

Health Service list of prescription drugs. However, he had been responsible for the diversification into emerging markets, a new organisational structure (called '*global products responding to regional needs*'), as well as joint ventures in India and Japan.

By the end of the 1990s, some analysts were sceptical on whether the merger of Glaxo with Wellcome had produced any synergies at all. It was true that sales of revitalised Wellcome products through Glaxo's marketing muscle had helped to avoid slipping in the rankings, but it was also true that the drugs '*pipeline*' was unimpressive and many new products had failed to live up to expectations. The merger had, indeed, brought Glaxo presence in certain therapeutic areas that it had not exploited before (such as antivirals), while Wellcome benefited from greater financial discipline and focus. But both companies had been used to cash and profit rich years. So analysts wondered whether costs had really been brought under control, whether Glaxo Wellcome had relied too much on disposals to flatter its earnings performance and, on balance, many were disappointed that augmented R&D facilities had done little to replenish the '*pipeline*' by producing new potential '*blockbusters*'.

THE BIRTH OF GLAXO SMITHKLINE

In 1998, the merger between the two top British drug companies seemed virtually complete with Glaxo Wellcome shareholders having 59.5% of the new group, leaving 40.5% to SmithKlineBeecham shareholders. With a market capitalisation of $110 billion US dollars, the deal would create the biggest pharmaceutical company and the world's third biggest corporation. The chief executive for the new group was going to be Jan Leschly, a former international pro-tennis star turned pharmaceutical executive and SmithKline Beecham's CEO. The new chairperson would be Sir Richard Sykes, Glaxo's CEO. But after a weekend meeting of intense negotiations and to everyone's surprise, the deal was called off. The following trading day $6.6 billion or 10% of SmithKline Beecham's market capitalisation was knocked off while the stock price of Glaxo lost 13 percent. Formally, Glaxo Wellcome's directors indicated that they were not prepared to proceed on the agreed basis. Informally, SmithKline directors claimed that Glaxo Wellcome reneged on the original agreement that Leschly would be leader of the new colossus. Glaxo executives never challenged this version of the events. Neither were there comments on whether Mr.

Leschly's suggestion of spinning off the entire research effort into a separate capital raising company might have been rejected by Sir Richard and Glaxo as too radical, sacrificing innovation in the pursuit of short-term cost reductions.

Both Leschly and Sykes had worked together in the past and some sort of rivalry seemed to have emerged since then. Leschly's patriarchal management style and SmithKline's financial rigour and performance-related culture seemed to have clashed with Sykes' passionate (sometimes even messianic) belief in science and Glaxo's more traditional management model. But it appears that if Leschly and his colleagues had retreated on the CEO issue, the merger would have gone through, and Leschly would have been $100 million dollars richer - the value of his shares and stock options in SmithKline, according to an estimate published in The Economist.

Another explanation offered for Mr. Leschly's bitter reaction against the possibility that he might not be the chief executive of the new group was based on matters of principle and dignity. As CEO of SmithKline Beecham and before that as the CEO who delivered Squibb to Bristol-Myers, Leschly had done well financially. With or without the merger with Glaxo Wellcome he had already amassed enough for him and his family to fulfil any conceivable material wants. At the same time, Sykes and his management board disliked Lechly's management style and feared the merger would turn into a takeover by SmithKline people. Glaxo's management board also wanted to break with tradition (as Skyes had not lead the initial move to merge) and claim the top post, because Glaxo Wellcome was the biggest of the proposed partners in terms of market capitalisation, products, and R&D expenditure.

The fact remained that after the failure to merge SmithKline still lacked the R&D funds to pursue its many leads for new drugs. Other major drug companies continued with their plans and merged, while later that year Glaxo Wellcome still remained without partner as managers also failed in their talks to amalgamate with Bristol-Myers Squibb.

After the first round of merger talks collapsed in acrimony in 1998, renewed interest in the merger emerged after Jan Leschly's retirement announcement in mid-1999, which effectively removed the barrier to the merger. This was also the time when industry participants learnt that Pfizer, the US drug giant, began negotiating with Warner-Lambert, another US competitor, to create the world's second-largest drug maker with the potential for a 6.7%

global market share, $4.5 billion dollars in R&D spent, and $287 billion dollars in market capitalisation. Sir Richard Sykes said about his company's determination to do a deal:

> "This is where two big successful organisations come together, not to protect future earnings growth but actually to increase critical mass to really outperform the industry…. The more effort, the more money, and the more power you can put to research, the stronger the company is going to be."[1]

Significantly, as part of the new deal Sir Richard Sykes agreed to become non-executive Chairman, a post of influence but little management responsibilities, while the Chief Executive of the new GlaxoSmithKline would be Jean Paul Garnier. Known simply as *'JP'*, he had been raised in Normandy (in the North of France), where he grew steadily on a diet of British and US movies and music (he still claims Jimi Hendrix as a patron saint). Mr Garnier got a master's degree and a doctorate from France's Université Louis Pasteur before accepting a Fulbright scholarship to Stanford University. Except for a few years in various parts of Europe, Mr Garnier's career had kept him in the US ever since where he got a business degree. He joined SmithKline in 1990 as president of the pharmaceutical division and moved to number one after Leschly retired.

British and European regulators were swift to give clearance to the emergence of GlaxoSmithKline, though some time after that the Federal Trade Commission (FTC), the US competition regulator, forced the groups to sell medicines for chemotherapy-induced nausea and herpes with annual sales of almost $400 million dollars. At that point managers felt the most substantive issues had been dealt with. However, the FTC continued to have concerns on the merged company's perceived domination of the US smoking-cessation market and this caused a second delay in taking the merger forward. The concerns of the FTC were based on the fact that, at the time, SmithKline had the leading over-the-counter brand and Glaxo the only approved prescription drug to help smokers quit. Two key products which the FTC felt would give the combined company control over 90% of that market.

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[1] *Pharmaceutical Executive, May 1999, p. 37*

For some observers, managers at GlaxoSmithKline failed to envision that creating the world's biggest pharmaceutical firm would involve very complicated regulatory submission process. Others argued that the arrogant approach by the new company management team to the FTC was to blame. Yet others felt that regulators were burdened with the recent wave of mega-mergers (in pharmaceuticals and elsewhere) and that they were also influenced by the US presidential race (which put the spotlight on healthcare spending). In any event, managers intimated that some regulatory delays were anticipated but it was never thought regulatory concerns in the US over monopoly power of the new group in certain therapy classes would consume more than 10 months of negotiations and backtrack the merger process twice. Further, lengthy negotiations with US regulators prevented the early implementation of the new organisational structure. Executives were prevented from specifying how economies of scale in labs would be achieved, how performance would improve or how co-operation across business units would be implemented. Delays in getting regulatory clearance also prevented managers from stopping speculation that the company could eventually split up into separate business or announce how would they reckon with incompatible information technology platforms. All this, in turn, resulted in low morale and a '*brain drain*' of middle managers (although occurring mainly among administrative staff). Nevertheless, developments were worrying for a corporation which had yet to be born and which was already involved in a process full of mishaps.

BUSINESS PORTFOLIO

As one of the key points of the merger, managers considered building operational headquarters in the US while corporate headquarters would remain in the UK. The new company's increasing leanings to the US in style and markets puzzled many, as Britain was home for both originating companies and the UK one of the world's leading centres for the research, development, and manufacture of prescription medicines. Britain's pharmaceutical output doubled between 1980 and 2000 in real terms while exports boomed and research and development of prescription drugs increasingly became a high-technology business and one of the most successful bits of the *'knowledge economy*'. But the fortune of the British pharmaceutical industry seemed closely linked to that of its two main representatives: Glaxo

Wellcome and SmithKline Beecham. When announcing the merger, Mr Garnier said that the new company was proud of its UK roots:

> "But a world-class competitor cannot operate all its functions from a market that represents only 6% to 8% of its existence. The US, by contrast, accounts for 45% of the global pharmaceutical market."[2]

Indeed, table 2 shows that US would be an important market for GlaxoSmithKline as that market represented about half the business (based on 1998 combined pharmaceutical sales). Europe and the rest of the world will account for 34% and 21% respectively. In addition to having a broad portfolio of products, the new company would lead in four of the five largest therapy classes, which together represented roughly half the global pharmaceutical market. This was complemented by a leading position in the vaccines market. The new company would also have blockbuster treatments for asthma, depression, AIDS and migranes. Not surprising new drugs still in the '*pipeline*' were expected to reinforce the new pharmaceutical's position in the anti-infective group, but other strong growth products were expected in the alimentary and metabolic group as well as a new vaccine (Infantrix) and a respiratory drug (Seretide/Advair). Top managers then claimed that the new group could be expected to have a solid base in selected therapeutic markets while delivering sales of £17 billion pounds per annum or 7.4% of the world's pharmaceutical market.

Another key point to the merger were expected savings of £250 million pounds from combined R&D operations. Those savings were to be reinvested in R&D to produce an annual research budget of £2.4 billion pounds, the largest in the world after the new Pfizer. Top executives also expected the combined company to save an annualised £1 billion pounds after three years. These savings would come on top of previously announced restructuring at both companies, expected to cut a combined £570 million a year. But analysts of pharmaceutical companies at investment banks were puzzled by these figures. On the one hand, analysts were disappointed by the planned savings. Most estimated the figure to be between £1.1 billion and £1.5 billion, as well as some sort of immediate disposal of factories, reduction of intermediate capacity or outsourcing plan. On the other

[2] *Chemical Market Reporter, January 2000, p. 24*

hand, analysts were encouraged by potential pay-offs that could come from the complementary research skills of the two companies. In other words, Glaxo Wellcome's investment in technology to automate the chemistry of developing drugs combined well with SmithKline's leadership in genomics (which promises a wealth of drug development opportunities). In fact, SmithKline Beecham had an existing '*pipeline*' of four promising drugs in the final stages of development. This was indeed very attractive to Glaxo Wellcome, who relied heavily on the generic sales of its '*blockbuster*' drug Zantac. However, only 7% of Glaxo Wellcome's sales depended on drugs whose US patents expired before 2006 as compared with SmithKline's 33 per cent.

Table 2: Global Presence and Product Leadership of GlaxoSmithKline

1998 Pro Forma Sales Figures

	Sales (Percent of total combined sales)	Market Share (% of total sales)	Rank
Region			
North America	45	8.9	1st
Europe	34	7.6	1st
Rest of the World	21		
Asia Pacific		7.5	1st
Middle East / Africa		7.6	1st
Latin America		4.9	4th
Japan		1.9	18th
Therapy Class			
Anti-infectives	25	16.9	1st
Central Nervous System	18	11.6	2nd
Respiratory	15	16.8	1st
Alimentary & Metabolic	10	7.0	2nd
Vaccines	5	N/a	1st
Consumer Health	16	N/a	n/a
Other Pharma	11	N/a	n/a

Source: Presentation to Stock Analysts, January 2000

HUMAN RESOURCE MANAGEMENT

As part of the merger process, plans were drafted for the amalgamation of corporate and support operations of the new pharmaceutical colossus in most countries. This made labour unions unhappy because of the lack of consultation. Corporate executives claimed that there was nothing to consult about until the legal merger had taken place and thus, the newly introduced European regulation on consultation would not be broken. Nevertheless, unions feared at least 15,000 job losses, no less than 14% of the 105,000 strong combined global workforce would be lost.

As for the 300 or so senior managers likely to be made redundant, Spencer Stuart, an international recruitment consultancy, was brought in to look into areas of potential overlap between business units rather than the universe of managers at the new corporation, and would leave the vital R&D and marketing teams intact. By bringing in a recruitment consultancy to carry out a management audit, top executives once again expected to develop a level playing field so that few key individuals were lured away. This fear was further supported by anecdotal evidence which suggested that the most valuable executives were likely to *'jump ship'* to competitors (including small, entrepreneurial biotechnology start ups) before the merger process was over and this could be a reason why most mergers between pharmaceuticals failed to add shareholder value. As one top manager of another new big pharmaceutical said at the time:

> "We learnt from other mergers to spend more time on cultural values and the way we wanted to behave in the future… Senior managers felt the final report captured the real competencies, and we believe we're the first merger not to have lost market share."[3]

Once the FTC approved of the merger, no divestitures were required in the smoking cessation market and the new company revealed plans to re-engineer its R&D and marketing operations. At the time, Jean Pierre Garnier considered that organising 15,000

[3] *Financial Times, August 23 2000, p. 23*

scientists across several time zones, with an annual budget in the billions of pounds, would require a radical new structure. This "*facilities master plan*" would allow to assess which, if any, of the 24 global R&D sites should be closed. However, rivals such as Pfizer, Novartis or Aventis, which had already restructured their core operations, questioned how radical Garnier's plan really was.

ORGANISATIONAL STRUCTURE

The new plan considered breaking up discovery efforts through a combination of centralisation and decentralisation. Investments to generate new chemical entities (NCE) would concentrate on traditional activities and genetics while aiming to develop economies of scale. Discovery efforts would then be broken into six autonomous sub-units while aiming to maintain the excitement of a small discovery outfit. Drug development (including clinical trials) and marketing would again be co-ordinated by the central organisation.

Maintaining a single effort to discovery NCEs aimed to apply scare skills and expensive equipment across a range of diseases. There was to be two administrative divisions or the partition into Genetics Research and Drug Discovery Research. The emphasis on genetic research followed the new company inheriting substantial investments in the use of genomics[4] in drug discovery: at its formation, GlaxoSmithKline would have over 500 patent filings for genomics-based drugs. Actually, just as merger proceedings evolved, SmithKline brought to clinical testing one genomic-based drug to treat obesity and one to treat hypertension, which were likely to take only five years to get to the market.

The plan for the new structure at GlaxoSmithKline also considered creating six sub-units (one in Italy, two in the UK and three in the US) out of the middle section of the '*pipeline*', the part of the drug generation process considered to be that where bright ideas are incorporated into drugs. The six business units, called Centres of Excellence (Cedds), were to organise the efforts of the 24 R&D sites across the world, work semi-autonomously and compete to attract financial resources from head office (and eventually from venture capitalists and even the stock market). The six sub-units were empowered to use molecules discovered within internal early research divisions, brought in from academia or from

[4] Genomics, the study of genes and their function, promised to increase treatment effectiveness while limiting side effects by identifying people who would definitely respond to a specific medicine.

external biotechnology groups. It was hoped that as a result of the plan, the new company would avoid greater scale and associated bureaucracy while maintaining agility, entrepreneurial spirit and individual accountability in a key part of drug discovery. Moreover, attract talent by emulating the culture at biotechnology firms, including the introduction of big share option packages through which scientists receive royalties on the sale of medicines they helped to invent. But observers were sceptical as to how autonomous the six '*internal biotech*' would be allowed to become or whether the new structure would increase short-term productivity.

Finally, the plan for the new structure at GlaxoSmithKline also considered clinical trials and marketing to be undertaken on a massive scale, often across continents, and simultaneously complying with strict regulatory conditions. Scale at this last stage of the '*pipeline*' aimed to achieve corporate control and uniformity as well as capitalise on global reach. For instance, shortly after the merger was announced, two licensing agreements were signed by SmithKline Beecham while looking to strengthen links with the Japanese pharmaceutical sector. Since marketing partnerships were seen as the only way to enter some markets (particularly for non-Americans to enter the US or for non-Japanese to enter Japan) the deals could become very important to make the best of the new organisational structure. But, at the same time, creating a difference through licensing agreements of late-stage products would not be easy. For instance, Pfizer had a successful record of marketing drugs in the US created elsewhere while many other big and medium sized pharmaceuticals also had gone along the licensing route into Japan.

CONSUMER HEALTH

Greater scale in marketing was attractive to managers because, while regulatory approval proceeded in the US, SmithKline Beecham became the world's second-biggest toothpaste manufacturer following the completion of its acquisition of Block Drug of the US for $1.24 billion dollars with a cash bid worth $53 per share. The deal added Block's Sensodyne toothpaste to Smithkline's range of dental care brands, which included Aquafresh, Macleans and Odol. Consumer goods sales, including toothpaste and drinks such as Lucozade, Ribena and Horlicks, would then make £2.5 billion pounds or a third of SmithKline Beecham's sales and 15% of the combined 1999 sales of Glaxo and SmithKline.

When questioned on the subject of consumer health care, Jean-Pierre Garnier was said to be committed to the consumer health business because he saw this area as being key for GlaxoSmithKline extending the life of certain prescription pharmaceutical brands, such as "*blockbuster*" Tagamet, by switching them to over-the-counter sales. However, analysts at investment banks speculated that the lower-margin consumer unit could be sold and the money reinvested in pharmaceuticals assets. SmithKline Beecham had been willing to sell individual brands in the past. Opinion was thus divided as to whether the Block Drug acquisition represented greater commitment to consumer health or a strengthening of the business in preparation for a sale. Yet for others growth into consumer health meant to signal another significant acquisition for GlaxoSmithKline in the not too distant future, while questioning which were the core competencies that would deliver the much needed advantage in prescription pharmaceuticals markets.

The debate around the role of health care in the business portfolio of GlaxoSmithKline suggested that new company was at crossroads. The merger could yield a wealth of new drugs, for the good of shareholders and patients alike. And the new company seemed to have everything needed to be the best in the business, but so did Glaxo and Wellcome or Beecham and SmithKline Beckman when they merged.