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9B18A070

maha research labs: sales force expansion

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Toward the end of March 2018, Mohammed Isaquddin Kureshi, the managing director of Maha Research Labs Private Limited (MRL), sat in his office charting his 2020 vision for MRL. He realized his company, which he had set up in 2007, was growing and doing reasonably well in the Indian pharmaceutical market. By 2016, the company had achieved sales revenue of ₹500 million,[[1]](#footnote-1) and by 2017, it had registered a 31.8 per cent growth over the previous year and achieved sales worth ₹670.2 million (see Exhibit 1). Kureshi thought it was natural for the company to set an ambitious growth target of nearly 50 per cent in 2018, aiming for a net revenue of ₹1 billion.

He set the target for the current year keeping in mind his vision for MRL in 2020: a pan-Indian presence and sales revenue worth ₹2 billion. By 2017, MRL had a strong footprint in the western states; in order to realize his vision, Kureshi decided to expand rapidly over the next year, expanding into the northern part of India in July 2018, the southern part in October 2018, and the eastern part in March 2019. To do so, the company had to answer a few urgent questions that would be key to deciding its sales targets: How should the sales organization be designed? What would be an appropriate sales force structure? Should the company opt for a generalist sales force structure or a specialist sales force structure? What was the optimal size for the sales force? What processes should the company follow to design the sales territories?

company BACKGROUND

Maha Research Labs, which was set up in 2007 with an initial investment of ₹3 million, five employees, and seven brands, was a manufacturer and supplier of pharmaceutical products, including included imports and exports. During its initial three years, the company had marketed its products in eight sales territories, and Kureshi had taken care of all the marketing and sales activities. The company began its expansion in 2010 by marketing 22 brands in 10 sales territories. By December 2017, the company had a portfolio of 50 brands and 75 employees. The company was committed to delivering high-quality, international-standard products to Indian and overseas markets. It followed good manufacturing practices, and all of its products were procured from government-approved pharmaceutical companies that adhered to proper quality controls.

MRL’s product line included analgesics, antibiotics, anti-allergy medications, cough syrups, and a range of nutritional products (see Exhibit 2). Its product portfolio was focused, and its distribution network was broad: three carrying-and-forwarding agents and more than 100 stockists distributed its products to customers through retail pharmacies in different sales territories (see Exhibit 3). This network gave the company distinct strategic advantages that facilitated both integration and consistently good performance in the competitive pharmaceutical market.

**SALES MANAGEMENT AT MAHA RESEARCH LABS**

The company’s biggest promotional investment was its sales force—people who worked hard to build customer relationships with the right focus and targeting, enhance call efficiencies, acquire new customers, and increase the accountability of resources. Kureshi believed that an effective sales force was essential for pharmaceutical companies and central to maximizing coverage, improving sales, and optimizing costs. He felt that a well-structured, organized, and forward-looking sales force would guarantee consistent revenue growth and profitability. According to Kureshi, “a more organized and efficient sales force meant less wasted time and more productivity.”

Sales Organization

Until 2017, MRL had thrived with a location-based sales structure and a generalist sales force. The generalist salespeople sold all the company’s products in their designated sales territories. This approach was similar to the structure of most competitors with a product range such as MRL’s. The sales team was divided according to geography. The major advantage of following a location-based structure was that it reduced selling expenses, avoided duplication of effort, and reduced the travel burden on individual sales representatives. The company tried to maintain parity between the number of sales representatives and the number of customers in each geographical region.

Pharmaceutical companies that had specialized ranges of products for cardiology, cancer, and diseases of the kidney, lung, and liver preferred a specialist sales force structure. Most leading and multinational pharmaceutical companies were moving toward a specialist sales force structure, as generalist salespeople might find it difficult to explain new, complex, and high-margin drugs. A specialist sales force structure was expensive, and it involved duplication of sales efforts and increased travel time for the sales team.

While MRL’s decision regarding sales targets hinged on past performance, the decision regarding sales territories depended on the number of potential physicians in a particular area. As of March 2018, MRL’s sales force was made up of 50 professional sales officers (PSOs) and seven area sales managers (ASMs). Eight PSOs, grouped geographically, reported to an ASM. The ASMs were answerable to a zonal sales manager, who reported to Kureshi. Each new PSO underwent 14 days of training at the company’s facility, and all PSOs attended an annual week-long refresher course in the same facility. ASMs worked with each PSO for three days each month for field training and performance reviews.

Role of a Professional Sales Officer

Pharmaceutical selling differed from regular selling, and the PSOs were the backbone of the pharmaceutical industry in India. They were directly responsible for both generating demand and ensuring an unhindered supply of products in their sales territories. In terms of demand generation, the PSO’s role was similar to that of a missionary: selling by persuading physicians and other health professionals to prescribe the company’s products. This role included reaching out to physicians to share knowledge on product formulation, usage, and dosage; taking feedback about products; addressing queries and complaints; keeping physicians aware of recent developments in the industry; delivering samples; and building a rapport with individual physicians. The PSO’s job was to get more physicians to write more prescriptions to help increase sales revenue and profits.

On the supply side, the PSO ensured that products were available for consumers by reviewing the sales data and stock levels of retail pharmacies and dealers. PSOs were also responsible for product withdrawals due to breakage or expiry. Hence, they acted as intermediaries between the company and its customers. The non-selling responsibilities of PSOs included maintaining records (e.g., client-information analyses of sales data) and preparing various reports (e.g., daily call reports, expense reports, travel plans, and monthly reports). MRL also used its sales force to gather information on customers, changes in the general market environment, and key consumer insights. The most important skills and competencies companies sought in PSOs were good communication skills, a result-oriented focus, good product knowledge, good negotiation skills, and strong ethics.

PSOs were required to make at least 10 physician calls and six pharmacy visits per day and a minimum of 220 physician calls and 132 pharmacy visits per month. They also had to divide their time between physicians in different categories, spending 50 per cent of their time dealing with A-class physicians, 30 per cent with B-class physicians, and 20 per cent with C-class physicians.[[2]](#footnote-2) The PSOs each had 180 customers, of which 50 were in class A, 100 were in class B, and 30 were in class C. They also had to achieve the required growth of value and volume targets on monthly and yearly bases.

Sales Process

Missionary selling was the main sales style used in pharmaceutical selling; thus, a PSO’s role was to convince physicians of the effectiveness of a branded medicine they could prescribe for their patients. Missionary salespeople were also referred to as detailing salespersons. Detailing, which involved discussing the features and benefits of products with physicians and pharmacy retailers, provided a platform for physicians to learn about products’ indications, dosages, side effects, and prices. Kureshi stressed the importance of the sales force’s effectiveness in the different selling activities; it was critical for PSOs to execute marketing priorities. PSOs were required to follow a disciplined, planned calling system for regular visits to physicians, pharmacy retailers, stockists, and hospitals. PSOs were also instructed to detail no more than three products to each physician in order to maximize the likelihood that physicians and others would recall the brand.

THE INDIAN PHARMAceutical INDUSTRY

The Indian pharmaceuticals market witnessed growth at a compound annual growth rate of 17.90 per cent, during 2005-16, with the market increasing from US$6 billion in 2005 to US$36.7 billion in 2016, and it was expected to reach US$55 billion by 2020. The primary growth drivers for the industry on the demand side were an improved standard of living, increased accessibility of drugs, the growing prevalence of lifestyle-related diseases, increased penetration of health insurance, and a thriving export market. On the supply side, primary growth drivers included a skilled workforce and low-cost manufacturing capabilities. The industry also had ample government support in the form of several key reforms and investment commitments.[[3]](#footnote-3)

By 2020, the Indian pharmaceutical industry would likely become the sixth-largest in the world by absolute size. Some notable trends in the industry included increased expenditure on research and development (R&D), growth in the export of generic drugs (20 per cent of the global market) due to the national industry’s cost advantage, value creation through joint ventures and acquisitions (more than 70 per cent of all merger and acquisition deals in the past three years), international expansion, and reduced wait times for drug approvals and new facilities.[[4]](#footnote-4)

The pharmaceutical industry was divided into four segments: (1) active pharmaceutical ingredient (API) producers; (2) formulators; (3) contract research and manufacturing services (CRAMS); and (4) biosimilar markets. The API producers manufactured common and generic drugs. These firms had low bargaining power and played on high volumes. However, a smaller number focused on niche drugs and enjoyed high margins. With a 7.2 per cent market share, India was the world’s third-largest generic API merchant. It was also the global leader in terms of drug master file applications in the United States. Most Indian companies started as API producers, but with the advent of patents in 2005 and increasing competition, some had moved up the ladder to become formulators (e.g., Dr. Reddy’s Laboratories Limited). While the API producers dealt with bulk manufacture of drugs, the formulators made tablets, capsules, and other formulations. The domestic market for formulations was US$11.2 billion in 2016. In 2016, India was the largest exporter of formulations by volume and 12th in terms of export value.[[5]](#footnote-5)

The third segment, CRAMs, was where India’s skilled workforce and cost-effectiveness gave a distinct advantage to this fragmented industry of more than 1,000 players. The last segment, the biosimilar market segment, was small (US$300 million in 2015 in India) but was expected to grow to US$40 billion by 2030 as a large number of biosimilar drugs would be going off patent in the United States.[[6]](#footnote-6)

While the top four players in the highly competitive Indian pharmaceutical industry held 20 per cent of the market share, the top 10 companies held 39 per cent of the market share. The first strategy of these companies was achieving cost leadership through the acquisition of API producers. Second, they invested in R&D to achieve differentiation; and third, they focused on new markets or segments. The opening of the country to 100 per cent foreign direct investments and India’s attractiveness as a manufacturing hub meant that domestic firms would soon face tough competition from financially robust international players.

Future opportunities seemed bright for the industry in India because of its genetically diverse population, which would likely be a magnet for investment in the clinical trials market. Rising incomes were expected to increase the demand for high-end drugs, which would likely pave the way for high-end drug production in the country. The rural market, which accounted for 70 per cent of the population, was largely untapped, so there was high-demand growth there, and firms were investing in expanding their distribution structures. However, with the presence of innumerable pharmaceutical companies, the pharmaceutical marketing industry in India had become hyperactive, and this put pressure on the operating expenses of companies such as MRL and affected their future growth opportunities. Government price controls on many medicinal products further reduced the profitability of the pharmaceutical companies.[[7]](#footnote-7)

MISSION 2020

MRL’s target was to have a pan-Indian presence with sales revenue worth ₹2 billion by 2020. The company planned to build on its strong presence in western India and expand across northern, southern, and eastern India in three phases through 2018.

Sales Force Expansion

According to Kureshi, in 2017, India had approximately 900,000 doctors, distributed across urban, semi-urban, and rural areas in different zones of the country. Most pharmaceutical companies using the generalist sales structure followed the strategy of having their PSOs, each with a physician list of 220 doctors, meet 10 physicians and six pharmacy retailers daily. The PSOs with companies that followed the specialist sales structure aimed to meet seven physicians and four pharmacy retailers daily and had physician lists of 160 doctors each.

MRL aimed to target 10,000 A-class physicians, 18,000 B-class physicians, and 7,000 C-class physicians in each of the four zones. Its PSOs were expected to make visits to each of these categories of physicians at a specific frequency: they were to meet with A-class physicians every fortnight, with B-class physicians every month, and with C-class physicians every month and a half. MRL wanted its PSOs to work at least 22 days a month, making the mandatory 10 physician calls and six pharmacy retailer visits daily, as well as devoting 20 per cent of their time on non-selling activities such as training and administrative tasks. Following an industry analysis of competitors, Kureshi’s team suggested that MRL should locate 75 PSOs in the north, 70 in the south, and 60 in the east, with the intent that each PSO would achieve a yearly sales target of ₹8 million.

THE DILEMMA

MRL was poised to expand, helping to realize Kureshi’s vision of achieving sales revenue worth ₹2 billion by 2020. While the company’s location-based sales structure had helped it achieve steady growth since its inception in 2007, would this same sales force structure continue to be successful as MRL expanded over the next year? Sales targets depended on past performances and sales territories, on the number of potential customers in a particular area. Would MRL need to revisit the decisions on its sales targets and its design of the sales organization now that expansion was imminent and the ₹2 billion revenue target had been announced to be achieved by 2020? Would Kureshi do better to opt for a generalist or specialist sales force structure? While the existing sales model had worked so far, would the expansion plans affect the optimal size of the sales force or the process MRL should follow in designing its sales territories?

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EXHIBIT 1: SELECTED FINANCIALS FOR MAHA RESEARCH LABS, 2013–2017 (IN ₹ MILLIONs)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **2013** | **2014** | **2015** | **2016** | **2017** |
| Total Revenue | 251.7 | 305.8 | 387.5 | 508.4 | 670.2 |
| Cost of Sales | 75.2 | 89.3 | 111.9 | 134.6 | 197.6 |
| Gross Profit | 176.5 | 216.5 | 275.6 | 373.8 | 472.6 |
| Marketing & Selling Expenses | 45.2 | 57.1 | 72.4 | 99.8 | 148.1 |
| Other Expenses | 4.7 | 7.1 | 9.6 | 12.7 | 21.6 |
| Net Profit/(Loss) | 126.6 | 152.3 | 193.6 | 261.3 | 302.9 |

Note: ₹ = INR = Indian rupee; ₹65.03 = US$1 on March 25, 2018. Figures have been changed to maintain confidentiality.

Source: Company documents.

EXHIBIT 2: MAHA RESEARCH LABS’S TOP 10 PRODUCTS (BY SALES)

|  |  |
| --- | --- |
| **Brand Name** | **Category** |
| Algesic Tablets | Pain Management |
| Algesic-SP Tablets | Pain Management |
| FG-CAL Tablets | Calcium Supplement |
| Mahamox | Antibacterial Range |
| M. Panto DSR Capsules | Gastro-protective |
| FG-IRN-XT Tablets | Haematinic |
| Mahapod | Antibacterial Range |
| Maflox | Antibacterial Range |
| Enervit Capsules | Nutritional Supplement |
| M. Envervit Syrup | Nutritional Supplement |

Source: Company documents.

EXHIBIT 3: LOGISTICS at MAHA RESEARCH LABS

Central Warehouse

C&F Agents

Stockist

Retail  
Pharmacy

Customer

Note: C&F = carrying and forwarding.

Source: Company documents.

Exhibit 4: MAHA RESEARCH LABS’S customer caTEGORIZATION

|  |  |  |  |
| --- | --- | --- | --- |
| **Category of Physicians** | **Planned Frequency** | **Number of Physicians** | **Business per Month** |
| **A** | Once in 15 days | 50 | > ₹15,000 |
| **B** | Once in 30 days | 100 | ₹8,000–₹14,999 |
| **C** | Once in 45 days | 30 | < ₹8,000 |

Source: Company documents

1. ₹ = INR = Indian rupee; ₹65.03 = US$1 on March 25, 2018; all currency amounts are in ₹ unless otherwise specified. [↑](#footnote-ref-1)
2. Physicians were categorized on the basis of the amount of annual business they generated for the company. A-class physicians generated business valued at ₹15,000 and above, B-class physicians generated business valued at ₹8,000–₹15,000, and C-class physicians generated business valued at less than ₹8,000. [↑](#footnote-ref-2)
3. Indian Brand Equity Foundation, *Pharmaceuticals*, January 2017, accessed September 8, 2017, www.ibef.org/download/Pharmaceutical-January-2017-D.PDF. [↑](#footnote-ref-3)
4. Ibid. [↑](#footnote-ref-4)
5. Ibid. [↑](#footnote-ref-5)
6. Ibid. [↑](#footnote-ref-6)
7. Press Trust of India, “Implementation of New Drug Pricing Policy to Impact Profits: Wyeth,” *Hindu Business Line*, August 5, 2013, accessed April 11, 2017, www.thehindubusinessline.com/companies/implementation-of-new-drug-pricing-policy-to-impact-profits-wyeth/article4991779.ece. [↑](#footnote-ref-7)