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GlaxoSmithKline: Reinventing Incentives and Performance

Hema Bajaj, Manjari Srivastava, and Ronald Sequeira wrote this case solely to provide material for class discussion. The authors do not intend to illustrate either effective or ineffective handling of a managerial situation. The authors may have disguised certain names and other identifying information to protect confidentiality.

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It was January 2015, and the disenchantment of a young front-line manager was spelled out in his unusual resignation letter. He was quitting the company and the pharmaceutical industry to join the armed forces. The manager had joined the industry with the intention of making an impact on the lives of millions of people who did not have access to proper medical services. However, the realities of the industry—hard to achieve sales targets, difficulty in accessing doctors, and prevalent malpractices in the industry— had left the manager dissatisfied. With a mission to serve, he was moving on. Eyes fixed on the letter, Ronald Sequeira, executive director of Human Resources of GlaxoSmithKline (GSK) India, reflected on the challenges that lay ahead in managing its young employees and reinvigorating the values the organization stood for.

GSK was a large multinational with interests in pharmaceutical and healthcare products. Like any other player in the industry, a large part of its earnings came from sales-based incentives. Studies done by consultants across the industry had shown that 20–40 per cent of total earnings came through sales incentives. The system had worked well for the organization so far. From 2006–2012, the Indian business had shown a growth in revenue of close to 60 per cent while profits increased by 87 per cent in the same period (see Exhibit 1). Consequently, the share price of the locally listed company had also grown significantly. While the performance indicators looked promising, instances of ethical dilemmas experienced in different territories raised concern among senior leaders and could no longer be ignored in light of the 2008 financial meltdown in major countries. The aftereffects of the crisis could still be felt and had led to increased regulatory pressures worldwide. Added to these were GSK’s own stringent ethical norms and corporate governance standards.

GlaxoSMithKline (GSK)—History in India

The company was incorporated in India on November 13, 1924 under the name of H.J. Foster & Co. Limited as an agency house for distributing the well-known Baby Food Glaxo of the then UK company, Joseph Nathan & Co.[[1]](#footnote-1) On March 1, 1950, the company changed its name to Glaxo Laboratories (I) Ltd.; the company grew worldwide and in India through alliances and acquisitions. In 1962, it took over the business of the Indian branch of Allen & Hanburys Ltd. (UK), as this company had been acquired by Glaxo Laboratories Ltd., UK. In 1968, it acquired the whole capital of BDH Group Ltd. As of July 1, 1968, the company became a public limited company and its name was changed to Glaxo Laboratories (India) Ltd. (Glaxo).

Glaxo continued growing inorganically and acquired the entire shareholding of Glindia Investments Ltd., Sesame Investments Pvt. Ltd., and Samgir Investments Pvt. Ltd. Glaxo and Burroughs Wellcome merged in 1995 to form Glaxo Wellcome (India). Glaxo Wellcome (India) emerged as the largest pharmaceutical company in India with a combined market share of 7.2 per cent. Continuing with the trend of growing through mergers, Glaxo Wellcome (India) and Smithkline Beecham Pharmaceutical (India) Ltd. merged to become GlaxoSmithKline Pharmaceuticals Ltd. in 2001. This merger was one of the largest global mergers in the pharmaceutical industry. The swap ratio was fixed at one equity share of GIL (Glaxo (India)) for every two shares of SBPI (SmithKline Beecham Pharmaceuticals (India)). In 2002, the number of stockists (distributors) was brought down from 6,000 to 4,500, and the number of clearing and forwarding (C&F)[[2]](#footnote-2) agents was reduced from 60 to 31.

The Pharmaceutical Industry

The pharmaceutical industry witnessed a great deal of change in the late 1990s and 2000s. Many patents had expired, and rivalry among large pharmaceutical companies increased as did stiff competition from producers of generic pharmaceuticals. To be a relevant and sizeable player in the market, many pharmaceutical companies took the inorganic route to growth. Spending in research and development (R&D) by the top ten pharmaceutical companies increased globally to US$70.5 billion.[[3]](#footnote-3) Though modest by international standards, the top five Indian pharmaceutical companies also spent ₹12.56 billion[[4]](#footnote-4) in 2010. This amount rose to ₹80 billion by 2017.[[5]](#footnote-5) With such high spending, to create stakeholder value, pharmaceutical companies had immense pressure to increase revenues to sustain their profits and incomes. Often, this pressure was passed on to the front-line, customer-facing, and revenue-generating sales team. Study after study showed that stress levels among sales teams were high in pharmaceutical sectors.[[6]](#footnote-6)

The Incentive System: Causes of Concern

Variable pay formed a substantial portion of front-line employees’ compensation in a number of industries. Earned pay was a considerable component of the total pay for the front-line sales force and their front-line managers. Higher proportions of variable components led to two types of behaviours—firstly, it engendered self-drive among employees to work hard, perform better, and earn higher; secondly, the higher variable component in their pay propelled managers to exert incessant and unrelenting pressure on the medical representatives (MBAs—the front-line sales people) who reported to them. Among the most prominent reasons for the stress faced by the pharmaceutical sector’s sales force were working hours and continuous pressure for improved performance.[[7]](#footnote-7) Increased emphasis on meeting targets coupled with difficult working conditions, such as traveling long distances and working early mornings and late nights, led to burnout and counterproductive behaviours[[8]](#footnote-8) on the part of both managers and the ground level sales force.

The quota system and a heavy reliance on achieving targets (see Exhibit 4) created a great deal of stress among employees:

The medical representatives are the ones who bring revenue in the industry. Other functions are all cost centres, so there was great emphasis on meeting targets. This created stress and sometimes led to individuals in their own capacity indulging in unethical practices, for example, sharing a part of their incentives with the dealers and retailers, [and] prompting them to buy more drugs from the company even if earlier stock has not sold off. Therefore, too much bonus payment is also not a good thing.

One medical representative who had been with the company for almost four years and valued the GSK brand name, complained about brand dilution which was an outcome of uncontrolled focus on meeting numbers:

I joined the organization because of the brand name and values associated with the company. But over time, the medical representatives in the sector started assuming that achieving sales was of paramount importance, and they started focusing more on meeting their sales targets. As an organization that was focused [on] not only the right outcomes but also on the right means, there was a need internally to remind people of and reinforce our values.

Competition in the industry had changed the nature of sales. Companies were pitching themselves on the basis of price and incentives for doctors. Focus on patients’ needs was lost. One regional manager in the sales division lamented:

People in our industry started talking about product promotion, but these are pharmaceutical products and not instant consumption goods (e.g., food and soap). When we talk about patient benefit, there are so many factors—diagnosis, line of treatment, adverse effects and so on—that are important. We should engage the doctors [and] talk about new research, new discoveries, and latest developments or new scientific indications so that the doctors are better equipped to treat their patients.

The above views were corroborated by a senior leader:

Transparency is our main value. We want people to see us as a transparent organization that is completely driven by data, completely driven by scientific knowledge. We want healthcare professionals to look at us and think that this is not just another sales representative pushing a molecule but someone who is coming and talking about it from the point of why and under what symptoms and conditions one should prescribe that molecule.

Recounting an example of a common problem as witnessed in the industry, a senior official remarked:

Since representatives had a hard sales number to deliver, other aspects of performance got glossed over. The achievement of a target overshadowed other aspects. For example, if I as a supervisor had a star performer, who was achieving 102–105 per cent targets and was winning sales contests, everything was fine.

What was happening at the ground level in some places ran contrary to the organization’s values. The organization valued patient focus, integrity, respect for people, and transparency. With change in leadership at the highest echelons globally, the company found renewed emphasis in strengthening organizational culture and values. People at the senior level and older employees who had spent substantial time in the organization understood the company culture and were embedded in its principles and ideals. These principles now had to be taken to the ground level—to the entry level sales force who were responsible for generating revenues and also formed a link between the organization and its stakeholders. This group was the most affected by performance pressures and the resulting ethical dilemmas.[[9]](#footnote-9)

Winds of Change

As the Indian business grappled with these challenges, the dynamic new global leadership led by chief executive officer Andrew Witty from 2008 onwards, decided that a new system was necessary to set standards in the pharma world in the interests of patients. Even though current sales were not impacted, there was regulatory pressure and increased consumer awareness about the functioning of pharmaceutical companies. Leaders moved towards weakening the link between incentives and sales targets as the latter was increasingly being identified as a “not so strong” motivator of patient-focused business (where the needs of the patient were paramount in the launch and sale of products). The leadership team had numerous questions before them that needed to be answered. If sales targets were not predictors of a patient-focused outlook and individual and business performance, what was? How could predictors of performance be identified and inferred? Could these predictors be rewarded? The team wondered whether India should be a Wave 1country to lead change or take the option to be a Wave 3 country and learn from what others did. What could be the fallout of any change in performance parameters and incentives? How should business success be defined over the next four quarters?

Path of Transformational Change

GSK’s response to ethical dilemmas and yearning to re-establish patient focus was transformative. The organization rescinded its earlier performance and compensation systems that rewarded achievement of sales targets. The outcome-centric performance management system (PMS) had yielded great financial returns for the organization. However, over time, the company realized that the existing PMS was not totally aligned with the organization’s vision and values.

Top management was clear that any new system had to revolve around the philosophy of fairness and transparency to all stakeholders and should also provide multiple platforms for dialogue between its many stakeholders including employees and customers.

In December 2014, GSK moved from target-driven sales to a no-sales target regime for MBAs and first- line sales managers, the ASMs. MBAs and ASMs deal closely with the trade and healthcare professionals (HCPs) and can influence them directly. The objective was to shift the focus of its sales force to ethical behaviour, dissemination of scientific knowledge among doctors, and customer and patient care. Sales targets were given to the regional sales managers (second-line sales managers) as they were not in direct and frequent contact with the doctor; therefore they were less likely to use unfair means to influence their behaviour. One senior member of the leadership team said:

Performance is a great concern because it translates into financial incentives for individuals within GSK. There are two major ways in which we have tied compensation to performance: one is through incentives for sales people—GSK’s current system has tried to break the reliance of sales employees’ compensation on the volume of business generated. The second way of establishing performance—pay alignment—is through the claw-back provision.[[10]](#footnote-10)

Redefined Performance and Incentives

The new performance management system consisted of three key performance indicators (KPIs): knowledge, action, and application of knowledge.

Knowledge

For a long time, the organization had emphasized enhancing employees’ need to remain updated with knowledge of ailments, their cures, and the competition’s new products and sales figures. The first KPI of the revised PMS was acquisition of knowledge—disease–product knowledge (DPK), commercial knowledge, testing, and compliance. Knowledge levels were tested once every four months (quad) with weights assigned to each component (see Exhibit 6). To maintain transparency, these tests were supervised by regional business managers (RBMs), training managers, and the product management team. The knowledge scoring system also followed a differentiator from level one to level four. GSK followed a bell curve by business unit for assessing this KPI, which had four grades or levels (see Exhibit 6).

Action

Action was measured in terms of numbers of doctors met and sales calls made—reach and coverage, respectively.[[11]](#footnote-11) For example, MBAs were required to meet 11 doctors and 7–8 stockists (distributors) a day. To qualify for monthly achievements, representatives must have worked for a minimum 10 days in the field during the month and new employees must have worked three full months in the quad. There was no bell curve fitting on reach and coverage.

The entire marketing team and area business managers (ABM), MBAs, and RBMs from sales were also supplied with iPads with full information on product and disease knowledge. The organization digitalized and did away with all pamphlets, brochures, and anything that had to be carried in the field. Handling information was made easier, and approaching doctors became less awkward.

Application of Knowledge

The third important component in the new PMS was application of knowledge. This component was comprised of business planning, role-play assessment, and in-clinic assessment. Each aspect of knowledge application was evaluated by a panel of at least two members. Each aspect had a weight of 10 per cent (see Exhibit 5).

Business Planning

In each quad, a business plan was prepared by MBAs. Outlining how the brand awareness for various products the MBAs were promoting would be increased. How could they increase market share and expand the reach of their products? This was done through accurate interpretations of data and resulted in SMART (specific, measurable, attainable, relevant, and timely) objectives and KPIs to measure effectiveness of actions. One RBM explained:

A business plan is an individual plan. Suppose in a territory there are only four–five products which play a major role—we call them priority products. Out of the four priority products maybe two are not doing well in an ABM’s territory. So, we make an individual plan for those priority products. The plan would be based on how the market is growing, what our market share for the product is, and what the nature and level of competition faced is.

Other things that formed a part of the business plan were: What was the competition doing? How can we provide science behind molecules to the HCP? How can we ensure that DPK scores were higher in the future? Information on competition was obtained from HCPs, pharmacies, and the sales force of other pharmaceutical companies. Plan quality had a weighting of 40 per cent and execution had a weighting of 60 per cent. The bell curve was also instituted at the regional level and by business unit (see student spreadsheet, product number 7B19C028).

Role play assessment

As a part of training, role plays featuring calls to doctors were performed and assessed internally. Four sequential parameters on which representatives were evaluated were the following: 1) identifying the needs of customers, 2) identifying their treatment goals, 3) explaining features and benefits of the product and its relevance to the doctor’s treatment goals, and 4) closing the calls.

In-clinic assessment

In-clinic assessments were another significant part of knowledge application, wherein MBAs were assessed by the ABMs and RBMs on every planned visit. Similar to the role play’s assessment, four sequential parameters on which MBAs were evaluated were the following: 1) identifying the needs of customers, 2) identifying the physician’s treatment goals for the patient, 3) explaining the features and benefits of the product and its relevance to the doctor’s treatment goals, and 4) closing the calls. Unlike role plays that took place in a simulated setting, in-clinic assessments were done while a medical representative communicated with the doctor. An ABM made the following observation:

The manner in which medical representatives present information about a product to doctors really matters to the organization. An ABM or RBM would join the medical representatives in the field and that’s when they would observe how the medical representative was interacting with the doctors, what kind of scientific knowledge the person was using, and what the representative was saying about the therapy and the product. Our concern was whether it was being delivered with 100 per cent accuracy or not. It really measured the in-clinic effectiveness. Assessment by ABMs had a 40 per cent weighting whereas evaluation by RBMs who were required to assess each team member at least once in six months, had a weighting of 60 per cent.

The entire process was documented; scores on in-clinic effectiveness were shared with the MBAs as well as the sales training team. MBAs were concerned about this aspect of in-clinic effectiveness. Performance of in-clinic effectiveness was rather challenging with the target of meeting 11 doctors a day. The question was whether it was a practical approach because generally the waiting time at the doctors’ chamber was quite long.

Half-yearly performance review meetings with the MBAs were also being contemplated to seek feedback and make course corrections if needed. The review was deliberated upon to specify training needs and review the goals for the rest of the performance year.

The annual performance exercise, which was planned at the end of the performance year, served three goals: assessing performance for the entire year (January to December); assessing potential—leading to enhanced roles or career level movement, and; raising the bar of performance and defining goals for the next performance year.

Communicating Changes

GSK believed in establishing a strong bond with its employees; therefore, communication was focussed on a great deal.GSK initiated town hall meetings where the sales team interacted with the managing director and other senior management executives to understand the rationale behind moving from a sales-target focus to a process-focused performance or incentive system.

Management also saw these forums as an important platform to establish a better connection with employees and seek feedback. After the address by senior management, the floor was thrown open to employees to share their opinions and raise relevant questions.

To address some early problems that arose while moving to a patient-focused selling approach, multiple platforms were made available to employees to bring out issues in private and in consultation with their manager or human resources representative. Concerns could be reported to the heads of compliance, human resources, legal, and finance departments.

Secure email in-boxes were made available that were accessed by designated staff. Letters could also be sent through a post office box in Philadelphia to the global compliance officer for GSK. Emails or telephone calls could be placed to compliance officers using the Global Ethics & Compliance link on the company website. It would take time for changes to be accepted. Were the people in the organization ready? Did these changes make sense to them?

The Gains and Pains of Change

The new performance and incentive systems were met with a mix of excitement, hope, scepticism, and denial. Many people from within and outside the organization considered the new system a step forward and applauded the spirit and foresight of the new system.

Recounting how the new system seemed in sync with the values of the company, a regional manager made the following observations:

If you look at GSK values and where we stand in the minds of doctors, we just cannot go with only a sales orientation or sales-oriented mindset. It is better we speak sense—we speak science and our business will automatically flow. We have some of the best products (let’s say for example in oncology and cardiology), so we are not required to create a sales pitch around rates. We don’t need to do what other newly mushrooming pharmaceutical companies are doing. They compete on price. We wanted to highlight patient benefits—benefits related to great diagnosis [and] world class, up-to-date, and appropriate treatment. We should engage the doctor in the activities that are academic in nature, share science and research, and [discuss] how this information can be translated into patient benefits.

Counting the benefits of knowledge assessment, an ABM said:

Emphasis has now shifted to values, transparency, respect for people, integrity, and patient focus. In everything we do, we have to keep the value of being fair to the patient as the fulcrum of our organization. We discourage hard-selling only and somehow generating prescription[s] and getting a sales number. Instead, we are making sure that prescribers understand why they should be prescribing a molecule and that they understand the science behind the molecule. Our salespeople are now focusing on scientific knowledge dissemination, understanding the requirements of the doctors and their concerns, and [appreciating] how knowledge helps patients and improves their health.

Focusing on knowledge acquisition, role play, and in-clinic effectiveness also helped the company assess the performance gaps of employees and address them more productively:

Now I know exactly the root cause of performance gaps: representatives may lack knowledge regarding the product or disease, have communication problems, not understand the requirements of doctors, or are not reaching out to enough practitioners. Our process driven PMS has helped us in diagnosing competence issues—where they occur and how we address them quickly and precisely.

KPI of reach and coverage also ensured that all sources of potential business were being tapped unequivocally by the MBAs. Generating sales from established sources, while ignoring new outlets, was discouraged once the organization started emphasizing a fixed number of field visits to identified doctors every month. With this plan, the MBAs were now no longer held accountable for a drop in sales that was due to events beyond their control. According to a medical representative,

We are told to follow 100 per cent of the process. The company compensates us on the basis of process. So, because of unwarranted situations over which we have no control, we are not penalized. Earlier, if two products had gone out of supply or if I missed my sales target, I would have foregone my entire incentive. At present, I have no sales target but am responsible for reach and coverage which to a large extent are under my control, so I don’t miss out on my incentives. I think, on average, people are earning more incentives than they previously did under the old PMS.

One noteworthy result of business planning was increased awareness among MBAs regarding how the market behaved. According to an MBA:

Now I keep a tab on how the market is behaving. If a product market is growing by 30 per cent and we have only, let’s say, a 2 per cent market share, I know I am missing out on an immense opportunity. In this case, I am inspired to increase my visits to this market. In the next month, I will plan four more visits instead of only one. I will do more doctor-related activities here. I will call for more scientific meetings or SPM-scientific promotional meetings here. I will call a specialist to talk with general practitioners regarding this disease area. In such meetings, the specialist can talk about the current trend of the disease area [and] types of products that are more beneficial in treating patients suffering from these diseases. This helps to create awareness and is instrumental in enhancing prescriptions and our business. I include all this in my business plan.

The new system also helped in enhancing transparency in the rating process. According to an ABM:

I cannot give a higher ranking because I like someone. I am held accountable on why I have rated someone one, two, or three. Now I have documents for the entire process—all KPIs—and I have to give these documents to my supervisors to support my ratings. The trainer and RBM are also involved in the evaluation process. It is not the ABM’s sole discretion now.

According to an MBA, feedback from their supervisors has increased in frequency and quality:

Now on the day my ABM accompanies me on field visits, I end up getting immediate feedback. He has to evaluate my in-clinic performance and send the report; as a consequence, he shares my positives, negatives, and ideas for improvement with me.

The organization seems to have benefitted as its engagement index showed a 91 per cent participation rate. On a scale of 1–5, the engagement score was 4.07. This was an achievement considering the engagement scores were lower until only a few years ago.

With the new system came some issues and challenges. Many high performers who thrived under the sales target regime found the new system too cumbersome, subjective, and difficult to understand:

The new incentive system is complicated and too difficult to understand. I just don’t know where I will slip and how my incentives will be calculated. I am at the mercy of too many factors and people. Doctors are also complaining about having no samples being offered to them. It is stifling here. Many of my high performing friends have quit. If it were not for the work environment here, I also would have left but will wait for a while. If things don’t improve, I am on my way out too.

Some of the ABMs found themselves reeling under too much pressure. Along with field visits and performance targets, they had the added burden of evaluation on multiple fronts. One such ABM shared her predicament:

Firstly, when this system came out, we thought it would certainly improve our lives. But no. Now we have to maintain a lot of documentation. We miss deadlines sometimes and get lots of flak from our line managers. Secondly, earlier if I had doubts I could go to my line manager and ask about the way forward. He would take out a calculator, make some calculations, and tell me what was supposed to be done. That is no longer the case. Calculator-using ability has gone down. Now my line manager is confused about what has to be done and how, and whether it is the right thing to do. So we keep on going up and down with what has to be done.

Some of the RBMs were not happy either. They got sales targets, but they could not pass them on to ABMs and MBAs. According to one regional manager, “We are the ones who have lost the most. We have no authority—only responsibilities and targets. The buck stops with us. Our MBAs are empowered and choose to ignore us. How are we supposed to deliver?”

With mixed reports coming in from all quarters, Sequeira knew that he had work to do. Many people were adapting fast to the new system while a few resisted. Some MBAs were performing well under the earlier system but were not so successful under the new system and left the organization. Management had anticipated this turn of events and was fine with employee turnover on this account. A revolutionary system had been launched. It had worked in sending the right messages to front-line employees, but more work needed to be done to make it more acceptable and functional. How should he address the subjectivity of the system, simplify it for his salesforce, and address the concerns of his first- and second-line managers?

Exhibit 1: Performance of GSK India (2010–15) in US$ Millions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **15 Months Ended March 2015\*** | **2013\*** | **2012\*** | **2011\*** | **2010** |
| PROFIT AND LOSS ACCOUNT | |  |  |  |  |
| Sales | 506.949 | 391.455 | 403.014 | 361.016 | 325.295 |
| Profit before tax | 120.832 | 106.139 | 150.155 | 139.109 | 130.909 |
| Tax | (41.977) | (34.142) | (47.938) | (43.810) | (43.153) |
| Profit after tax and before exceptional items | 78.854 | 71.997 | 102.217 | 95.300 | 87.755 |
| Exceptional items (net of tax) | (7.662) | 3.758 | (15.084) | (30.303) | (2.670) |
| **Net profit** | 71.192 | 75.755 | 87.134 | 64.996 | 85.085 |
| **Balance brought forward** | 166.029 | 172.521 | 167.636 | 175.778 | 158.374 |
| Dividends | (79.908) | (63.926) | (63.926) | (57.534) | (51.141) |
| Tax on distributed profit | (16.267) | (10.746) | (9.609) | (9.105) | (8.032) |
| Transfer to General Reserve | (7.118) | (7.576) | (8.714) | (6.500) | (8.509) |
| Balance carried forward | 133.928 | 166.029 | 172.521 | 167.636 | 175.778 |
| **BALANCE SHEET** |  |  |  |  |  |
| Equity capital | 12.785 | 12.785 | 12.785 | 12.785 | 12.785 |
| Reserves | 266.711 | 291.697 | 290.613 | 277.016 | 278.658 |
| Borrowings | 0.471 | 0.625 | 0.693 | 0.741 | 0.779 |
| **Subtotal** | 279.967 | 305.106 | 304.091 | 290.542 | 292.222 |
| Fixed assets | 35.967 | 24.442 | 20.104 | 17.407 | 17.758 |
| Investments | 7.195 | 8.705 | 15.484 | 24.121 | 24.204 |
| Net deferred tax | 12.515 | 13.903 | 13.063 | 9.278 | 8.513 |
| **Net assets (current and non–current)** | 224.290 | 258.056 | 255.440 | 239.736 | 241.746 |
| **OTHER KEY DATA** |  |  |  |  |  |
| Dollar per $.15 equity share |  |  |  |  |  |
| Dividends | 0.094 | 0.075 | 0.075 | 0.068 | 0.060 |
| Special additional dividend |  |  |  |  |  |
| **Total** | 0.094 | 0.075 | 0.075 | 0.068 | 0.060 |
| Earnings per equity share | 0.084 | 0.089 | 0.103 | 0.077 | 0.100 |
| Book value | 0.330 | 0.359 | 0.358 | 0.342 | 0.344 |

EXHIBIT 1 (CONTINUED)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **OTHER KEY DATA**  **Dollar per $ 0.15 Equity Share** | **15 Months Ended March 2015** | **2013\*** | **2012\*** | **2011\*** | **2010** |
| Dividends | 62.50 | 50.00 | 50.00 | 45.00 | 40.00 |
| Special additional dividend | - | - | - | - | - |
| **Total** | 62.50 | 50.00 | 50.00 | 45.00 | 40.00 |
| Earnings per equity share | 55.68 | 59.25 | 68.15 | 50.84 | 66.55 |
| Book value | 218.61 | 238.16 | 237.31 | 226.67 | 227.96 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of employees | 4,657 | 5,034 | 4,706 | 5,055 | 4,338 |

* The company divested its fine chemicals business on September 30, 2007 and its animal health business on July 31, 2006.
* The company bought back and extinguished 26, 19.529 equity shares during 2005.
* The accounting year of the company changed from January–December to April–March—taking effect from the current year. Consequently, the current year’s financial statements are for the 15 months from January 1, 2014 to March 31, 2015. Therefore, the current year’s figures are not comparable with those of the previous year.
* To facilitate comparison, figures have been adjusted or regrouped where necessary to line up with the financial statements.

Note: \*The years 2013, 2012, and 2011 are based on the revised schedule VI (see “Revised Schedule VI,” KPMG, accessed August 19, 2019, <https://home.kpmg/in/en/home/trainings/advisorytrainings/aaslearningsolutions/revisedschedulevi.html>).

Source: The above is an extract from GSK, *Annual report 2015,* accessed March 8, 2017, www.gsk.com/media/4697/gsk-annual-report-2015.pdf.

Exhibit 2: Organization Structure of GSK (India)

Broad representation of the prevailing structure adapted for the case study

Managing Director

HR

Director

Legal

Director

Pharma Director

Mass Markets

Medical Director

Finance Director

Pharma Director Mass Specialities

Technical Director, Contractual, GMS Finance

Regulatory Affairs

Director, South Asia

Quality Control Director

Vaccines Director

Communication and

Government Affairs Director

Company Secretary

Note: Pharma = Pharmaceutical, HR = Human Resources, GMS = Global Manufacturing and Supply.

Source:Summarized and adapted from discussions with members of the organization.

Exhibit 3: Sales Organization of GSK India

**Pharmaceuticals Director**

Business Unit Head

Therapy Area 2

Business Unit Head

Therapy Area 3

Marketing Head

Business Unit Head

Therapy Area 4

Business Unit Head

Therapy Area 5

Business Unit Head

Therapy Area 1

RBM

6 Nos

RBM

6 Nos

RBM

6 Nos

RBM

6 Nos

RBM

6 Nos

ABM

6 Nos

ABM

6 Nos

ABM

6 Nos

ABM

6 Nos

ABM

6 Nos

MBA

6–9 Nos

MBA

6–9 Nos

MBA

6–9 Nos

MBA

6–9 Nos

MBA

6–9 Nos

Note: “Nos” = Numbers, RBM = Regional Business Manager, ABM = Area Business Manager, MBA = Medical representative.

Source: Summarized and adapted from discussions with members of the organization.

Exhibit 4: Sales Incentives at GSK India (2013–14)

|  |  |
| --- | --- |
| **Activity: Monthly**  1. Call average  2. Coverage  3. Timely submission of stock and sales statements of all stockists and other documentation | 90 Marks |
| **Competency**  Information gathering and usage, and knowledge of competitors’ information  Product & therapy knowledge | 40 Marks |
| **Sales Target Performance** | 150 Marks |
| **Primary Performance to Target Strategic Brand** | 130 Marks |

Source:Summarized and adapted from documents provided by the organization and discussions with members of the organization.

Exhibit 5: Compensation Philosophy of gsk india

LOC Sales

(Rx) 40%

Individual

KPI 60%

Base Salary

Business Planning

(10%)

In-Clinic Assessment

(10%)

Role-Play Assessment (10%)

Application

of

Knowledge

Action

Knowledge

Target variable component cannot exceed 33% of fixed component.

Base Salary = Basic + DA + HRA + Allowances (medical, KAS, education, additional, communication), Medical representative allowance (career ladder), Kit allowance, and LTA.

LOC Sales = Annual payout.

Individual KPI = Quad payout.

Note: KAS = knowledge, action, application of knowledge; DA = dearness allowance; HRA = house rental allowance; LTA = leave travel assistance; LOC = Local Company (i.e., GSK India), KPI = Key Performance Indicator.

Source: Adapted from incentive plans provided by the organization.

Exhibit 6: Knowledge Test at gsk india

Knowledge Scoring System

|  |  |  |  |
| --- | --- | --- | --- |
| **Areas** | | **Questions** | **Number of Questions** |
| Disease Product Knowledge | Pathology | Disease information, treatment goals, etc. | 20% |
| Product | Product description, dosage, competitors’ product information | 20% |
| Promotion | Key messages, product advantages, objection handling, patient profiles, | 20% |
| Commercial Knowledge | | External environmental knowledge, competitor understanding | 20% |
| Governance and Compliance | | Pharmaco-vigilance  Medical governance  Scientific engagement | 10% |
| Corporate Compliance  GSK code of practice  Write right | 10% |

Bell Curve by Business Unit

|  |  |  |
| --- | --- | --- |
|  | **Rating** | **Multiplier** |
| Top | 10% | 2× |
|  | 20% | 1.3× |
| Base | 55% | 1× |
|  | 12% | 0.7× |
| Bottom | 3% | 0.3× |

Source: Adapted from incentive plans provided by the organization.

Exhibit 7: Action for medical representatives (MBAs) at gsk india

To qualify for monthly marks, representatives must have worked a minimum of 10 days in the field during the month; to qualify for a quad incentive, new employees must have worked 3 full months in the quad.

**Reach and Coverage Calculation**

**Customer Reach:**

On achieving

80% reach : 40 points/Month

Every 1% reach over 80% : 0.5 point/Month

**Coverage:**

On achieving

80% reach : 40 points/Month

Every 1% reach over 80% : 0.5 point/Month

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Max Points/Month** | **Total points/Quad** |
| Reach/Month | 50 | 200 |
| Coverage/Month | 50 | 200 |
| **Maximum points/Month** | **100** | **400** |

Action scoring system

|  |  |  |
| --- | --- | --- |
| **Score Range** | **Rating** | **Multiplier** |
| 96%–100% | 1 – Exceptional | 1.3 × |
| 91%–95% | 2 – Strong | 1.0 × |
| 86%–90% | 3 – Partial | 0.7 × |
| 80%–85% | 4 – Low | 0.3 × |

Note: These calculations do not include a bell curve.

Source:Adapted from incentive plans provided by the organization.

Exhibit 8: Application of Knowledge at gsk india

Business planning

Role-play assessment

In-clinic assessment

Evaluation by panel

Evaluation by panel

Evaluation by panel

10%

10%

10%

Panel to have minimum two members.

Source:Adapted from incentive plans provided by the organization.

Exhibit 9: Business Planning for gsk india

**Business Planning Scoring System**

* Plan would be prepared in each quad.
* Execution would be on the revised plan.
* Plan and execution in each quad.
* Plan Quality Weighting = 40%.
* Execution Weighting = 60%.

**Bell curve at regional level, by business unit**

|  |  |  |  |
| --- | --- | --- | --- |
| **Score Range** | **Rating** | **Target Distribution** | **Multiplier** |
| Top 10% | 1 – Exceptional | 10% | 2× |
| 11%–30% | 2 – Outstanding | 20% | 1.3× |
| 31%–85% | 3 – Strong | 55% | 1× |
| 86%–97% | 4 – Partial | 12% | 0.7× |
| 98%–100% | 5 – Low | 3% | 0.3× |

Exhibit 10: In-Clinic Assessment factors at gsk india

**In-Clinic Effectiveness Evaluation**

* Assessment by ABMs, RBMs on every visit in given format
* One assessment on the total number of days of joint fieldwork (FW) in a month
* Assessment on overall HCPs interaction for all FW days
* RBMs ensure assessments are done for all team members at least once every 6 months
* Weightage ABMs 60%, RBMs 40%
* RBM’s ratings applicable for the quad in which a medical representative was assessed
* ABMs conduct minimum one assessment for each team member at least once every month
* Average marks for all ABMs’ assessments done during the period to be considered for calculating weightage
* If RBM’s FW is not possible, marks given by ABMs considered for incentives

**In Clinic or Role-Play Assessment**

|  |  |
| --- | --- |
|  | **In-clinic / Role-play assessment** |
| Max Score in QTR | 48 |
| Score Achieved |  |
| % Achieved |  |

**Bell Curve at Regional level and by Business Unit**

|  |  |  |  |
| --- | --- | --- | --- |
| **Score Range** | **Rating** | **Target Distribution** | **Multiplier** |
| Top 10% | 1 – Exceptional | 10% | 2× |
| 11%–30% | 2 – Outstanding | 20% | 1.3× |
| 31%–85% | 3 – Strong | 55% | 1× |
| 86%–97% | 4 – Partial | 12% | 0.7× |
| 98%–100% | 5 – Low | 3% | 0.3× |

Note: Bell curve for the scores achieved between 40–100% only; see student spreadsheet (Product number 7B19C028) with new incentive plan. RBM = Regional Business Manager, ABM = Area Business Manager, HCP = Health-care Practitioner.

Source: Created by case authors based on interviews at GSK and company files.

1. “GlaxoSmithKline Pharmaceuticals History | GlaxoSmithKline Pharmaceuticals Information - The Economic Times,” accessed March 31, 2017, https://economictimes.indiatimes.com/glaxosmithkline-pharmaceuticals-ltd/infocompanyhistory/

   companyid-13715.cms. [↑](#footnote-ref-1)
2. Distribution is done through retail and dealer channels in the market; clearing and forwarding (C&F) agents store the goods of a company in the warehouse and send supplies according to the agencies’ order to the respective destinations. [↑](#footnote-ref-2)
3. Ben Adams, “The top 10 Pharma R&D Budgets in 2016,” April 26, 2017, accessed July 19, 2018, www.fiercebiotech.com/special-report/top-10-pharma-r-d-budgets-2016. [↑](#footnote-ref-3)
4. ₹= INR = Indian rupee; US$1 = ₹64.78 on April 1, 2017. All currency amounts are in ₹ unless otherwise specified. [↑](#footnote-ref-4)
5. Kiran Kabtta Somvanshi, “Top Five Indian Pharma Companies Together Spent over Rs 8000 Crore on R&D Spend in FY17,” June 28, 2017, accessed July 19, 2018, https://economictimes.indiatimes.com/industry/healthcare/biotech/pharmaceuticals/

   top-five-indian-pharma-companies-together-spent-over-rs-8000-crore-on-rd-spend-in-fy17/articleshow/59049624.cms. [↑](#footnote-ref-5)
6. Lakhwinder Singh Kang, “Stressors among Medical Representatives: An Empirical Investigation,” *Indian Journal of Industrial Relations* 40, no. 3 (2005): 339–356, accessed July 19, 2018. [↑](#footnote-ref-6)
7. G. Harris, G. Mayho, and L. Page, “Occupational Health Issues Affecting the Pharmaceutical Sales Force,” *Occupational Medicine* 53, no. 6 (2003): 378–383, accessed July 19, 2018. [↑](#footnote-ref-7)
8. Counterproductive behaviours included exaggerating the number of calls made, trying to sell products in other people’s territories, and similar unproductive activities. [↑](#footnote-ref-8)
9. Examples of malpractice included medical representatives (MBAs) pushing the distributors to buy more stock at the end of the month to help meet the representatives’ targets. Also, the representatives might share part of their incentive to lure distributors into buying additional products even when the latter had plenty of stock on hand. These practices were not real sales as the stock piled at the distributor’s end and was not being bought by the end customer. [↑](#footnote-ref-9)
10. The claw-back provision, also known as the “executive financial recoupment program,” mandates that GSK establish a program that “puts at risk of forfeiture and recoupment an amount equivalent to up to three years of annual performance pay (i.e., annual bonus, plus long-term incentives) for an executive who is discovered to have been involved in any significant misconduct.” [↑](#footnote-ref-10)
11. Reach was defined as the number of doctors met, and coverage was the total number of doctor visits made. For example, in a territory with only two doctors where each doctor was met twice in a month, the reach would be two and coverage four (2×2). On the other hand, if one doctor was met once and another twice, reach would be two and coverage three (1×1+1×2). [↑](#footnote-ref-11)