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9B19M002

Cipla Limited: Taking inhalation therapy to the masses

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In the second week of March 2014, Cipla Limited (Cipla), a leading pharmaceutical company in India, was nearing the end of its financial year (FY) 2013–14. Debashis Sarkar, head of Cipla’s respiratory division, had just concluded a meeting with his team members. The meeting’s agenda had included a review of the progress of the division’s sales and marketing objectives for FY 2013–14 and a plan for the FY 2014–15 objectives. A performance assessment revealed that the division held a majority share in most of the therapies under the respiratory umbrella. As a pioneer in inhalation therapy, Cipla was globally acclaimed for its range of inhalers for obstructive airway diseases, including asthma and chronic obstructive pulmonary disease (COPD). Taking inhalation therapy to the masses, especially in rural and semi-urban areas, had been the prime objective of the respiratory division in FY 2013–14. That objective required strengthening its reach in the general practitioner segment (i.e., primary care physicians) and extending optimal medical care to patients who were otherwise sub-optimally treated. The recent employment of an extensive sales force, coupled with innovative promotional campaigns, had generated promising results in the specialist segment. However, the division was still short of achieving the desired impact in the general practitioner segment.

The team had proposed a further increase in sales and marketing expenditures, but the idea did not appeal to Sarkar, who was known for his creative thinking and unconventional approach. Offering a different viewpoint, Sarkar instead proposed establishing a lateral structure of knowledge experts whose advice would resonate well with the target audience and who would support the existing sales team in its market expansion efforts. The thought was derived from his October 2013 experimental initiative in Delhi, where he had appointed two doctors as respiratory therapy managers (RTM), working closely with Cipla’s sales team. The initiative had quickly enhanced Sarkar’s business expansion efforts and had helped him achieve his divisional objectives. However, his major dilemma was determining how to expand the plan to apply it across all of India. The unconventional idea was currently not being practiced by any other pharmaceutical company in India. Sarkar weighed the pros and cons of his plan, hoping to devise a blueprint for implementation and scaling up.

**EXECUTIVES INVOLVED**

Sarkar was a seasoned professional with more than 15 years of experience in the pharmaceutical industry and a strong educational background. After achieving a postgraduate degree in mathematics, he had supplemented his professional education in management at the prestigious Indian School of Business in Hyderabad. Sarkar had been at Cipla since 2004, during which time he had held important strategic portfolios such as head of marketing for chronic business and business head for the regions of East India, Delhi, and Rajasthan. He had played an important role in establishing Cipla as a market leader in key therapeutic segments, including the areas of urology and human immunodeficiency virus (HIV). With a strong passion for marketing and strategy, he had spearheaded the launch of many brands that had eventually become leaders in their respective categories. As a member of the leadership team of Cipla’s domestic business, he had contributed actively to key strategic decisions. He was known for his innovative approach within the established business domain.

In addition to Sarkar, Cipla’s key decision makers were members of the respiratory division. Basant Pachisia was in charge of the Breathefree team and was based in Mumbai. Other team members, who were part of the Delhi sales team, included the divisional sales manager, Vijay Singh, and the regional managers, Farhan Pasha and Vishal Sharma.

**BACKGROUND on ASTHMA**

Asthma was a medical condition in which a person’s airways became narrow and inflamed, causing difficulty in breathing.[[1]](#footnote-1) It was usually associated with tightness in chest, cough, shortness of breath, and wheezing. Although asthma affected people of all ages, children were most susceptible. Asthma was incurable and required lifelong medications; however, with proper management, an asthmatic patient could lead a normal and active life.

In 2012, India had approximately 24 million asthmatic patients, which represented 10 per cent of asthma cases worldwide. India’s incidence of childhood asthma ranged from 2.1 per cent to 11.8 per cent.[[2]](#footnote-2) Statistics indicated that the overall prevalence rate of asthma had increased from 41.9 per 1,000 people in 2004–2005 to 54.9 per 1,000 people in 2011–2012. Various factors contributed to the condition’s disparity across regions (see Exhibit 1).[[3]](#footnote-3) Leading risk factors that led to the development of asthma were high population density; damp environments; and exposure to indoor allergens, tobacco smoke, and chemical irritants (see Exhibit 2). Lifestyle factors such as cooking in a closed environment and concurrent use of biomass and solid fuels had the highest impact on women and children, although these causes were least suspected.[[4]](#footnote-4) Statistics indicated that the sale of asthma prevention medicines in India had increased by 43 per cent in a span of four years, but its use was still low in rural and semi-urban areas.[[5]](#footnote-5)

Inhalation therapy was considered the most effective method of asthma management worldwide. However, various obstacles prevented the distribution of inhalers to the masses in India, both at the practitioner and patient levels. Most primary care physicians in rural and semi-urban areas held education degrees in alternative forms of medicine, such as bachelor’s degrees in Ayurvedic medicine and surgery (BAMS) or bachelor’s degrees in Unani medicine and surgery (BUMS). They had limited knowledge about the treatment protocols of modern allopathic medicine, so they mainly relied on oral and injectable medicines instead of inhalation therapy, which meant that they were delivering sub-optimal treatment to their patients. Moreover, most patients preferred oral medications to inhalers because they felt that there was a social stigma associated with the use of inhalers. If they used inhalers, they tended to be secretive about it. Patients had a misconception that inhalers were meant for serious diseases, and that once their use was started, it would be a lifelong commitment. Lack of adherence to inhalation therapy further worsened the situation. Sarkar saw both a need and an opportunity to bring inhalation therapy to bottom of the pyramid (BOP) consumers, as he explained:

Statistical data and field observations revealed that there was a huge untapped market for penetration and expansion of inhalation practices in rural and semi-urban areas. The added advantage was negligible competition in this sphere as leading pharmaceutical players were not focusing on the bottom of the pyramid. Being a pioneer in inhalation therapy, the need of the hour was to convert this opportunity into a measurable business outcome.

Although most physicians and chest specialists in urban areas were active prescribers of Cipla’s inhalation portfolio, the sales team had not been successful in generating the same impact at the general practitioner segment. Due to low awareness about inhalation therapy at the practitioner’s end and the social stigma attached to it, rigorous efforts and significant time were needed before an observable change could be seen. Because the main focus of the sales team was generating sales, the team had invested little time in the BOP segment, with its relatively low business potential compared to that of chest physicians. Despite the opportunity that a largely untapped market presented, Sarkar was unsure how to leverage the commercial potential of the BOP segment. It appeared that innovative methods for market expansion were necessary.

**OVERVIEW OF the INDIAN PHARMACEUTICAL INDUSTRY**

In 2013, the value of the Indian pharmaceutical industry was estimated at US$12 billion.[[6]](#footnote-6) Globally, it ranked third in volume and 14th in value. It was highly fragmented, with the top 10 companies contributing approximately 41 per cent of total sales. Apart from domestic consumption, the industry exported drugs, vaccines, and biopharmaceutical products to many regulated and semi-regulated markets. Approximately 60 per cent of domestic sales were generated from metropolitan and Tier 1 cities, with the remaining 40 per cent coming from the rest of the country. India’s urban regions had recorded annual growth of 10 per cent, whereas rural regions were growing at a rate of 14.5 per cent. This rate of growth was primarily due to improved health care infrastructure and increased penetration of pharmaceutical companies in these regions.[[7]](#footnote-7)

**Bottom of the Pyramid Markets**

The BOP segment was defined on the basis of an economic pyramid, where privileged populations represented the narrow top of a pyramid and underprivileged populations represented the wide-ranging bottom. The BOP segment represented about two-thirds of the population. According to a report by the World Economic Forum, in 2009, people with an income of less than $8 per day constituted the BOP segment. Another report claimed that 70 per cent of India’s population earned an annual income of less than $4,000 and therefore belonged to the BOP segment. Of that group, 78 per cent lived in rural areas.[[8]](#footnote-8) Rural India, which held 67 per cent of the country’s population, consisted of about 600,000 villages. In 2010, these markets accounted for 17 per cent of total industry sales.[[9]](#footnote-9) The Indian BOP health market was significant because it consisted of approximately 155 million households, with $26.6 billion in total annual health spending.[[10]](#footnote-10)

A closer look at these markets revealed that BOP populations were largely underserved in terms of basic necessities, especially health care. The limited availability of health care was characterized by a huge gap between demand and supply. These markets had poor health care infrastructure and a doctor-to-patient ratio of 1:20,000 in comparison to urban areas, where the ratio stood at 1:2,000. Literacy levels were low, and people lacked awareness about various diseases and their treatment. The first contact care providers for these groups were primary care physicians located nearby, who focused mainly on acute diseases. BOP patients also visited primary health care centres,[[11]](#footnote-11) which essentially consisted of government-established single physician clinics that provided only basic facilities. These populations relied mostly on alternative forms of medicine, such as Ayurvedic and Unani practices. Some price-sensitive BOP households delayed treatment until health conditions became more serious before choosing to contact heath care providers.

Despite various challenges related to accessibility and affordability, the BOP populations represented a largely untapped market with significant unfulfilled demand. The main reasons were an increasing incidence of disease, an increasing ability to pay, an absence of a viable business model, and a failure to expand the existing infrastructure.[[12]](#footnote-12) However, penetrating BOP markets required both pursuit of social responsibility and adaptation of current marketing strategies.

**COMPANY OVERVIEW**

Cipla was incorporated in 1935 with the motto “Caring for Life.” Headquartered in Mumbai, it was a leading global pharmaceutical company with an annual turnover of US$2.36 billion (see Exhibit 3). With an employee base of more than 25,000 employees, it had a presence in more than 80 countries. It had over 43 state-of-the-art manufacturing facilities that manufactured a product portfolio of more than 1,500 products consisting of branded and generic medicines. The products were available in over 50 dosage forms across various therapeutic categories. Over a span of eight decades, Cipla had been instrumental in introducing many novel molecules and combinations. The company followed a patient-centric approach. Its main aim was to make high-quality medicines accessible to patients at affordable prices. The company operated in multiple therapeutic areas, including women’s health, children’s health, infectious diseases, critical care, cardiovascular care, diabetes, respiratory health, HIV, hepatitis, and oncology. Cipla was a strong competitor in the multiple therapies segment and the market leader in most categories under the respiratory umbrella. The company’s strong research and development department focused on developing new products and improving existing products.

**Inhalation Therapy and Cipla**

Medicine was inhaled directly through an inhaler for fast relief. With a growing number of patients with respiratory disorders, the market for inhalation therapy was constantly increasing. According to statistics from IMS MAT, as of March 2013, the market for respiratory medicines in India was estimated at ₹57.23 billion,[[13]](#footnote-13) which increased to ₹64.45 billion in March 2014. Cipla was known for pioneering inhalation therapy and was the leading company operating in this domain, both nationally (see Exhibit 4) and in the Delhi area (see Exhibit 5). It had established itself as a leader in most categories of inhalation therapy (see Exhibits 6 and 7).

Cipla had been at the forefront of innovation and offered the world’s largest portfolio of inhalation products. Its therapeutic basket consisted of various combinations of 27 molecules across a range of devices to suit the individual needs of patients. The company manufactured metered dose inhalers, dry powder inhalers, nasal sprays, nebulization solutions, and a range of inhaling accessory devices. Cipla was the third-largest manufacturer of metered dose inhalers in the world. With the launch of a new form of transparent inhaler called the Rotahaler in 1996, it had heralded an era of patient-friendly inhalation therapy and was successfully transforming the lives of millions of asthmatic patients.

**Awareness Initiatives by Cipla**

Cipla had introduced various awareness initiatives to promote adoption and correct use of inhalation therapy. These initiatives consisted of continuing medical education programs for health care practitioners and large-scale patient education programs (see Exhibit 8). The most significant of these public service programs was called Breathefree. Introduced on Cipla’s 75th anniversary, the program was developed into a comprehensive support system for patient care. Clinics and counselling centres under the Breathefree umbrella were established across the country. The team consisted of more than 600 Cipla Breathefree educators working to spread awareness about respiratory diseases and inhalation therapy. The major role of Breathefree educators was to assist people in diagnosis of the disease and advise them on the importance of treatment adherence to lead a normal life. A website was set up as an important source for information, solutions, and support for chronic airway diseases. The site also formed an important link between patients and their advisors.[[14]](#footnote-14)

**The Respiratory Therapy Manager IDEA AND CONCEPTUALIZATION**

RTMs were doctors who held degrees in alternative systems of medicine. They were added to the sales teams with the objective of creating a new prescriber base for inhalation therapy. Their main task was to provide assistance to primary care physicians, especially those who held BAMS or BUMS degrees, in the adoption and correct use of inhalation practices to treat asthma, thereby helping primary care physicians to both expand their practices and deliver optimal treatment to their patients. The concept emerged from an experimental initiative during a field visit by Sarkar to the Ayurvedic and Unani Tibbia College in Delhi (Tibbia College). The institute offered bachelor’s and master’s degrees in Ayurvedic and Unani medicine. At an asthma awareness camp at the college in September 2013, Sarkar met BAMS/BUMS doctors and learned about the scarce employment prospects available to them. Most students felt that they would not be given the same respect as graduates with bachelor of medicine and surgery degrees (degrees from modern schools of medicine rather than degrees in alternative medicine). Therefore, establishing a private practice in urban areas would be difficult and only rural or semi-urban areas would be open to them. This issue was especially serious for female graduates.

Sarkar had a “eureka” moment. He had been looking for unconventional ways to bring inhalation therapy to the BOP markets after efforts by Cipla’s sales and marketing team had failed to yield productive results. He saw an opportunity in the graduates he met and wondered how they could help Cipla’s sales team introduce inhalation therapy to practicing alternative-medicine doctors. In Delhi, Cipla’s sales professionals worked in different divisions (see Exhibit 9). Approximately 80 sales representatives worked in the respiratory division with support from the marketing team at Mumbai, which consisted of the marketing head, a group product manager, and various product managers. As part of the sales team, RTMs would provide strong lateral support to the sales team members.

When Sarkar first proposed his idea to the graduates, most were reluctant, seeing it as a front-line sales position that did not interest them. The concept was also unfamiliar to them; no other pharmaceutical company in India had doctors as part of the sales team. However, after further discussion about the position of knowledge experts working with general practitioners to improve the use of inhalation therapy, five graduates agreed to give it a try. Two of the doctors, Mohammad Faiz and Mohammad Irshad Alam, would take part in Cipla’s first trial run as RTMs.

**TRIAL RUN**

**Training and Induction**

The two RTMs were given extensive training for seven days in the first week of October 2013 at Cipla’s head office in Mumbai. The first part of the training, provided by Cipla professionals, was on the basics of the respiratory system, asthma, and COPD. It covered details of treatment, current epidemiology, and inhaler techniques. Further training was then provided by inhalation therapy experts in Delhi. Because the new doctors were from a non-managerial background, they were also given training on basic selling skills, customer profiling, product pitch, situation handling, and follow-up. The RTMs were assigned to urban slums in Delhi, including Daryaganj and parts of South Delhi, for an initial breakthrough. The target was to reach 50 doctors and work on a dot-convert-shift methodology.[[15]](#footnote-15) Those doctors who became active prescribers of inhalation therapy would be transferred to the sales team for business generation and follow-up. A new set of doctors would then be targeted by RTMs. The concept was meant to help the sales team retain its core focus on business generation, while the RTMs supported the company’s expansion efforts by bringing inhalation therapy to the BOP segment.

**Methodology Adopted**

The RTMs briefed targeted doctors about the use of inhalation therapy and correct protocols for treating asthma patients. RTMs were able to secure appointments with practitioners and develop a rapport thanks to a peer effect. They had an understanding of the target audience and the grass-root problems of prescribing inhalation therapy, which made their in-clinic discussion more effective. The adopted approach was qualitative, requiring them to spend long hours at the doctor’s clinic to facilitate the conversion from oral medicine to inhalation therapy. Promotional and training material on the use of inhalation therapy was available in Hindi, which helped make the RTMs’ task less daunting.

The RTMs were supported by members of the executive team; Pachisia played a crucial role through his team of Breathefree educators, who offered repeated training to patients, created awareness about asthma and its management, and advised them about the appropriate use of inhalers. Regional managers Singh and Sharma also contributed to the flawless execution of the trial run by driving existing business, whereas Pasha was an important link between the RTMs and the sales team to ensure synergy between both groups. Pasha helped the RTMs garner a strong foothold at the general practitioner segment and helped the sales team leverage business potential from the converted doctors.

**Outcome**

The RTMs were the major vehicle for social change in the area of inhalation therapy, driving the adoption of new inhalation practices. Within six months, an average of 31 of 50 doctors targeted by each RTM had started prescribing inhalation therapy. An increase was also seen in the average monthly sales of inhalers (see Exhibit 10). The trial was seen as an overwhelming success by Cipla’s management, something that the core sales team could not have achieved despite previous efforts and major promotional campaigns. However, management wanted to be sure that the outcome was a result of the planned strategic initiative, rather than something achieved by chance. Faiz was asked to meet with top management officials in the Mumbai head office and brief them on how they were able to achieve such impressive results. To assess the actual impact of the initiative, management also advised Sarkar to replicate the same effect in other territories.

**WAY FORWARD**

After receiving approval from management, Sarkar was looking forward to expanding the initiative and making it a countrywide phenomenon. Although initial results were promising, there was uncertainty about the sustainability of the concept when replicated on a large scale. The immediate challenge was how to integrate a “hit and trial” approach into the existing sales and marketing framework and leverage optimal efficiency. Some health care practitioners had also expressed resentment over the approach, which posed a business risk. Therefore, various immediate challenges were anticipated.

**Key Challenges**

*Recruitment and Continuous Deployment*: Recruitment and continuous deployment of RTMs was a major practical challenge. Because the concept was new and unconventional, it was difficult to find the right candidates using conventional methods of recruitment. This meant that recruitment would have to be done at the regional level, but attracting a suitable talent pool at the regional level was difficult. The absence of a defined career path at the start, coupled with upcoming opportunities in the government sector, could turn the initiative into only a stop-gap measure and could spark a high attrition rate. In addition, the unconventional compensation structure provided a relatively low salary, mainly due to the low revenue potential of the BOP markets.

*Motivation to Work in Rural and Semi-Urban Areas*: The weak infrastructure of rural and semi-urban areas, coupled with difficult working conditions, made the job profile less attractive than other mainstream positions. The RTMs also felt that it was socially demeaning to be stationed in such areas. They felt they were viewed as sales representatives rather than knowledge experts, which could have an adverse effect on their social status.

*Performance Management Design for RTMs*: Another major challenge was determining how to design key result areas (KRA) for the RTM position to drive maximum output, while avoiding any overlap with the existing KRAs of the sales team. The work done by RTMs was a concept-building activity and was therefore purely qualitative in nature, which made it difficult to quantify each RTM’s performance. Also, the primary KRA of the sales team was revenue generation, whereas RTMs were mainly promoting inhalation therapy to family practitioners, which made it difficult to measure quantifiable business outcomes.

*Synergy between the Sales Team and RTMs*: The sales team and the RTMs had different priorities, despite managing the same end objective. RTMs were focused on establishing inhalation therapy as a concept, whereas the sales team’s core focus was business generation. Defining the hierarchy of RTMs, with respect to the sales team, was also a key concern. Cipla had to find a means to establish synergy between the two teams and overcome the antipathy that was gradually setting in.

*Training*: Training the RTMs and supplying adequate materials for RTMs to use was yet another challenge. Most materials for training and marketing teams were only available in English, so the entire training content had to be created in an easy-to-understand format in the language and vernacular of the target audience. This task required additional human resources who were trained to write scientific content, with an understanding of possible communication barriers. Ideally, the background of the trainers would be similar to that of the target audience, and they would be motivated to accept the challenge. The many different languages spoken across the vast country further added scope to the challenge.

*Challenges at the Value-Chain Level*: Creating and managing sustainable demand in BOP markets was difficult. Poor infrastructure made the target markets inaccessible and the effort-to-impact ratio low.

**Conclusion**

The concept of RTMs had provided Sarkar with an approach to leverage the untapped potential of BOP markets for promoting inhalation therapy to treat asthma. The results of the trial run were promising. Sarkar was planning to extend the concept’s reach at the level of general practitioners in rural and semi-urban areas. However, the unconventional RTM method was not currently being practiced by any other pharmaceutical company in India. Therefore, Sarkar would have to weigh the pros and cons of the concept and devise a blueprint for implementation and expansion.

**Exhibit 1: Prevalence rate of Asthma for diagnosed cases, India and sub-region (2011–12)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Geographies** | **Prevalence Rate (per 1,000)** | | **Percentage of Distribution (N = 204**,**568)** | | |
| **Reported (N)** | **Diagnosed (N)** | **Reported** | **Diagnosed** | **Population** |
| **India** | 54.90 (11,229) | 9.10 (1,855) | - | - | - |
| Rural | 59.80 (8,070) | 9.50 (1,286) | 71.90 | 69.30 | 66.00 |
| Urban | 45.40 (3,159) | 8.20 (569) | 28.10 | 30.70 | 34.00 |
| Poorer States | 73.50 (6,073) | 9.90 (816) | 54.10 | 44.00 | 40.40 |
| Richer States | 42.30 (5,156) | 8.50 (1,039) | 45.90 | 56.00 | 59.60 |
| Northern States | 83.30 (4,801) | 9.80 (565) | 42.80 | 30.50 | 28.20 |
| Southern States | 40.20 (1,694) | 10.30 (432) | 15.10 | 23.30 | 20.60 |
| Eastern States | 54.00 (1,812) | 8.30 (279) | 16.10 | 15.00 | 16.40 |
| Western States | 30.30 (1,244) | 7.40 (304) | 11.10 | 16.40 | 20.10 |
| Central States | 66.40 (1,426) | 11.70 (251) | 12.70 | 13.50 | 10.50 |
| North-Eastern States | 28.80 (252) | 2.70 (24) | 2.20 | 1.30 | 4.30 |

Note: Reported cases include both diagnosed cases and cases having short breadth; Diagnosed cases include only those cases diagnosed with asthma by a doctor; Poor states include Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Uttar Pradesh, Uttarakhand, Orissa, Rajasthan, and Assam; Rich states include Jammu and Kashmir, Himachal Pradesh, Punjab, Andhra Pradesh, Karnataka, Kerala, Tamil Nadu, West Bengal, Gujarat, Goa, Maharashtra, Madhya Pradesh, Sikkim, Nagaland, Meghalaya, Tripura, Mizoram, Arunachal Pradesh, and Manipur; Northern states includes Jammu and Kashmir, Himachal Pradesh, Punjab, Uttar Pradesh, and Uttarakhand; Southern states include Andhra Pradesh, Karnataka, Kerala, Tamil Nadu, and Pondicherry; Eastern states include Bihar, West Bengal, Orissa, and Jharkhand; Western states include Rajasthan, Gujarat, Goa, Maharashtra, Daman and Due, Dadar, and Nagar Haveli; Central states include Madhya Pradesh and Chhattisgarh; North-Eastern states include Assam, Sikkim, Nagaland, Meghalaya, Tripura, Mizoram, and Arunachal Pradesh.

Source: Prakash Kumar and Usha Ram, “Patterns, Factors Associated and Morbidity Burden of Asthma in India,” PLOS ONE, accessed September 29, 2018, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0185938>.

**Exhibit 2: Risk factors for Asthma**

|  |  |  |  |
| --- | --- | --- | --- |
| **Attributes** | **Prevalence Rate per 1,000 (N)** | **Percentage Distribution of Population Reported** | |
| **Asthma** | **No Asthma** |
| Sex |  |  |  |
| Male | 52.00 (5,312) | 47.30 | 50.00 |
| Female | 57.70 (5,917) | 52.70 | 50.00 |
| **Age Group** |  |  |  |
| Less than 5 years | 130.50 (2,221) | 19.80 | 7.70 |
| 5–14 years | 51.40 (2,073) | 18.50 | 19.80 |
| 15–29 years | 28.10 (1,551) | 13.80 | 27.80 |
| 30–44 years | 37.00 (1,499) | 13.40 | 20.20 |
| 45–65 years | 68.00 (2,891) | 25.80 | 20.50 |
| Over 65 years | 110.50 (994) | 8.90 | 4.10 |
| **Marital Status** |  |  |  |
| Married | 48.50 (4,797) | 42.70 | 48.70 |
| Never married | 57.30 (5,229) | 47.20 | 45.10 |
| Others | 85.80 (1,132) | 10.10 | 6.20 |
| **Completed Year :schooling** |  |  |  |
| 11 years and above | 27.30 (849) | 7.90 | 16.20 |
| 5–10 years | 35.60 (2,235) | 20.90 | 32.30 |
| 1–5 years | 52.50 (2,281) | 21.30 | 22.00 |
| 0 years | 87.90 (5,325) | 49.80 | 29.50 |
| **Smoke** |  |  |  |
| No | 53.80 (10,166) | 90.50 | 92.50 |
| Yes | 68.00 (1,063) | 9.50 | 7.50 |
| **Chew Tobacco** |  |  |  |
| No | 53.90 (9,851) | 87.70 | 89.40 |
| Yes | 63.00 (1,378) | 12.30 | 10.60 |
| **Drink Alcohol** |  |  |  |
| No | 55.10 (10,617) | 94.50 | 94.10 |
| Yes | 51.00 (612) | 5.50 | 5.90 |
| **Vegetarian** |  |  |  |
| Yes | 55.10 (3,089) | 27.50 | 27.50 |
| No | 55.00 (8,133) | 72.50 | 72.50 |
| **Nutritional Status** |  |  |  |
| Normal weight | 52.00 (2,934) | 33.80 | 41.80 |
| Underweight | 77.20 (4,598) | 53.00 | 43.00 |
| Overweight | 51.40 (771) | 8.90 | 11.10 |
| Obese | 67.00 (373) | 4.30 | 4.10 |
| **Wealth Quintile** |  |  |  |
| Middle | 52.50 (2,303) | 20.80 | 20.00 |
| Poorest | 84.90 (2,441) | 20.60 | 20.00 |
| Poor | 65.30 (2,470) | 21.10 | 19.90 |
| Rich | 46.00 (2,080) | 19.90 | 20.00 |
| Richest | 39.50 (1,928) | 21.80 | 13.60 |
| **Type of Fuel Used** |  |  |  |
| Clean only | 38.80 (1,726) | 15.40 | 22.10 |
| Others | 59.40 (9,503) | 84.60 | 77.90 |

**EXHIBIT 2 (CONTINUED)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Attributions** | **Prevalence Rate per 1,000 (N))** | **Percentage Distribution of Population Reported** | | |
| **Asthma** | | **No Asthma** |
| **Hours Burning Stove** |  |  |  | |
| Less than 3 hours | 53.20 (4,002) | 35.90 | 37.20 | |
| 3 hours and more | 56.10 (7,150) | 64.10 | 62.80 | |
| **Religion** |  |  |  | |
| Hindu | 53.80 (8,815) | 22.00 | 18.30 | |
| Muslim | 63.40 (1,761) | 20.50 | 21.50 | |
| Others | 50.60 (653) | 5.80 | 6.30 | |
| **Caste** |  |  |  | |
| General | 53.30 (3,179) | 28.30 | 29.30 | |
| Other backward class | 56.10 (4,706) | 42.00 | 41.10 | |
| Scheduled castes | 60.20 (2,599) | 23.20 | 21.00 | |
| Scheduled tribe | 42.30 (735) | 6.60 | 8.60 | |
| **Place of Residence** |  |  |  | |
| Rural | 59.80 (8,070) | 71.90 | 65.70 | |
| Urban | 45.40 (3,159) | 28.10 | 34.30 | |
| **Total** | 54.90 (11,229) | - | - | |

Source: Prakash Kumar and Usha Ram, “Patterns, Factors Associated and Morbidity Burden of Asthma in India,” PLOS ONE, accessed September 29, 2018, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0185938>.

**EXHIBIT 3: Cipla Limited BALANCE SHEET**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cipla Limited Standalone Balance Sheet (in ₹ Billion)** | | | | | |
|  | March 18 | March 17 | March 16 | March 15 | March 14 |
|  | 12 Months | 12 Months | 12 Months | 12 Months | 12 Months |
| Sources of Funds | | | | | |
| https://img-d05.moneycontrol.co.in/images/blank.gifhttps://img-d05.moneycontrol.co.in/images/blank.gifTotal Share Capital | 1.61 | 1.61 | 1.61 | 1.61 | 1.61 |
| Equity Share Capital | 1.61 | 1.61 | 1.61 | 1.61 | 1.61 |
| Reserves | 139.53 | 126.40 | 118.25 | 109.21 | 99.22 |
| Net Worth | 141.14 | 128.01 | 119.86 | 110.81 | 100.83 |
| Secured Loans | 1.74 | 3.24 | 0.00 | 0.01 | 0.00 |
| Unsecured Loans | 0.00 | 0.00 | 11.32 | 13.80 | 8.77 |
| Total Debt | 1.74 | 3.24 | 11.32 | 13.81 | 8.77 |
| Total Liabilities | 142.88 | 131.25 | 131.18 | 124.62 | 109.60 |
| Application of Funds | | | | | |
| https://img-d05.moneycontrol.co.in/images/blank.gifhttps://img-d05.moneycontrol.co.in/images/blank.gifGross Block | 56.29 | 50.89 | 42.40 | 59.36 | 53.94 |
| Less: Revaluation Reserves | 0.00 | 0.00 | 0.00 | 0.09 | 0.09 |
| Less: Accumulated Depreciation | 13.09 | 8.54 | 4.14 | 23.42 | 18.70 |
| Net Block | 43.20 | 42.35 | 38.26 | 35.85 | 35.15 |
| Capital Work in Progress | 4.63 | 5.56 | 5.51 | 3.61 | 3.77 |
| Investments | 46.37 | 42.86 | 42.56 | 44.21 | 35.87 |
| Inventories | 30.38 | 26.54 | 29.18 | 32.89 | 25.11 |
| Sundry Debtors | 23.36 | 19.39 | 18.96 | 20.59 | 17.28 |
| Cash and Bank Balance | 2.28 | 0.58 | 0.53 | 0.83 | 0.46 |
| Total Current Assets | 56.02 | 46.51 | 48.68 | 54.31 | 42.85 |
| Loans and Advances | 20.73 | 18.79 | 17.38 | 13.86 | 11.51 |
| Total Current Assets, Loans, and Advances | 76.75 | 65.30 | 66.06 | 68.16 | 54.36 |
| Current Liabilities | 22.84 | 20.94 | 17.40 | 22.20 | 16.37 |
| Provisions | 5.23 | 3.88 | 3.81 | 5.01 | 3.18 |
| Total Current Liabilities, and Provisions | 28.07 | 24.82 | 21.21 | 27.21 | 19.55 |
| Net Current Assets | 48.68 | 40.48 | 44.85 | 40.95 | 34.81 |
| Total Assets | 142.88 | 131.25 | 131.18 | 124.62 | 109.60 |
| https://img-d05.moneycontrol.co.in/images/blank.gifContingent Liabilities | 45.11 | 47.61 | 47.35 | 17.60 | 12.01 |
| Book Value | 1.75 | 1.59 | 1.49 | 1.38 | 1.26 |

Note: ₹ = INR = Indian rupee; ₹1 = US$0.02 on March 15, 2014.

Source: Company documents.

**EXHIBIT 4: Leading companies in the Respiratory domain (All of India)**

|  |  |
| --- | --- |
| **India RESPIRATORY SYSTEM** | |
|  |  |
|  | MAT July 2014 |
| **Corporation** | **Values (in ₹ Billion)** |
| Cipla | 13.08 |
| Lupin Limited | 2.84 |
| Zydus Cadila | 3.32 |
| Glenmark Pharma | 2.31 |
| Abbott | 3.89 |
| Sun | 2.45 |
| Mankind | 1.85 |
| Dr. Reddy’s Labs | 2.04 |
| GlaxoSmithKline | 3.02 |
| Centaur | 1.80 |
| **Grand Total** | 66.62 |

Note: MAT = moving annual total; ₹ = INR = Indian rupee; ₹1 = US$0.02 on March 15, 2014.

Source: Adapted by the case author using data from IMS MAT (company subscription).

**EXHIBIT 5: Leading companies in Respiratory segment – Delhi**

|  |  |
| --- | --- |
| **India RESPIRATORY SYSTEM** | |
| State = DELHI | |
|  |  |
|  | MAT August 2014 |
| **Corporation** | **Values (in ₹)** |
| Cipla | 865,907,296 |
| Lupin Limited | 147,765,116 |
| Sanofi | 152,723,059 |
| Wockhardt Limited | 136,713,166 |
| Sun | 186,310,273 |
| GlaxoSmithKline | 161,895,029 |
| Glenmark Pharma | 74,473,241 |
| Dr. Reddy’s Labs | 67,255,650 |
| Emcure | 46,602,707 |
| Mankind | 43,990,029 |
| **Grand Total** | 3,229,045,188 |

Note: MAT = moving annual total; ₹ = INR = Indian rupee; ₹1 = US$0.02 on March 15, 2014.

Source: Adapted by the case author using data from IMS MAT (company subscription).

**EXHIBIT 6: Overview of Inhalation Therapy Market in India**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  | MAT August 2014 |
| **Molecule** | **Product** | **Corporation** | **Values (in ₹)** |
| R03cr – Formoterol + Budesonide | Foracort | Cipla | 1,654,455,419 |
| R03cr – Formoterol + Budesonide | Budamate | Lupin Limited | 590,187,433 |
| R03cr – Formoterol + Budesonide | Formonide | Zydus Cadila | 443,291,135 |
| R03cp – Salmeterol + Fluticasone | Seroflo | Cipla | 1,443,370,056 |
| R03cp – Salmeterol + Fluticasone | Esiflo | Lupin Limited | 344,497,066 |
| R03cp – Salmeterol + Fluticasone | Seretide | GlaxoSmithKline | 180,752,641 |
| R03cs – Ipratropium + Levosalbutamol | Duolin | Cipla | 1,028,403,666 |
| R03cs – Ipratropium + Levosalbutamol | Combimist-L | Zydus Cadila | 172,049,062 |
| R03cs – Ipratropium + Levosalbutamol | Salbair-I | Lupin Limited | 128,887,395 |
| R03cs – Ipratropium + Levosalbutamol | Duoset | Cipla | 22,793,153 |
| R03cs – Ipratropium + Levosalbutamol | Combolin | Cipla | 1,217,480 |
| R03c2 – Budesonide | Budecort | Cipla | 1,251,850,225 |
| R03c2 – Budesonide | Budate | Lupin Limited | 103,188,148 |
| R03c2 – Budesonide | Bunase | Macleods Pharma | 71,647,362 |
| R03c2 – Budesonide | Budenase Aq | Cipla | 22,109,499 |
| R03c5 – Salbutamol | Asthalin | Cipla | 1,122,317,662 |
| R03c5 – Salbutamol | Salbair | Lupin Limited | 19,244,410 |
| R03c5 – Salbutamol | Ventorlin | GlaxoSmithKline | 69,249,127 |
| R03ck – Salbutamol + Beclomethasone | Aerocort | Cipla | 1,081,381,063 |
| R03ck – Salbutamol + Beclomethasone | Salbair-B | Lupin Limited | 51,625,539 |
| R03ck – Salbutamol + Beclomethasone | Derisone | Zydus Cadila | 19,379,926 |
| R03cf – Fluticasone + Formoterol | Maxiflo | Cipla | 270,304,739 |
| R03cf – Fluticasone + Formoterol | Formoflo | Lupin Limited | 142,504,819 |
| R03cf – Fluticasone + Formoterol | Combihale-Ff | Dr. Reddy’s Labs | 125,623,470 |
| R03g1 – Inhaler Device | Rotahaler Transpar | Cipla | 119,868,302 |
| R03g1 – Inhaler Device | Zerostat-Vt Spacer | Cipla | 69,555,275 |
| R03g1 – Inhaler Device | Revolizer | Cipla | 77,687,140 |
| R03g1 – Inhaler Device | Lupihaler | Lupin Limited | 61,524,720 |
| R03g1 – Inhaler Device | Huf Puf Kit | Cipla | 28,173,824 |
| R03g1 – Inhaler Device | Baby Mask | Cipla | 29,622,080 |
| **Grand Total** |  |  | 13,751,580,857 |

Note: MAT = moving annual total; ₹ = INR = Indian rupee; ₹1 = US$0.02 on March 15, 2014.

Source: Adapted by the case author using data from IMS MAT (company subscription).

**EXHIBIT 7: Overview of Inhalation Therapy Market in Delhi**

|  |  |  |  |
| --- | --- | --- | --- |
| **Molecule** | **Product** | **Corporation** | MAT August 2014 |
| **Values ₹** |
| R03cr – Formoterol + Budesonide | Foracort | Cipla | 69,259,949 |
| R03cr – Formoterol + Budesonide | Budamate | Lupin Limited | 21,718,499 |
| R03cr – Formoterol + Budesonide | Symbicort | AstraZeneca | 3,841,260 |
| R03cp – Salmeterol + Fluticasone | Seroflo | Cipla | 76,517,859 |
| R03cp – Salmeterol + Fluticasone | Seretide | GlaxoSmithKline | 15,152,561 |
| R03cp – Salmeterol + Fluticasone | Esiflo | Lupin Limited | 16,863,745 |
| R03cs – Ipratropium + Levosalbutamol | Duolin | Cipla | 97,483,919 |
| R03cs – Ipratropium + Levosalbutamol | Salbair-I | Lupin Limited | 8,200,459 |
| R03cs – Ipratropium + Levosalbutamol | Iprazest | Macleods Pharma | 1,121,461 |
| R03c2 – Budesonide | Budecort | Cipla | 110,314,541 |
| R03c2 – Budesonide | Budate | Lupin Limited | 7,068,173 |
| R03c2 – Budesonide | Budez | Sun | 1,908,494 |
| R03c2 – Budesonide | Budenase Aq | Cipla | 1,842,711 |
| R03c5 – Salbutamol | Asthalin | Cipla | 83,493,759 |
| R03c5 – Salbutamol | Ventorlin | GlaxoSmithKline | 1,864,774 |
| R03c5 – Salbutamol | Salbair | Lupin Limited | 617,827 |
| R03cz – Levosalbutamol | Levolin | Cipla | 29,476,833 |
| R03cz – Levosalbutamol | Salbair Neb | Lupin Limited | 1,046,292 |
| R03cz – Levosalbutamol | Salbair | Lupin Limited | 545,599 |
| R03cd – Tiotropium | Tiova | Cipla | 19,398,729 |
| R03cd – Tiotropium | Tiate | Lupin Limited | 8,304,095 |
| R03cd – Tiotropium | Tiomist | Zydus Cadila | 486,039 |
| R03cf – Fluticasone + Formoterol | Formoflo | Lupin Limited | 7,528,566 |
| R03cf – Fluticasone + Formoterol | Maxiflo | Cipla | 5,332,658 |
| R03cf – Fluticasone + Formoterol | Combihale-Ff | Dr Reddys Labs | 1,783,636 |
| R03g1 – Inhaler Device | Rotahaler Transpar | Cipla | 3,537,136 |
| R03g1 – Inhaler Device | Zerostat-Vt Spacer | Cipla | 3,794,321 |
| R03g1 – Inhaler Device | Lupihaler | Lupin Limited | 2,095,909 |
| R03g1 – Inhaler Device | Revolizer | Cipla | 1,741,630 |
| R03g1 – Inhaler Device | Huf Puf Kit | Cipla | 752,640 |
| R03g1 – Inhaler Device | Nebzmart | Glenmark Pharma | – |
| R03g1 – Inhaler Device | Zerostat | Cipla | 997,923 |
| R03g1 – Inhaler Device | Transpacer-Vm | Lupin Limited | – |
| R03g1 – Inhaler Device | Mini Zerostat Spac | Cipla | – |
| R03g1 – Inhaler Device | Baby Mask | Cipla | 398,505 |
| **Grand Total** |  |  | 777,016,068 |

Note: MAT = moving annual total; ₹ = INR = Indian rupee; US$1 = ₹61.27 on March 15, 2014.

Source: Adapted by the case author using data from IMS MAT (company subscription).

**EXHIBIT 8: Awareness initiatives by Cipla Limited**

|  |  |  |
| --- | --- | --- |
| **Name of Program** | **Target Audience** | **Brief** |
| Good Nebulization Practice (GNP) | Doctors and paramedics | Aims to create awareness about hygiene and maintenance of nebulizer |
| INCEPT Package | General practitioners | With the concept of “Try, Test, and Treat,” aims to assist general practitioners in usage of nebulization therapy |
| Progress to Prosper (P2P) | General practitioners | Comprehensive package to update general practitioners on asthma treatment and management |
| Assemble to Adapt (A2A) | General practitioners | Updating general practitioners on acute asthma management and nebulization |
| Refresher Course on Asthma Management (ROAM) | General practitioners | Workshop to update general practitioners on airway disease management |
| Breathefree | Doctors, chemists, and patients | Mass awareness about asthma, its management, and use of inhalers |

Source: Created by the case author using company documents.

**EXHIBIT 9: Sales Structure at Delhi office of Cipla Limited**

Head of Therapy

*Debashis Sarkar*

North Zone

West Zone

East Zone

South Zone

Sales Manager

*Gaurav Gupta*

Business Manager

(10)

Corporate

Sales Manager

*Mukesh Thakur*

*Vishal Sharma*

Sales Manager

*Vijay Singh*

*Yashu Arora*

Sales Manager

*Neepun Mago*

*Ajay Sharma*

Sales Manager

*Amit Johar*

Business Manager

(13)

Business Manager

(09)

Business Manager

(14)

Business Manager

(06)

Territory Manager

(69)

Territory Manager

(90)

Territory Manager

(63)

Territory Manager

(93)

)

Territory Manager

(35)

Regional Manager

(03)

Regional Manager

(04)

Regional Manager

(03)

Regional Manager

(04)

Regional Manager

(02)

Source: Company documents.

**EXHIBIT 10: Conversion outcome Resulting from RTM Trial Run in Delhi**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pre RTM Snapshot** | | | | **Post RTM 0–3 Months** | | | **Post RTM 4–6 Months** | | |
| Total doctors targeted (GP) | Total active prescribers (GP) | Average monthly sales  (₹ Million) | Number of Dot doctors (GP) | Number of Dot doctors targeted (GP) | Number of doctors converted (GP) | Average monthly sales (in ₹ Million) | Number of Dot doctors targeted (GP) | Number of doctors converted (GP) | Average monthly sales (in ₹ Million) |
| 1,900 | 170 | 0.22 | 1,730 | 450 | 12 | 0.27 | 438 | 31 | 0.33 |

Note: RTM = respiratory therapy manager; GP = general practitioner; Dot = Doctors with no prescription to Cipla; ₹ = INR = Indian rupee; ₹1 = US$0.02 on March 15, 2014.

Source: Company documents.

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