# NOTESKARTS

Pharmacy Education Platform

**B.Pharm 8th Semester**

**BP803ET**

# PHARMA MARKETING MANAGEMENT

(Theory) — 45 Hours

## UNIT — IV MARKETING CHANNELS & PSR

*As per PCI / AKTU Syllabus*

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# UNIT — IV PHARMACEUTICAL MARKETING CHANNELS & PSR (08 Hours)

## UNIT IV SYLLABUS — AT A GLANCE (08 Hours)

**PART A — Pharmaceutical Marketing Channels**

1. Designing the Channel
2. Channel Members & Their Roles
3. Selecting the Appropriate Channel
4. Conflict in Channels
5. Physical Distribution Management
6. Tasks in Physical Distribution

**PART B — Professional Sales Representative (PSR)**

7. Duties of PSR
8. Purpose of Detailing
9. Selection & Training of PSR
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# PART A — PHARMACEUTICAL MARKETING CHANNELS

## PHARMACEUTICAL MARKETING CHANNELS — Introduction & Definitions

📌 **Definition:** A Marketing Channel (also called Distribution Channel or Trade Channel) is a set of interdependent organisations involved in the process of making a product available to consumers or industrial users. It describes the path a pharmaceutical product takes from the manufacturer to the ultimate end user (patient).

### Importance of Distribution Channels in Pharma

- Drugs manufactured at centrally located factories must reach patients across millions of locations — villages, towns, cities.
- Channels bridge the physical, geographical, time, quantity, and assortment gaps between manufacturer and patient.
- An efficient channel ensures product availability, freshness (expiry management), correct storage (cold chain for biologics/vaccines), and timely delivery.
- Channel efficiency directly impacts market share — a drug unavailable at a pharmacy loses a sale permanently.
- Estimated 99% of Indian pharma products reach patients through intermediary channels.

### Functions Performed by Channel Members

| Function | Description | Pharma Example |
|---|---|---|
| Information | Gathering and sharing market intelligence | Stockist informs company about competitor scheme in territory |

| Function | Description | Pharma Example |
|---|---|---|
| Promotion | Spreading word about products to attract buyers | Retailer recommending a brand; POS display |
| Contact | Finding and communicating with prospective buyers | Stockist reaching out to new retail chemists in area |
| Matching | Shaping and fitting the offer to buyer's need | Pharmacist dispensing exact prescribed quantity |
| Negotiation | Agreeing on price and other terms | Stockist negotiating purchase price, credit period |
| Physical Distribution | Transporting and storing goods | C&F agent warehousing and delivering to stockists |
| Financing | Credit facility to channel partners | Company offering 30-day credit to stockist |
| Risk Taking | Bearing uncertainty of carrying out channel work | Stockist absorbing expiry losses on slow-moving drugs |

## DESIGNING THE PHARMACEUTICAL DISTRIBUTION CHANNEL

Designing a pharmaceutical distribution channel involves determining the optimal structure, length, and intensity of distribution to ensure maximum market coverage while managing costs and maintaining brand integrity.

### Channel Design Decisions — Step-by-Step

- **Step 1 — Analyse Customer Needs:** Identify what target customers (pharmacists, hospitals, patients) need — order frequency, lot size, delivery speed, product variety, service requirements.
- **Step 2 — Establish Channel Objectives:** Define objectives based on product type, target segment, geographic scope — e.g., 'achieve 80% retail coverage in Tier 1 & 2 cities within 6 months of launch.'
- **Step 3 — Identify Channel Alternatives:** Enumerate possible channel structures — direct selling, one-level, two-level, three-level channels (detailed below).
- **Step 4 — Evaluate Channel Alternatives:** Evaluate options on three criteria: Economic (cost vs. revenue), Control (ability to manage the channel), Adaptive (flexibility to change).
- **Step 5 — Select the Optimal Channel:** Choose the best channel based on evaluation — most pharma companies use a two-level or three-level channel.

## Pharmaceutical Channel Levels (Structures)

The 'level' refers to the number of intermediary layers between manufacturer and patient:

| Channel Level | Structure | Used For |
|---|---|---|
| Zero-level (Direct) | Manufacturer → Patient/Hospital | Institutional sales, hospital tenders, specialty/oncology drugs, vaccines to government |
| One-level | Manufacturer → Retailer → Patient | Limited geographic markets; high-value specialty drugs with select stockists |
| Two-level (Most Common) | Manufacturer → C&F Agent → Stockist → Retailer → Patient | Standard pharmaceutical distribution across India — most branded generics |
| Three-level | Manufacturer → C&F → Super Stockist → Sub-Stockist → Retailer → Patient | Deep rural penetration; remote geographies with poor logistics infrastructure |

## Standard Indian Pharmaceutical Distribution Structure

The most widely used pharmaceutical distribution model in India follows this flow:

| |
|---|
| **MANUFACTURER (Factory / Manufacturing Plant)** |
| ↓ Primary Sale (Invoice) |
| **C&F AGENT (Carrying & Forwarding Agent)** |
| ↓ Secondary Sale |
| **SUPER STOCKIST / STOCKIST (Wholesale Distributor)** |
| ↓ Tertiary Sale |
| **SUB-STOCKIST / SEMI-WHOLESALE CHEMIST** |
| ↓ |
| **RETAIL PHARMACY / CHEMIST (9 Lakh+ outlets across India)** |
| ↓ |
| **PATIENT (End Consumer)** |

**Point:** India has a unique 'stockist-based' distribution model. Unlike Western countries where wholesalers are few and large, India has over 60,000 stockists (distributors) spread across cities and towns, making it one of the world's most complex pharma distribution networks.

# CHANNEL MEMBERS — Roles, Functions & Responsibilities

## Clearing & Forwarding (C&F) Agent

📌 **Definition:** A C&F Agent is a third-party logistics partner who acts as the company's depot in each state. The company invoices the C&F, who then receives, stores, and dispatches drugs to stockists in that state. The C&F does not take title (ownership) to the goods.

| Aspect | Details |
|---|---|
| Number per Company | One per state (28 states = 28 C&F agents typically) |
| Ownership of Goods | No — goods belong to company; C&F earns commission (1–2% of sales) |
| Functions | Receive goods from factory → Store in state depot → Invoice & dispatch to stockists → Maintain state-wise inventory records |
| Regulatory Requirement | Must hold valid drug licence (storage and sale) for the state |
| Advantages | Company maintains stock control; reduces direct logistics burden; state-level tax efficiency |
| Limitations | Fixed commission cost; C&F performance directly impacts stockist servicing quality |

## Super Stockist

A Super Stockist is a large-scale wholesale distributor who purchases drugs from the C&F agent and supplies to multiple sub-stockists or directly to large retailers in a defined region. Super stockists are particularly important for deep rural market penetration.

- Covers larger territory — a district or multiple taluka-level areas.
- Provides credit facility to sub-stockists and retailers (typically 7–15 days credit).
- Maintains larger inventory and can handle bigger order volumes.
- Earns 3–5% margin on MRP.
- Role in reaching Tier 3 and Tier 4 towns.

## Stockist (Wholesale Distributor / Distributor)

📌 **Definition:** The Stockist (also called Distributor or Wholesale Chemist) is the primary channel intermediary in the Indian pharmaceutical system. A company's stockist purchases drugs from the C&F agent and distributes to retail pharmacies in a defined geographical territory (usually a city or district).

| Aspect | Details |
|---|---|
| Appointment | Formally appointed by pharma company with a signed stockist agreement |
| Territory | Exclusive territory — usually one city or district per stockist |
| Margin Earned | 7–10% on MRP (varies by company and product) |
| Drug Licence | Must hold valid retail + wholesale drug licence (Form 20 & 21) |
| Responsibilities | Stock all company's products → Service retailer orders → Maintain cold chain → Collect payments → Report expiry |
| Selection Criteria | Financial soundness, infrastructure (storage space, refrigeration), market reputation, existing retail contacts |
| Performance Metrics | Secondary sales (to retailers), inventory days, claim settlement timeliness, new chemist addition |

**Remember:** The stockist is the PIVOT of the pharma distribution system. An under-performing stockist = lost sales even if MR detailing is excellent. Companies dedicate specific field roles (Area Sales Managers) to manage stockist relationships.

## Sub-Stockist / Semi-Wholesale Chemist

- Intermediate layer between stockist and retailer — used in high-density retail markets.
- Purchases from stockist at sub-stockist margin (usually 5%) and sells to small retailers.
- Facilitates credit extension to smaller retail chemists who may not have direct stockist accounts.
- Common in high-retail-density areas like Mumbai, Delhi, Chennai market hubs.

## Retail Pharmacy (Retail Chemist)

The retail pharmacist is the final member of the distribution chain and the most critical point of contact with the patient.

| Aspect | Details |
|---|---|
| Numbers in India | ~9 lakh (900,000+) registered retail pharmacy outlets |
| Types | Independent chemists, pharmacy chains (Apollo, MedPlus), hospital pharmacies, Jan Aushadhi stores, e-pharmacies |
| Margin Earned | 18–20% on MRP for branded drugs; higher for generics |
| Drug Licence | Form 20 (retail) and Form 20-B (wholesale) under D&C Act; must have registered pharmacist |

| Aspect | Details |
|---|---|
| Role in Promotion | Dispensing prescribed drugs; OTC recommendation; counselling; product advocacy |
| Influences | Stockist relationship, company MR visits, margin incentives, pharmacist training programs |

### Hospital / Institutional Channel

- Hospitals, nursing homes, government health facilities — purchase directly from company or via authorised hospital distributors.
- Government procurement: State health departments, TNMSC, KMSCL, HITES — bulk tenders with negotiated prices.
- Hospital formulary: Products must be listed on hospital's approved drug formulary to be purchased.
- Account Management (KAM): Dedicated company executives manage large hospital accounts.
- High-volume, low-margin segment — important for market presence and physician exposure.

## SELECTING THE APPROPRIATE CHANNEL

Channel selection is one of the most critical strategic decisions in pharmaceutical marketing. The ideal channel balances market coverage, cost-efficiency, and brand control.

### Factors Governing Channel Selection

- **A. Product Characteristics:** Perishability, value, complexity, and regulatory requirements of the drug determine channel needs.

| Product Type | Recommended Channel |
|---|---|
| OTC / FMCG health products (e.g., vitamins, antacids) | Intensive distribution — maximum retail outlets, supermarkets, e-pharmacies |
| Branded Rx drugs (antibiotics, antihypertensives) | Selective distribution — quality stockists in each territory; MR-driven |
| Specialty drugs (oncology, biologics) | Exclusive/direct distribution — limited specialty pharmacies, direct hospital supply |
| Cold-chain products (vaccines, insulin) | Specialised cold-chain channel — refrigerated transport and storage mandatory |
| Government / Tender market (essential medicines) | Direct tender — company → government depot → PHC/hospital |

- **B. Market Characteristics:** Size, geographic spread, and density of the target market.
  - Large, dispersed market → multi-level channel with super stockists and sub-stockists.
  - Concentrated urban market → shorter channel; direct stockist-to-retail model sufficient.
  - Rural/tribal belt → three-level channel essential for adequate penetration.

- **C. Company Characteristics:** Financial strength, brand equity, size of field force.
  - Well-established large pharma companies: Can afford selective distribution with appointed stockists.
  - New/small companies: May rely on super stockists or third-party distribution for cost efficiency.

- **D. Intermediary Characteristics:** Availability, capability, and willingness of channel partners.
  - Financial soundness of stockist — ability to invest in stock.
  - Storage facilities — especially cold chain for biologics and vaccines.
  - Existing distribution reach — number of retail chemists serviced.

- **E. Competitive Channels:** If competitors use a particular channel effectively, a company must match or differentiate.

### Distribution Intensity Strategies

| Strategy | Definition | Pharma Application | Examples |
|---|---|---|---|
| Intensive Distribution | Sell through as many outlets as possible | OTC products requiring maximum consumer reach | Crocin, Eno, Digene — available at every chemist, supermarket, convenience store |
| Selective Distribution | Use a limited number of carefully selected outlets | Branded Rx drugs through appointed quality stockists | Branded antihypertensives through approved stockist network |
| Exclusive Distribution | Only one or very few outlets in each territory | High-value specialty drugs, biosimilars, oncology drugs | Roche's cancer drugs through select oncology specialty pharmacies |

## CONFLICT IN PHARMACEUTICAL DISTRIBUTION CHANNELS

📌 **Definition:** Channel conflict occurs when one channel member's actions prevent another channel member from achieving its goals. It is a common occurrence in the pharmaceutical distribution system due to competing interests among manufacturer, C&F, stockist, sub-stockist, and retailer.

## Types of Channel Conflict

- **A. Vertical Channel Conflict:** Conflict between different levels of the same channel — e.g., manufacturer vs. stockist, or stockist vs. retailer.
  - Example 1: Company changes stockist margin from 10% to 8% — stockist protests by reducing stocking.
  - Example 2: Company sells directly to hospital at discounted price, undercutting the stockist's business.
  - Example 3: Retailer complains that the stockist delivers only top-selling SKUs and ignores slow movers.
- **B. Horizontal Channel Conflict:** Conflict between members at the same level in the channel — e.g., two stockists in the same territory, or two retailers competing for the same customer.
  - Example: Company appoints two stockists in the same city; both engage in price undercutting to attract retailers, eroding profitability.
  - Example: One retailer purchases from the stockist while a neighbouring retailer bypasses the stockist and buys from the super stockist at a lower price.
- **C. Multichannel Conflict:** Conflict arising when a company uses multiple channels that compete with each other for the same customers.
  - Example: A pharma company sells OTC products through retail chemists AND directly through its own e-pharmacy website at discounted prices. The retail chemists feel undercut and reduce promotion of the brand.
  - Example: Jan Aushadhi stores selling generic alternatives at low prices conflict with branded retail pharmacies.

## Common Causes of Channel Conflict in Pharma

| Cause | Description |
|---|---|
| Goal Incompatibility | Manufacturer wants maximum volume; stockist wants maximum margin — conflicting objectives |
| Unclear Territory Definition | Overlapping stockist territories causing inter-stockist competition |
| Price Discrepancies | Company's direct-sale prices to hospitals lower than stockist's selling price |
| Differential Treatment | Company gives better margins/schemes to large stockists, alienating smaller ones |

| Cause | Description |
|---|---|
| E-commerce Disruption | Online pharmacies undercutting retail chemist prices, causing retail vs. online conflict |
| Stock Withholding | Stockist hoarding during shortage situations, artificially inflating market price |
| Return Policy Disputes | Disagreement on expiry/damage return policies and credit note settlements |
| Multiple Stockist Appointment | Appointing more than one stockist in a territory leads to inter-stockist conflict |

### Resolving Channel Conflict — Strategies

- **1. Clear Territory Definition:** Clearly demarcate exclusive territories for each stockist in the agreement; avoid overlapping coverage areas.
- **2. Uniform Pricing Policy:** Maintain consistent pricing across channels — avoid direct-to-hospital prices that undercut stockist margins.
- **3. Joint Goal Setting:** Involve channel partners in annual target setting; align company and channel partner goals.
- **4. Co-option:** Including stockist representatives on advisory committees or regional councils — giving them a voice in policy decisions.
- **5. Mediation / Arbitration:** Using neutral third-party mediators to resolve disputes between conflicting channel partners.
- **6. Channel Diplomacy:** Area Sales Managers acting as relationship managers between company and stockists — addressing grievances promptly.
- **7. Trade Associations:** Industry bodies like AIOCD (All India Organisation of Chemists and Druggists) mediate conflicts between manufacturers and trade.

**Point:** AIOCD (All India Organisation of Chemists and Druggists) is the largest trade association of chemists in India. Pharmaceutical companies must maintain good relations with AIOCD as it can organise trade boycotts that disrupt distribution across the country.

## PHYSICAL DISTRIBUTION MANAGEMENT (PDM)

**Definition:** Physical Distribution Management (PDM) is the planning, implementing, and controlling the physical flow of materials, finished goods, and related information from the point of manufacture to the point of consumption in a manner that meets customer requirements and generates profit. In pharma, it is also called Logistics Management or Supply Chain Management.

## Strategic Importance of Physical Distribution in Pharma

- Drug availability = Patient safety: Non-availability of a critical drug (insulin, cardiac medication) can be life-threatening.
- Competitive advantage: Superior distribution gives a company market share edge over competitors.
- Cost management: Distribution costs account for 15–25% of a pharmaceutical product's selling price.
- Expiry management: Efficient distribution minimises the risk of drugs reaching near-expiry dates at retail level.
- Cold chain integrity: Vaccines, biologics, and insulin require temperature-controlled supply chains — failure can render products ineffective.
- Customer service level: Order fill rate, delivery time, and damage-free delivery directly impact stockist and retailer satisfaction.
- Regulatory compliance: GDP (Good Distribution Practices) as per Schedule M of D&C Act mandates proper storage and transport.

## The Total Cost Concept in PDM

- Physical distribution decisions involve trade-offs between different cost components. The goal is to minimise the Total Distribution Cost (TDC) while maintaining the desired service level:
- Total Distribution Cost = Transportation Cost + Warehousing Cost + Inventory Holding Cost + Order Processing Cost + Packaging Cost + Information/IT Cost

> **Point:** Minimising one cost component often increases another — e.g., reducing inventory holding cost by ordering less frequently increases transportation cost per order. PDM seeks the optimal trade-off across all components.

## Tasks / Components of Physical Distribution Management

- **Task 1 — Order Processing:** The process by which orders from stockists/retailers are received, verified, picked, and dispatched. Includes: order receipt (manual/ERP/e-portal), credit check, inventory availability check, picking list generation, dispatch.
  - Technology: SAP, Oracle Pharma ERP systems used by large companies for automated order processing.
  - KPI: Order processing time (target: <24 hours for primary orders; <12 hours for urgent orders).
- **Task 2 — Inventory Management:** Maintaining optimal stock levels at factory, C&F depots, and stockist level to prevent both stockout and overstock situations.

| Inventory Concept | Definition | Pharma Application |
|---|---|---|
| Safety Stock | Minimum buffer stock to cover demand uncertainty | Extra 2–4 weeks stock at C&F during seasonal demand peaks |
| Reorder Point (ROP) | Stock level at which a new order is triggered | C&F reorders from factory when stock falls to 4 weeks supply |
| Economic Order Quantity (EOQ) | Optimal order quantity that minimises total inventory cost | Balancing ordering cost vs. holding cost for each SKU |
| FIFO (First In, First Out) | Oldest stock dispatched first to prevent expiry | Mandatory in pharma — earlier manufactured batches dispatched first |
| Dead Stock / Slow Movers | Products with no or minimal movement | Products moving <10 units/month; require write-off or return policy |

- **Task 3 — Warehousing:** Storage of pharmaceutical products at various points in the supply chain — factory warehouse, C&F depot, stockist godown. All must comply with GDP (Good Distribution Practices).
  - Temperature control: Ambient (15–25°C), refrigerated (2–8°C for vaccines/biologics), frozen (-20°C for certain biologics).
  - Segregation: Separate areas for quarantine, approved, rejected, expired, and returned goods.
  - Pest control, humidity control, adequate ventilation — mandatory GDP requirements.
  - Security: Controlled access, CCTV, alarm systems — especially for Schedule X drugs.
  - Drug Licence: Warehouses must hold valid storage drug licence under D&C Act.
- **Task 4 — Transportation:** Physical movement of drugs from factory → C&F → stockist → retailer. Critical decisions: mode of transport, carrier selection, routing, scheduling.

| Mode | Used For | Pharma Example |
|---|---|---|
| Road (Trucks/Tempo) | Primary mode in India — factory to C&F; C&F to stockist | Insulated trucks for cold-chain products; bulk road transport for OTC |
| Rail | Long-distance bulk shipments — cost-effective but slower | Large companies dispatching bulk API or finished goods across states |
| Air Freight | High-value, urgent, or temperature-sensitive drugs | Emergency supply of critical biologics; export of bulk APIs |
| Courier/Last-Mile Delivery | Retail to patient delivery for e-pharmacies | 1mg, PharmEasy, Swiggy Instamart same-day pharmacy delivery |

- **Task 5 — Cold Chain Management:** A specialised, temperature-controlled distribution system for biologics, vaccines, insulin, and blood products that must be maintained between 2–8°C (refrigerated) throughout the supply chain.

  - Cold chain components: Refrigerated trucks (reefer vehicles), cold rooms at C&F depots, refrigerators at stockist, cold storage display at pharmacy.
  - Temperature monitoring: IoT-based data loggers tracking temperature continuously throughout transit.
  - Regulatory requirement: WHO-prequalified cold chain management for government vaccine programs.
  - Risk: Cold chain breach = product compromise; batch must be quarantined and tested before release.

- **Task 6 — Reverse Logistics (Returns Management):** Managing the return flow of expired, damaged, recalled, or overstocked drugs back through the channel.

  - Expired drugs: Retailer returns to stockist → stockist to C&F → C&F to company → destroyed per CPCB (Central Pollution Control Board) regulations.
  - Drug recall: Company initiates recall through MRs and stockist communication → product recovered and destroyed.
  - Return credit: Company issues credit notes to channel partners for accepted returns per return policy.

- **Task 7 — Demand Forecasting:** Predicting future drug demand to plan production, inventory, and distribution in advance.

  - Methods: Moving average, exponential smoothing, regression analysis, IQVIA prescription data-based forecasting.
  - Seasonal adjustment: Cold/cough drugs — peak in November–February; antidiarrheal drugs — peak in June–September monsoon.
  - New product forecasting: Based on analogous product data, physician survey, and clinical trial endpoints.

**Point:** GDP (Good Distribution Practices) is defined under Schedule M of the Drugs & Cosmetics Act. All C&F agents, stockists, and distributors must follow GDP guidelines to maintain drug quality throughout the distribution chain.

# PART B — PROFESSIONAL SALES REPRESENTATIVE (PSR)

## PROFESSIONAL SALES REPRESENTATIVE (PSR) — Definition & Duties

📌 **Definition:** A Professional Sales Representative (PSR), also known as Medical Representative (MR), Detail Man, or Pharmaceutical Sales Representative, is a trained healthcare sales professional employed by a pharmaceutical company to promote and sell its products to physicians, pharmacists, and other healthcare professionals within an assigned territory.

### Position of PSR in Company Hierarchy

| |
|---|
| **National Sales Manager (NSM) / VP Sales** |
| ↓ |
| **Zonal Sales Manager (ZSM)** |
| ↓ |
| **Regional Business Manager (RBM)** |
| ↓ |
| **Area Business Manager (ABM) / Area Sales Manager (ASM)** |
| ↓ |
| **Senior Medical Representative (Sr. MR)** |
| ↓ |
| **Medical Representative / PSR ← FRONTLINE ROLE** |

### Duties of the Professional Sales Representative (PSR)

A. Promotional Duties:

- **Product Detailing:** Visiting physicians and presenting product information using visual aids, clinical data, and product monographs. Primary duty of every MR.
- **Physician Coverage:** Ensuring regular, systematic coverage of all doctors in the assigned territory as per the prescribed call frequency.
- **Sample Distribution:** Distributing product samples to physicians as per company policy and regulatory guidelines.
- **Literature Distribution:** Providing promotional literature — product monographs, clinical reprints, patient education materials.
- **CME Organisation:** Organising Continuing Medical Education programs, small group meetings, and doctor symposia.
- **New Product Launch:** Introducing and detailing newly launched products in the territory.

B. Sales & Distribution Duties:

- **Stockist Management:** Ensuring adequate stock at stockist level; placing primary orders; monitoring secondary sales.
- **Market Development:** Adding new doctors, new pharmacies, and new stockists to expand market coverage.
- **Prescription Generation:** Stimulating physician prescription generation that drives secondary sales from stockist to retailer.
- **Retail Coverage:** Visiting retail pharmacists to ensure product availability, POS displays, and brand advocacy.

C. Reporting & Intelligence Duties:

- **Daily Call Reporting:** Submitting daily call reports (DCR) documenting each doctor and chemist visit.
- **Market Intelligence:** Reporting competitor activities, market trends, physician feedback, and product complaints.
- **Expense Reporting:** Submitting weekly/monthly expense claims for travel, accommodation, and promotional activities.
- **Sales Tracking:** Monitoring self-achieved sales vs. targets using IQVIA or company-provided prescription data.

## PURPOSE OF DETAILING

Detailing is the face-to-face visit by a PSR to a physician or pharmacist for the purpose of promoting a pharmaceutical product. It is the cornerstone of prescription pharmaceutical promotion.

### Objectives of Detailing

| Objective | Description | Stage in PLC |
|---|---|---|
| Create Awareness | Introduce a new molecule or brand to a physician who is unfamiliar with it | Introduction |
| Provide Education | Explain mechanism of action, clinical data, dosage regimen, safety profile in depth | Introduction / Growth |
| Build Interest | Generate physician curiosity and motivation to try the product in clinical practice | Growth |
| Establish Preference | Convince the physician to choose this brand over competitor brands in the same class | Growth / Maturity |
| Ensure Loyalty | Reinforce current prescribers; prevent brand switching to generics or competitors | Maturity |

| Objective | Description | Stage in PLC |
|---|---|---|
| Handle Objections | Address physician concerns about efficacy, safety, cost, or patient suitability with evidence | All stages |
| Generate Prescription | Secure a commitment from the physician to prescribe for suitable patients | All stages |
| Gather Feedback | Collect physician feedback on product performance, patient response, competitive landscape | All stages |

### Effective Detailing — RCPCA Framework

- **R — Rapport Building:** Open the call by building personal rapport — enquire about the doctor's practice, recent medical news, or a patient case relevant to the product.
- **C — Clinical Need Identification:** Identify the specific patient type or clinical need the physician faces that the product addresses.
- **P — Product Presentation:** Present the drug's solution using the visual aid — mechanism, clinical evidence, dosage, safety.
- **C — Concern Handling:** Proactively address or invite physician concerns and handle them with clinical evidence.
- **A — Action Closing:** Close the call with a specific prescription commitment — 'Would you try this for your next patient with uncontrolled hypertension?'

**Point:** Studies show that the average physician detailing interaction lasts only 90 seconds to 3 minutes. PSRs must communicate the most impactful clinical message in this brief window — making preparation and focus critical.

## SELECTION AND TRAINING OF PSR

### Selection of PSR

The selection process for a PSR involves identifying candidates who combine scientific knowledge, communication skills, and sales aptitude:

A. Eligibility Criteria:

| Criterion | Details |
|---|---|
| Educational Qualification | B.Pharm / D.Pharm (preferred) / B.Sc Life Sciences / BSc Biotechnology / BBA with science background |
| Age | Typically 21–30 years for fresher MR positions |
| Experience | Fresher or 0–2 years for entry-level; experienced for Sr. MR / ABM positions |

| Criterion | Details |
|---|---|
| Skills | Communication, persuasion, territory planning, scientific acumen, resilience |
| Physical Fitness | High field mobility required — travelling 6–8 hours daily; driving/two-wheeler licence often needed |
| Language | Regional language fluency essential — most physician conversations happen in local language |

B. Selection Process Steps:

- **Step 1 — Manpower Planning:** Identifying vacancy based on territory coverage gaps, sales targets, and attrition replacement.
- **Step 2 — Job Description Preparation:** Clear document stating duties, territory, KPIs, reporting structure.
- **Step 3 — Sourcing Candidates:** Job portals (Naukri, LinkedIn), campus recruitment (pharmacy colleges), employee referrals, walk-in drives.
- **Step 4 — Written Test:** Scientific knowledge test — pharmacology, therapeutic areas, basic selling concepts.
- **Step 5 — HR Interview:** Personality, communication, motivation, situational question assessment.
- **Step 6 — Panel Interview:** ABM/RBM and HR jointly interview candidate — role-play of a doctor call, territory planning exercise.
- **Step 7 — Reference Checks & Medical Fitness:** Verification of credentials; basic medical fitness examination.
- **Step 8 — Appointment & Joining Formalities:** Offer letter, territory assignment, induction date confirmation.

## Training of PSR

Training is a continuous process in pharmaceutical selling. A newly recruited PSR undergoes structured induction training before being deployed in the field:

| Training Phase | Duration | Content Covered |
|---|---|---|
| Induction Training (Classroom) | 2–4 weeks | Company overview, HR policies, product knowledge (pharmacology, clinical data), selling skills, visual aid practice, territory management, expense reporting, CRM tools |
| Field Training (On-the-Job) | 2–4 weeks | Accompanying experienced MR or ABM on actual doctor calls; observing and practising detailing under supervision |

| Training Phase | Duration | Content Covered |
|---|---|---|
| Product Training (Product Launch) | 1–3 days | Deep-dive training on newly launched drug — MOA, clinical trials, competitive comparison, messages, objection handling |
| Continuous / Refresher Training | Monthly/Quarterly | Cycle meetings — ABM shares updated messages, competition updates, skill reinforcement, role-plays |
| Advanced Training (Promotion) | 1 week | Leadership, team management, coaching skills — for MRs being promoted to ABM/Sr. MR |

**Training Areas for PSR:**

- Product Knowledge: Mechanism of action, pharmacokinetics, clinical trial data, dosage, safety profile, contraindications.
- Disease Knowledge: Pathophysiology of target diseases — essential for credible physician conversations.
- Selling Skills: RCPCA model, objection handling, closing techniques, body language.
- Territory Management: Doctor and chemist mapping, call planning, route optimisation.
- Regulatory Compliance: UCPMP guidelines, sample distribution rules, ethical marketing standards.
- Digital Tools: CRM (SalesForce, Knack), e-detailing apps, digital visual aids, reporting portals.

## SUPERVISING THE PSR

Supervision of PSRs is the responsibility of the Area Business Manager (ABM). Effective supervision ensures that PSR activities are aligned with company strategy, ethical guidelines, and sales targets.

### Tools & Methods of PSR Supervision

- **Field Work with MR (Joint Field Work — JFW):** ABM accompanies MR on actual doctor calls — observes detailing quality, call opening, message delivery, objection handling, and closing. Provides immediate feedback.
- **Daily Call Reports (DCR) Review:** MR submits DCR daily via CRM app — records of doctors visited, products detailed, samples distributed, feedback received. ABM reviews for coverage, call quality, and adherence to plan.
- **Call Average Monitoring:** Tracking the number of doctor calls per field day (target: 8–12 calls/day). Below-standard call average triggers coaching.
- **Secondary Sales Tracking:** Monitoring stockist-to-retailer sales data — direct measure of MR's prescription generation effectiveness.
- **Prescription Audit (Rx Audit):** Using IQVIA/AIOCD prescription data to verify actual prescription generation in MR's territory.

- **Expense Report Review:** Monitoring MR's field expense claims for adherence to company policy and budget.
- **Chemist Audit:** ABM directly visits retail pharmacies to verify MR's coverage claims and check product availability, visibility.
- **CRM Dashboard Monitoring:** Real-time tracking of MR location (GPS), call frequency, product mix detailed, and sample utilisation through mobile CRM apps.

### Frequency of Supervision Activities

| Activity | Frequency |
|---|---|
| Joint Field Work (ABM with MR) | Minimum 4–6 days per MR per month |
| DCR Review & Feedback | Daily — via CRM dashboard |
| Monthly Review Meeting | Once per month — ABM reviews performance vs. target, territory plan |
| Cycle Meeting (All MRs in area) | Every 2 months — product updates, competitive intelligence, skill refresher |
| Annual Performance Appraisal | Once per year — formal evaluation for increment and promotion |

## NORMS FOR CUSTOMER CALLS

Norms for customer calls (call norms) are standardised guidelines that define the minimum and target frequency, quality, and structure of PSR visits to physicians and pharmacists. They ensure systematic, equitable, and productive territory coverage.

### Call Frequency Norms

| Doctor Category | Classification Criteria | Target Visit Frequency |
|---|---|---|
| Category A (High Value) | Top prescribers — generate >80% of prescriptions; KOLs, specialists | 3–4 times per month |
| Category B (Medium Value) | Moderate prescribers — growth potential; GPs with some specialty patients | 2 times per month |
| Category C (Low Value) | Low prescribers — new graduates, occasional prescribers, potential future prescribers | 1 time per month |
| Category D (Accounts) | Hospitals, medical colleges, CMO/DMO offices — institutional targets | As per KAM plan — weekly or fortnightly |

## Daily Call Norms

| Metric | Standard Norm |
|---|---|
| Total Doctor Calls per Field Day | 8–12 calls (varies by company and urban/rural territory) |
| Field Days per Month | 22–24 days (excluding Sunday, holidays, office days) |
| Products Detailed per Call | 2–3 products (1 primary + 1–2 secondary products) |
| Chemist Calls per Day | 3–5 retail pharmacy visits per day |
| Sample Distribution per Call | As per sample quota — typically 1 strip per product per eligible doctor |
| Leave the Piece (LTP) Literature | At least 1 promotional piece left with the doctor after every call |

## Quality Standards for Each Call

- Each call must follow the structured detailing format (RCPCA or AIDA) — not a casual social visit.
- The visual aid must be used in every call — not merely distributed or left without explanation.
- At least one clinical data point or trial result must be communicated per call.
- Every call must end with a specific prescription commitment or follow-up action.
- The call must be documented in DCR within 24 hours with honest and accurate information.
- All calls must comply with UCPMP — no cash/gifts, no inappropriate hospitality.

## Call Planning — Territory Management

- **Doctor List Preparation:** Complete universe of doctors in territory, classified by specialty, potential, and call frequency.
- **Monthly Routing Plan:** Day-wise plan allocating which area/lane of the territory is covered each day — minimises travel time.
- **Priority Call Planning:** A-class doctors planned for peak morning hours (when doctors are most receptive); B and C class in afternoon.
- **Pre-call Research:** MR reviews doctor's profile, previous call notes, pending follow-ups before each visit.
- **Post-call Documentation:** Immediate DCR entry — what was discussed, physician's response, next action, samples given.

# MOTIVATING THE PSR

Pharmaceutical sales is a highly demanding, often solitary profession — PSRs work alone in the field, face frequent rejections, and operate under constant performance pressure. Keeping PSRs motivated is critical for sustained high performance and low attrition.

## Maslow's Hierarchy of Needs — Applied to PSR Motivation

| Need Level | PSR Application | Motivational Tools |
|---|---|---|
| Physiological (Basic) | Adequate salary to meet basic living costs | Competitive fixed salary, travel allowance, food allowance, accommodation reimbursement |
| Safety (Security) | Job security, health insurance | Permanent employment, Mediclaim for family, PF/ESI, gratuity |
| Social (Belonging) | Team camaraderie, acceptance by peers and physicians | Team meetings, cycle meetings, recognition within team, good manager relationship |
| Esteem (Recognition) | Achievement recognition, professional respect | Star performer awards, public recognition at conferences, 'Best MR' contests |
| Self-Actualisation (Growth) | Career advancement, personal development | Promotion to ABM, training programs, product management exposure, MBA sponsorship |

## Financial (Monetary) Motivators

- **Performance Incentive / Variable Pay:** Monthly or quarterly bonus linked to sales target achievement — typically 20–30% of fixed salary potential.
- **Sales Contest Prizes:** Cash prizes, gift vouchers, or trips for top performers in quarterly/annual sales contests.
- **Special Allowances:** Mobile allowance, internet allowance, vehicle maintenance allowance.
- **Annual Increment:** Performance-linked annual salary increase — top performers receive 10–20% increment.
- **ESOP (Employee Stock Option):** Large pharma companies offering stock ownership to senior MRs as long-term retention incentive.

## Non-Financial (Non-Monetary) Motivators

- **Recognition Programs:** 'MR of the Month/Quarter/Year' — certificates, public recognition at meets, name displayed at office.
- **Fast-Track Promotion:** High performers promoted to Sr. MR or ABM ahead of scheduled timeline.

- **Training & Development:** Sponsoring advanced courses, management training, pharma marketing certifications.
- **Autonomy & Trust:** Giving experienced MRs freedom to manage their territory without micro-management.
- **Good Management:** Supportive, empathetic ABM who coaches rather than just monitors — most critical non-financial motivator.
- **Work-Life Balance Initiatives:** Reasonable call norms, planned leave, no weekend field calls policy.
- **Company Pride:** Being part of a reputed, ethical company with strong brand recognition enhances PSR's self-esteem.

## EVALUATING THE PSR — Performance Appraisal

PSR evaluation (performance appraisal) is the systematic assessment of a sales representative's performance against defined KPIs (Performance Indicators). It determines salary increments, promotions, training needs, and corrective actions.

### Quantitative (Objective) Evaluation Parameters

| KPI | Description | Measurement Method |
|---|---|---|
| Sales Achievement vs. Target | Primary metric — % of monthly/quarterly sales target achieved | Sales data from stockist/C&F (primary sales) + secondary sales reports |
| Call Average | Number of doctor calls made per field day | DCR data — total calls / field days |
| Doctor Coverage | % of assigned doctors covered in a cycle | DCR analysis — covered doctors / total assigned doctors × 100 |
| New Doctor Addition | Number of new prescribers added to the doctor list | DCR — first-time call reports on new doctors |
| Prescription Count (Rx) | Actual number of prescriptions generated in territory | IQVIA prescription audit data |
| Product Mix | Whether all assigned products are being detailed (not just top products) | DCR analysis of product-wise call frequency |
| Sample Utilisation | Samples distributed vs. samples issued — efficiency of sampling | Sample receipt acknowledgement vs. samples issued |
| Chemist Coverage | Retail pharmacies visited and audited for product availability | PSR's chemist call records |

### Qualitative (Subjective) Evaluation Parameters

- Detailing quality — assessed by ABM during Joint Field Work (JFW).
- Product knowledge depth — tested during cycle meetings and training sessions.
- Doctor and chemist relationship quality — feedback from customers.
- Team collaboration and willingness to support colleagues.
- Ethical conduct — UCPMP compliance; no customer complaints.
- Planning and organisational skills — quality of monthly territory plan.
- Attitude, initiative, and ownership of territory performance.

### Appraisal Methods Used in Pharma

- **360-Degree Feedback:** Evaluation from ABM (manager), peers, and occasionally physician/chemist feedback — comprehensive but complex.
- **Management by Objectives (MBO):** MR and ABM jointly set measurable targets at start of year; year-end evaluation against those targets.
- **Balanced Scorecard:** Evaluation across four dimensions — Financial (sales), Customer (prescription generation, doctor relationships), Internal Process (call quality, reporting), Learning & Growth (training completion, new skills).
- **Graphic Rating Scale:** Simple rating scale (1–5 or 1–10) on various performance dimensions — easy to administer.

## COMPENSATION OF THE PSR

Compensation refers to the total remuneration package provided to a PSR, including all financial and non-financial rewards. An effective compensation structure must attract talent, motivate performance, and retain high performers.

### Components of PSR Compensation Package

| Component | Description | Typical Range (India) |
|---|---|---|
| Fixed Salary (CTC) | Base monthly salary — guaranteed regardless of performance | Fresher MR: ₹18,000–₹30,000/month; Sr. MR: ₹35,000–₹55,000/month |
| Performance Incentive (Variable Pay) | Monthly bonus based on sales target achievement | 20–40% of fixed salary; paid on achieving ≥80% of target |
| Daily Allowance (DA) / Field Expense | Per diem for food, local travel, miscellaneous field expenses | ₹300–₹600/field day depending on city/rural classification |
| Travel Allowance (TA) | Reimbursement for intercity travel (train/bus) | Actual fare reimbursement up to 2AC/AC bus |

| Component | Description | Typical Range (India) |
|---|---|---|
| Mobile / Phone Allowance | Monthly reimbursement for business calls and data | ₹500–₹1,500/month |
| Vehicle Allowance | Fuel/maintenance for MR's own vehicle used for field work | ₹3,000–₹8,000/month or ₹3–₹5/km |
| Medical / Health Insurance | Mediclaim for MR and family | Coverage: ₹2–₹5 lakh family floater |
| Provident Fund (PF) | 12% of basic salary — employer contribution | Statutory requirement under EPF Act |
| Gratuity | Long-term service benefit after 5+ years | 15 days salary per year of service |
| Annual Increment | Performance-linked yearly salary increase | Average 8–15%; top performers 20–30% |
| Contest Prizes | One-time rewards for sales contest winners | ₹10,000–₹1,00,000 or travel trip (domestic) |

### Types of Compensation Plans

- **Straight Salary Plan:** Fixed salary only — no variable pay. Provides income security but no performance incentive. Used for new recruits during probation.
- **Straight Commission Plan:** Pay purely based on sales performance — high risk, high reward. Not common in pharma as it can encourage unethical practices.
- **Combination Plan (Most Common):** Fixed salary (60–70%) + Performance Incentive (30–40%). Balances security with performance motivation. Standard across Indian pharma industry.
- **Salary + Bonus Plan:** Fixed salary + annual lump-sum bonus based on year-end performance. Good for long-term retention.

**Point:** The pharmaceutical industry in India has a high MR attrition rate (20–30% annually) — primarily driven by better compensation offers from competitors. Companies invest heavily in competitive compensation benchmarking through salary surveys (Aon, Mercer) to retain talent.

## FUTURE PROSPECTS OF THE PSR

The role of the PSR is evolving rapidly in response to digital transformation, changing physician preferences, regulatory tightening, and post-COVID healthcare landscape shifts. Understanding future prospects helps PSRs prepare for career growth and industry changes.

## Career Growth Path of a PSR

| |
|---|
| **Medical Representative (MR / PSR) — Entry Level (0–3 years)** |
| ↓ |
| **Senior Medical Representative (Sr. MR) — (3–5 years)** |
| ↓ |
| **Area Business Manager (ABM) / Area Sales Manager — (5–8 years)** |
| ↓ |
| **Regional Business Manager (RBM) — (8–12 years)** |
| ↓ |
| **Zonal Sales Manager (ZSM) — (12–15 years)** |
| ↓ |
| **National Sales Manager (NSM) / Business Unit Head — (15+ years)** |
| ↓ |
| **VP Sales / Director Sales / Product Management / Marketing Head** |

## Lateral Career Options for PSR

- **Product Management:** Experienced MRs with strong marketing insights transition to Brand Manager / Product Manager roles — managing product strategy rather than field execution.
- **Medical Affairs / Medical Science Liaison (MSL):** B.Pharm/M.Pharm MRs move to MSL roles — scientific communication with KOLs, clinical study management.
- **Training & Development:** Experienced MRs become pharma trainers — designing and delivering MR training programs.
- **Regulatory Affairs:** MRs with pharmacy background transition to regulatory submissions, clinical trial documentation.
- **Account Management (KAM):** Managing large hospital, government, or corporate accounts — specialised sales role.
- **Business Development:** Identifying and pursuing new market opportunities, partnerships, licensing deals.
- **Digital Marketing:** Experienced MRs moving to digital health, e-detailing, and pharma digital marketing roles.

## Future Trends Impacting the PSR Role

| Trend | Impact on PSR | PSR's Adaptation Required |
|---|---|---|
| E-Detailing & Digital Visits | COVID accelerated virtual doctor interactions; some HCPs prefer online meetings | PSR must master digital platforms — Zoom, e-detailing apps, digital visual aids |

| Trend | Impact on PSR | PSR's Adaptation Required |
|---|---|---|
| Reduced Physician Access | Doctors increasingly restricting MR access — appointment-based meetings, gatekeeper staff | PSR must build stronger physician value proposition; appointment-based calling |
| AI & CRM Technology | AI-driven call planning, predictive prescription analytics, automated reporting | PSR must be tech-savvy; CRM/digital tool proficiency becomes mandatory |
| Account Focus | Shift from mass detailing to fewer, deeper hospital/specialist relationships | PSR must develop consultative selling, KAM skills |
| Speciality Pharma Growth | Oncology, biologics, rare disease — complex science, small prescriber base | PSR needs advanced scientific training; MSL-PSR hybrid roles emerging |
| Patient-Centric Selling | Growing emphasis on patient outcomes, not just prescription generation | PSR must understand patient adherence, health outcomes, value-based selling |
| Regulatory Tightening | Stricter UCPMP enforcement; transparency registers being introduced | PSR must maintain impeccable ethical standards in all interactions |
| Generics & Biosimilars Growth | Patent expiry of blockbusters; generic competition | PSR must articulate differentiation beyond molecule — trust, quality, service |

**Remember:** The future PSR will be a 'Science-Savvy Digital Advisor' — combining deep clinical knowledge with digital communication skills, data analytics capability, and a patient-outcome focused approach, rather than the traditional 'product promoter' role.

## EXPECTED EXAM QUESTIONS — UNIT IV

★ **Exam Tip:** Unit IV is high-weightage — PSR duties, training, compensation, and channel conflict appear frequently. Both 10-mark and 5-mark questions are common from this unit.

**Long Answer Questions (10 marks):**

- Describe the pharmaceutical distribution channel structure in India. Explain the roles and functions of each channel member.
- What is channel conflict? Explain the types of channel conflict in pharmaceutical distribution and discuss the strategies to resolve them.

- Explain the concept of Physical Distribution Management. Describe the tasks involved in physical distribution of pharmaceutical products.
- Define PSR. Describe the duties, selection process, and training of a Professional Sales Representative in detail.
- Explain the concept of detailing. Describe the purpose of detailing and the steps of an effective detailing call.
- Discuss the methods of motivating, evaluating, and compensating a Professional Sales Representative.

**Short Answer Questions (5 marks):**

- Differentiate between C&F Agent and Stock list in the pharmaceutical distribution system.
- Write a short note on the ABC classification of doctors and norms for customer calls.
- Explain the importance of cold chain management in pharmaceutical physical distribution.
- Write a short note on the future prospects and career growth of a PSR in the pharmaceutical industry.
- What is the role of AIOCD in resolving pharmaceutical channel conflicts?
- Explain the components of PSR compensation with a focus on the combination plan.

★ **Exam Tip:** Draw the Indian Pharmaceutical Distribution Flow Diagram (Manufacturer → C&F → Stockist → Retailer → Patient) and the PSR Hierarchy Chart in your answer — examiners award extra marks for clear, labelled diagrams.

**— END OF UNIT IV NOTES —**

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