

Pharmaceutical Company Strategies and Distribution Systems in Emerging Markets

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Background

Decline in research productivity, slow growth in mature markets, a massive number of patent expirations, and pressures for cost containment from major payers together are forcing leading pharmaceutical companies to rethink their strategies for growth in emerging markets. According to Intercontinental Marketing Services (IMS) Health, by 2014 50% of market growth in pharmaceutical industry will come from 17 countries in emerging markets. With emerging economies representing close to 55% of the world's gross domestic product, pharmaceutical companies have identified new opportunities and markets for investment in these contexts. Rapid economic growth combined with continued population increases in countries like India, China, and Brazil offer new business opportunities for pharmaceutical companies. Additionally, improved technological capabilities and industrial development as a result of economic growth create improved methods for engaging in these developing markets.

In low- and middle-income countries, national growth requires health distribution systems that respond to the population's diverse range of health conditions including assured access to appropriate products, medicines, and vaccines to treat and manage those conditions. More specifically, many developing countries require health products, medicines, and vaccines that can address a double burden of disease; one of both communicable diseases (CDs), infectious diseases as well as noncommunicable diseases (NCDs), chronic diseases. In 2002, approximately 46% of the global burden of disease was attributable to NCDs (Young *et al.*, 2009). The resulting interaction between NCDs and CDs may increase susceptibility of individual health. A synergistic negative interaction of disease types also appears prevalent among individuals in low- and middle-income countries. For example, individuals with diabetes may struggle to manage their health with regard to exposure to infection, particularly to the eyes and feet. Likewise, close to a quarter of cancers in developing countries may be attributed to infectious agents. As a result of these and other interactions, individuals require treatment for single disease areas, as well as increasingly for multiple conditions, some of which may be more chronic in nature.

The challenges in managing pharmaceuticals in emerging countries are very different from those in advanced economies. In developed countries, the challenge is to enhance the efficiency of spending on pharmaceuticals. In most of the emerging markets, the main challenge is how to expand the pharmaceutical market to include a larger share of the population. In these economies, increased spending on pharmaceuticals could lead to higher benefits in health outcomes and in some cases could also catalyze economic growth. As social health insurance plans in some of the emerging countries expand in terms of their population coverage and the range of

services that are included, many are being cautious not to generate fiscal pressures at an early stage that may hamper their sustainability. The governments of many emerging market countries are attempting to expand the reach and coverage of their pharmaceutical systems in a way that avoids the high costs observed in the health systems of more developed economies.

The Unique Characteristics of Emerging Markets

For pharmaceutical manufacturers participating in pharmaceutical market growth in emerging markets, careful analysis of the structural differences in emerging market pharmaceutical systems is required. For many governments, strategies to ensure consistent access to medicines, vaccines, and health technologies in emerging markets are necessary. To ensure market growth in these countries, manufacturers often align their strategies with government strategies for improving access through innovative mechanisms like differential pricing schemes or local marketing and health education campaigns for high burden disease areas.

There are significant differences among developing countries in terms of total health expenditures, total pharmaceutical expenditures, strength of drug regulatory authorities, social health insurance, and relative division of distribution between public and private sector for pharmaceuticals. Distribution strategies will vary according to the exact set of factors present in a country. Main factors, which hold across most developing countries, are discussed below.

In mature developed markets, some form of health insurance usually reimburses pharmaceutical purchases in whole or in part. Large fractions of these populations are insured through state, employer, or private insurance. In contrast, many developing countries do not have a national health insurance system in place to ensure affordable access to services and health products for the population. Public or private health insurance is limited mainly to those with high expendable income or those employed in the formal sector. As such, the market for medicines is largely dependent on ability and willingness to pay for products. In low- or middle-income countries, purchasing of pharmaceuticals accounts for up to 40% of the total healthcare expenditure whereas in many established market economies, only 20% of costs are attributed to pharmaceutical drugs. Furthermore, in low-income countries approximately 80% of total pharmaceutical expenditures are out of pocket (Figures 1 and 2).

In countries like Brazil and China, newer programs of social insurance have created alternative methods to help ensure individual access to medicines through subsidies and/or targeted retail pharmacy programs for the rural poor. China has expanded its public health insurance system to cover almost

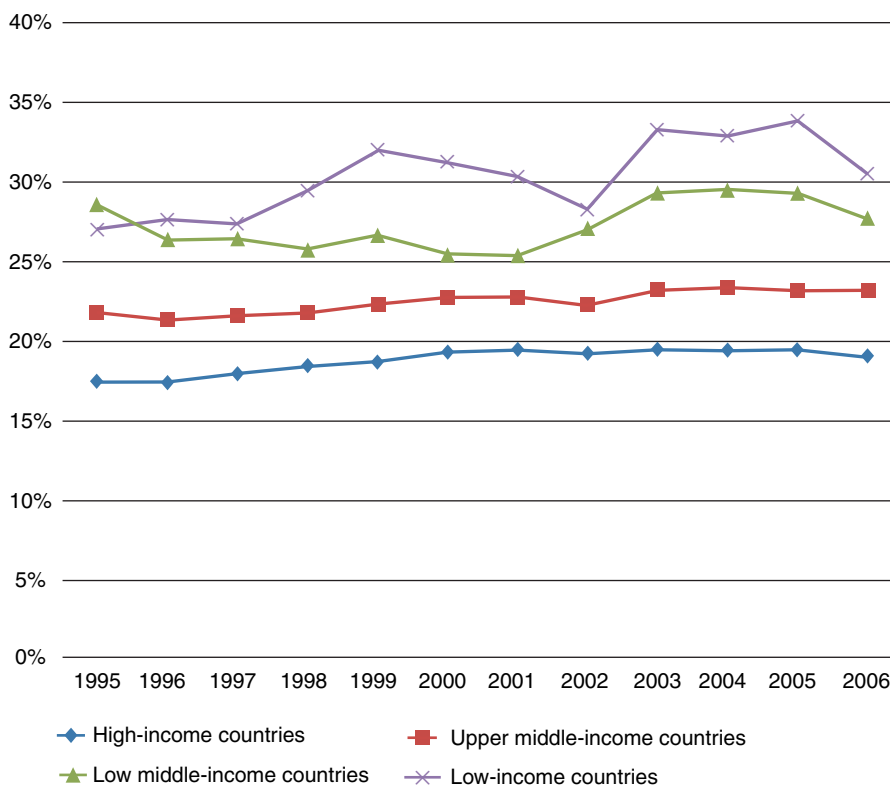


Figure 1 Average total pharmaceutical expenditure as a percent of the total health expenditure (1995–2006). Reproduced from Global Health Expenditure Database (1995–2006). National health accounts, World Health Organization. Available at: <http://www.who.int/nha/en/> (accessed 03.10.13).

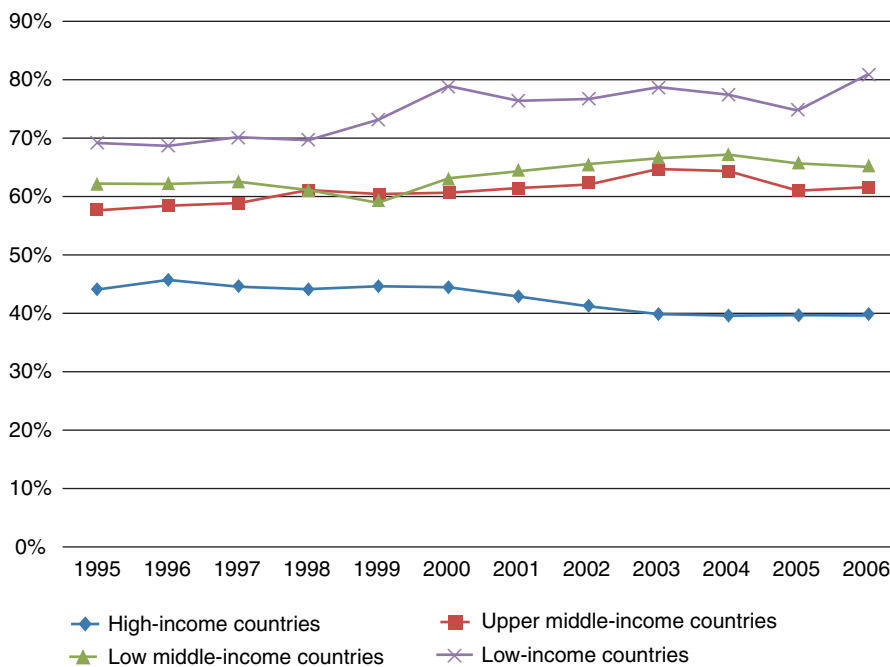


Figure 2 Average percent of total pharmaceutical expenditures that are out of pocket (1995–2006). Reproduced from Global Health Expenditure Database. National health accounts, World Health Organization. Available at: <http://www.who.int/nha/en/> (accessed 18.07.13).

Table 1 Differences in overall structure of pharmaceutical market in developed and developing countries

<i>Factor</i>	<i>Developed countries</i>	<i>Developing countries</i>
Payer/reimbursement	Strong presence of public or private insurance companies and limited out-of-pocket expenditure	Mostly payments are made out of pocket. Social health insurance systems are expanding in many emerging markets. Private insurance plans are also growing in some emerging market countries
Regulatory structure	Strong well-defined laws and overall good ability to enforce regulations	Weak fragmented regulatory structures, ill-defined laws in some instances, and poor ability to enforce regulations
Patented generic versus branded generic	The market for prescription drugs consists of patented drugs and generics	Poor regulatory structure creates a strong market for branded generics (brand is used as a signal of quality by the patient)
Prescription adherence	Prescription drugs can only be dispensed with a formal prescription	Retail pharmacies often dispense medicines and also act as the first point of healthcare contact for many patients
Balance of power in the system	Buyer (insurance companies or national health system) monopsony creates good balance of power between the manufacturer and the patients. In the US pharmacy benefit managers (PBM) and drug formularies are commonly used as a means to ensure further balance of power	Balance of power is tilted toward the manufacturer and the distribution channel. A large fraction of patients purchase using out-of-pocket funds and have little bargaining power
Price sensitivity	Pricing is crucial to gaining formulary or national reimbursement acceptance, but price sensitivity within bands is lower	Out-of-pocket payments lead to high price elasticity. Pricing is a key strategic differentiator

95% of the population. Since the early 1990s, Brazil has begun a social health insurance program called the Single Unified System (SUS) on which more than 75% of the population relies on exclusively for care. Approximately 20% of the population (wealthier socioeconomic strata and employees of certain businesses) purchases health insurance from private insurers who are regulated by the National Supplementary Health Agency. People who purchase private insurance receive a tax rebate, however, they still are required to contribute to the SUS through their income taxes. Lower-income groups tend to spend more out of pocket on medicines than higher-income groups in Brazil as higher-income groups typically purchase separate private insurance. Private sources of finance, such as out-of-pocket spending by families and companies with some direct and indirect government subsidies, fund most medicines in the Brazilian health system. Other developing countries such as Malaysia and Thailand have public health insurance plans with very high degrees of coverage. However, in most cases the breadth of services covered under the plans remains limited to catastrophic healthcare needs or very basic services such as immunization. Patients usually have to pay out of pocket for other outpatient or inpatient services and for purchasing medicines.

Also, in developed countries most pharmaceuticals are only obtained using a prescription provided by a physician and consumers purchase drugs from retail pharmacies. In many developing countries, adherence to prescription requirements is poor and patients may often obtain medicines at retail pharmacies without a formal prescription. Most developed countries have well-developed regulatory institutions to ensure the safety and efficacy of drugs. Regulatory agencies

in low- and middle-income countries are weak and have very limited capacity to enforce rules. As a result, the task of ensuring quality of medicines is placed on the patients. This creates a stronger market for branded generics in developing countries than in developed countries as branded medicines are used as a signal to patients for quality products.

In low-income countries, especially in Africa, direct purchasing and distribution of medicines by the government (Ministries of Health) represents a significant portion of overall market for pharmaceuticals (Table 1).

Pharmaceutical Distribution Systems in Developed Markets

In both developed and developing countries, given the large number of medicines and packaging variants, it is difficult for retail pharmacies to purchase all of these products directly from the manufacturer and stock them in their retail stores. If all retail pharmacies and hospitals ordered all their medicines from the hundreds of different manufacturers, the number of transactions would be exponentially large and inhibit a working system. Retail pharmacies therefore depend on a well-functioning distribution system consisting of distributors, wholesalers, and prewholesalers. Distributors typically store and distribute a manufacturer's product for a fee; however, they do not own the inventory they distribute. Wholesalers are intermediaries that purchase medicines from manufacturers or prewholesalers. Wholesalers store and distribute supplies while also managing the risks associated with purchased inventory.

In most developed countries a large fraction of the pharmaceuticals used are prescribed by clinical or hospital physicians, which patients obtain at retail pharmacies. In the US, for example, almost 75% of the pharmaceutical sales are covered by retail pharmacies. There are more than 57 000 pharmacies in the US and almost 50% of the retail pharmacy market consists of chain pharmacies including food stores with pharmacies (Yadav *et al.*, 2012). In contrast, many countries in Europe do not allow chain pharmacies. Some large chain pharmacies and hospitals purchase their drugs directly from manufacturers and run their own distribution networks. Some manufacturers also ship certain specialty products directly to retail pharmacies through a specialized logistics service provider. Even with these alternatives, the greater portion of distribution occurs through wholesalers and distributors.

In Europe the manufacturer frequently sends the product from production to a prewholesaler first who then ships the product to wholesalers or large hospitals. Wholesalers then distribute the product to retail pharmacies with an average delivery frequency of twice daily. Most wholesalers stock and distribute products from a number of different manufacturers and often multiple wholesalers operate in a particular region offering competition and choice to the pharmacies. In the US manufacturers ship their product to distributors who then distribute the product to the retail pharmacies several times a week. The lower delivery frequency to retail pharmacies in the US implies that on average pharmacies in the US carry more inventory than pharmacies in Europe, although this is not always true.

In most developed regions of the world the wholesaling and distribution segment of the distribution system is concentrated amongst a few players. The three largest US wholesalers, Cardinal Health, McKesson, and AmerisourceBergen, distribute more than 90% of all pharmaceuticals sold in the US. Increasingly, these companies behave more like distributors in that they have inventory management agreements with manufacturers under which they do not necessarily own stock or carry the associated inventory risk but instead receive a fee from the manufacturers. Similar to the US, in Europe, Japan and other developed regions of the world four to five major distributors with national coverage account for 90% of the market. This is due to the underlying economies of scale in the pharmaceutical distribution business.

Financial flows within developed market distribution chains are somewhat complicated. Although money flows from health plans/insurers to manufacturers with the retail pharmacy in between may seem straightforward, the nature of price negotiations and discounting makes this system more complex. In the US, for example, insurers may negotiate prices with manufacturers. Alternatively, health plans may create or contract specialized agencies called pharmacy benefit managers (PBMs) to obtain discounted prices from manufacturers for exclusiveness on formulary or volume-based discounts. Hospitals and other providers work through Group Purchasing Organizations (GPOs) for negotiating these discounts. The discounts obtained are then shared with health plans. Similar arrangements also exist in the UK.

Order information flows from the healthcare provider to the pharmacy when a prescription is 'called in.' Pharmacies and hospitals replenish their inventories by ordering from the distributors or wholesalers. The distributors and wholesalers

in turn order from the manufacturer when their stock needs replenishment. In addition, retail sales information and distributor sales information are collected by private third parties like IMS Health, which allow payers, manufacturers, and regulators to access information from each point in the supply chain. Owing to the nature of the financial flows and contracting with GPOs and PBMs, the distributor and the retail pharmacy also provide product sales information to the GPO and PBM.

Pharmaceutical Distribution Systems in Emerging Markets

Similar to the developed countries, in most emerging markets medicines in the private sector are distributed through a network of importers, wholesalers, subwholesalers, pharmacies, and drug stores (Pharmacies included a trained and certified pharmacist. Drug stores, often also referred to as chemists, are additional informal or formal retail distribution points for medicines typically without a trained/registered pharmacist. Many countries have formal regulatory mechanisms to allow for legal distribution of medicines through drug shops.) National importers and wholesalers create the link between pharmaceutical manufacturers and retail pharmacies, private clinics, hospitals, and other informal drug shops. However, for historical reasons, the pharmaceutical distribution system in most emerging markets has a different market structure compared to developed countries. The main differences include a lack of distribution networks with national reach; excessive fragmentation and too many small players; too many intermediaries between the manufacturer and the patient; poor IT and communication flow systems resulting in poor coordination across actors in the distribution channel.

For example, in 2007 the total number of retail pharmaceutical dispensing points in China was approximately five times that of the US (approximately 50 000 in the US and 140 000 in China) and the total number of wholesalers and distributors in China was close to 16 500 (Zhou, 2007). The total market share held by the top-three largest Chinese pharmaceutical distributors was only 42% as compared with that of the three leading distributors in the US, which account for 90% of the market share. Fragmentation of the wholesale market is commonly observed in most emerging markets with trends similar to that of China observed in India, Brazil, and other developing regions with large private sector markets for pharmaceuticals. Capital constraints faced by wholesalers coupled with corruption that favors certain wholesalers in purchasing by hospitals prevents large-scale consolidation in the industry. These factors do not allow scale economies to have their full effect and a fragmented wholesaling and distribution sector continues to exist.

Owing to the relative lack of distributors/wholesalers with nationwide coverage and reach, wholesalers often have to rely on regional subwholesalers or stockists, which adds another layer to the supply chain. High markups between multiple intermediaries in the distribution chain result in poor affordability and inability of the manufacturer to pursue growth strategies that rely on reaching larger proportions of the population at lower price points. Lack of information flows

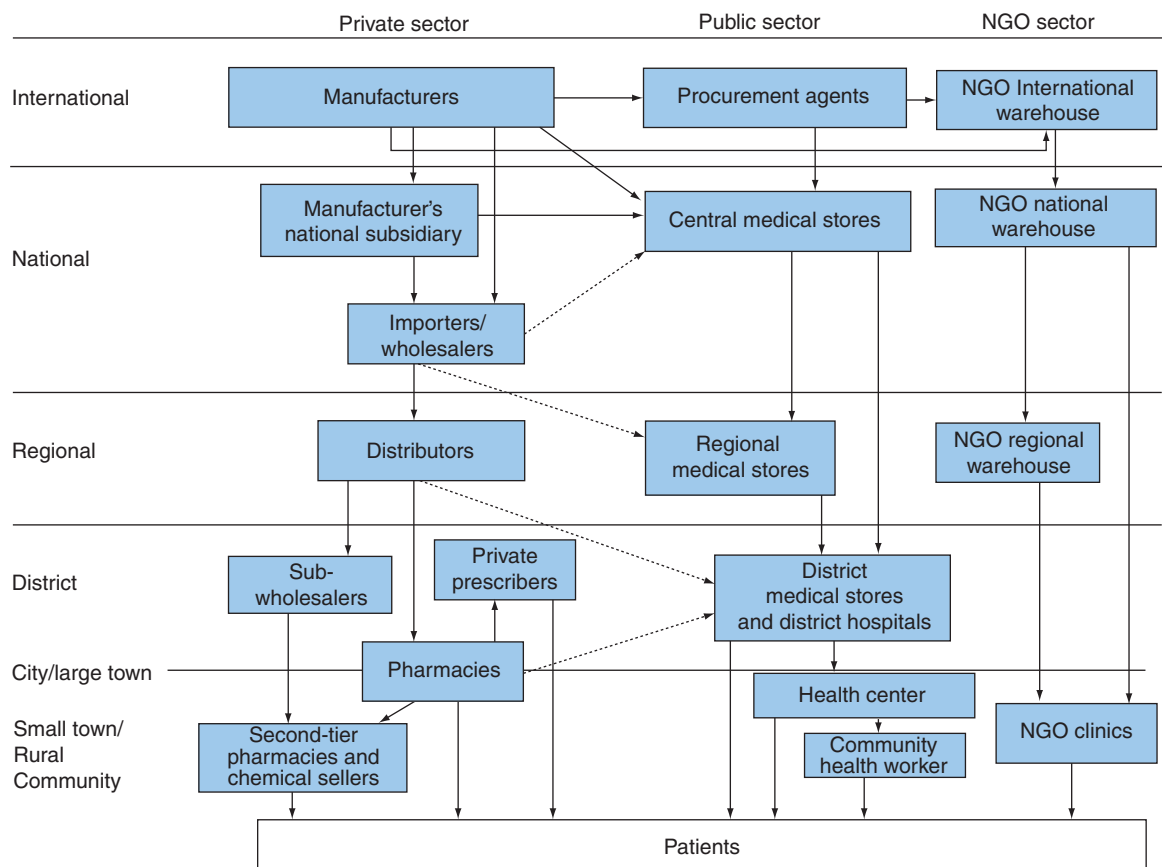


Figure 3 Distribution network for essential medicines in the public, private, and NGO channels in developing countries. Reproduced from Yadav, P., Tata, H. and Babaley, M. (2012). *The World Medicines Situation 2011: Storage and supply chain management*. Geneva: World Health Organization.

and opacity of information at different nodes in the system worsens the problem.

Apart from the private sector, in many low- and lower middle-income countries distribution of medicines also takes place in the public and nongovernmental organization (NGO)/faith-based sector (Figure 3).

In sub-Saharan Africa the predominant model is public sector distribution of medicines through a central medical store (CMS) which coordinates directly with regional or district stores. Transportation of goods is managed by a government/CMS owned and managed fleet. In addition to the CMS and regional or district stores, there are a number of primary and secondary distribution locations. These additional locations are present because of product- or program-specific supply chains setup by funding partners of the public sector. Increased availability of funding for the procurement of medicines over the past 5–10 years has highlighted weaknesses in the public sector medicine supply systems in some emerging markets.

Country case studies of Zambia and Jordan provide specific examples of distribution systems. The Zambian system represents a predominantly public sector medicine supply system. Jordan, by contrast, provides a private sector example. Each case outlines opportunities and challenges relevant to the previous distribution system review. The case study in Zambia outlines the difficulty the public sector has ensuring reliable supply and availability. In comparison the private sector in

Jordan has difficulty in ensuring quality and price of medicines (Tables 2 and 3).

Distribution and delivery systems may also depend on the involvement of NGOs or faith-based organizations. Pharmaceutical delivery in this context is typically arranged according to the customer's own prearrangement, courier services, drug supply organization delivery services, or direct delivery services. Variations in the distribution structures for this specific channel are considerable across countries.

Generally, procurement, distribution, and the overarching provision of pharmaceutical goods within a particular country are disaggregated across groups with limited information sharing between public sector, private sector, and NGO/donor groups. As a result, pharmaceutical procurement and distribution strategies lack the coordination and efficiency to ensure optimal market function. High transaction costs and opacity in the market due to excess fragmentation leads to higher retail prices of pharmaceutical products. Although coordination and information sharing is a problem in developed countries too, a wider use of information technology and the presence of information consolidators such as IMS Health makes it somewhat easier.

Price is a key strategic differentiator between distribution chains in developed markets compared to those in emerging markets. Emerging market distribution chains often involve high markups between multiple intermediaries, thus making it

Table 2 Case study – Zambia

<i>Public sector medicine supply distribution</i>	<i>Distribution opportunities and challenges</i>
<p>Government of Zambia stores and distributes medicines through a national medical store, Medical Stores Limited (MSL). Additional management support is contracted through Crown Agents</p> <p>Districts are distributed medicines on a monthly basis by the MSL according to preset allocations of medicines. Allocations are based on reported demand at the district level, of medicines. Districts send orders directly to the MSL utilizing information on their current stock levels as well as a review the monthly stock availability report provided by the MSL</p> <p>In addition to the demand information, all districts receive a standard, predetermined number of medicine kits every month</p>	<p>The MSL is engaged with typical demand expectations at each district. Such engagement enables the MSL to make discretionary decisions related to overestimated demand expectations after a period of product stockout. Although the MSL discretionary decision making may prevent a flood of stock from reaching the district level and expiry before potential use, it does not encourage transparent information flows</p> <p>Additionally, districts often order according to the stock availability report provided monthly by the MSL. If district level representatives know an item is out of stock, their orders to the MSL will reflect what they expect to be able to receive, not necessarily the true demand. The MSL in turn, overtime, operates on accurate demand information</p>
<p><i>Source:</i> Reproduced with permission from Yadav, P. (2007). Analysis of public, private and mission sector supply chains for essential drugs in Zambia. <i>Technical Report</i>. Zaragoza, Spain: MIT-Zaragoza International Logistics Program.</p>	

Table 3 Case study – Jordan

<i>Private sector medicine supply distribution</i>	<i>Distribution opportunities and challenges</i>
<p>The private sector supply chain in Jordan consists of several large importers and wholesalers from international manufacturers/suppliers. There are also a number of local manufacturers that produce generic medications, primarily for export to other countries. Medicines are sold within the country to private hospitals, retail pharmacies, and drug outlets</p> <p>Importers and wholesalers are often granted lines of credit from suppliers and manufacturers that vary in length based on the volume of orders. The longer the period of credit requested, the larger the order required per time period. As a result, importers and wholesalers are often responsible for the larger sized order, the interest on a line of credit as well as typical, distribution and related transportation costs of their goods within the country</p>	<p>National regulation of all importers and wholesalers ensures that pharmaceutical products have the required quality storage facilities. The local manufacturing groups have improved lead times as well as higher overall responsiveness for distribution of medicines within the country; however, their larger market is in exporting medicines to other countries</p> <p>Prices in the private sector tend to be high. Given the relatively small market for medicines in Jordan, it is often difficult for suppliers to reach economies of scale unless they tender to public and private sector facilities. The importers and wholesalers carry additional costs resulting from poor credit provisioning in the system and the high costs of credit</p>
<p><i>Source:</i> Reproduced with permission from Conesa, S. and Yadav, P. (2009). Analysis of the pharmaceutical supply chain in Jordan. <i>Technical Report</i>. Zaragoza, Spain: MIT-Zaragoza International Logistics Program.</p>	

difficult to ensure affordability. Reaching a larger portion of rural segments of a population with alternative pricing models can be a successful growth and pricing strategy, however, without an organized and efficient distribution system, high costs and multiple sources of uncertainty prohibit the widespread use of such approaches. Poor coordination between retail pharmacies, drug shops, private clinics, and other informal service channels precludes a systematic method for targeting inexpensively priced medicines specifically to the poor. It may also preclude increasing revenue for manufacturers at the time as improving access. Newer distribution strategies that ensure better flow tracking will enable strategies for high sales volumes (a benefit to manufacturers) with lower margins (a benefit to the general population) rather than the current model of high margin, low volume.

Strategy for Emerging Markets

Success in emerging markets requires selecting prices that lead to high affordability by the population and revenue growth for

the pharmaceutical company. In some cases partnerships or equity ownership in local companies helps achieve some of these objectives.

Differential Pricing in Emerging Markets

Pharmaceutical companies have used alternative pricing models to target emerging markets. Differential pricing is based on the economic principle that the greatest profit may be derived from pricing products closest to a consumer's maximum willingness and ability to pay for that product. Typically, consumers are placed within groups according to their wealth and products are distributed at different pricing tiers to the different groups. When well designed, differential pricing for pharmaceuticals can increase affordability for patients and increase profits for the pharmaceutical company. Many pharmaceutical companies have developed and implemented differential pricing schemes with success. GlaxoSmithKline (GSK) sells a portfolio of 25 medicines targeted at both CD and NCD areas at significantly lowered prices in

low-income countries. Merck also runs a differential pricing scheme for their diabetes medication Januvia. Novartis has developed a differential pricing scheme for insulin in developing countries. A distribution system with flow tracking and information sharing is essential to ensure medicines reach those communities most in need of preferential pricing.

Manufacturing Partnerships and Acquisitions in Developing Countries

Some pharmaceutical companies use joint ventures and acquisitions of local manufacturing companies as a strategy to achieve growth in emerging markets. This allows selecting prices more appropriate to the emerging markets without the risks of developed countries asking for the same prices as different companies manufacture the products. It also allows leveraging the marketing and distribution strengths of the local company. GSK has created a strategic partnership with Aspen Pharma, a South African generics manufacturer under which Aspen manufactures and distributes many of GSK's products in the region. GSK owns 18.5% equity stake in Aspen. Abbott Laboratories, another large multinational pharmaceutical company recently acquired Indian manufacturer Piramal Healthcare Limited to accelerate its growth in emerging markets.

Distribution Strategy for Emerging Markets

Apart from differential pricing, success in emerging markets will require distribution networks to reach areas, which the current distribution model does not reach. This may require major adjustments to current business models. Improving supply chain reach and efficiency will serve as the foundation of such a strategy. Although public investments in infrastructure will automatically increase supply chain reach and efficiency, it is unclear whether infrastructure growth will be able to match the needs to enable growth and coverage in a timely fashion.

Regional or Country-Level Prewholesaling Operations

The current structure of multiple wholesalers/importers purchasing directly from the manufacturer often creates supply chain inefficiencies. Manufacturers often sell to and invest in a single wholesaler to save on transaction costs. Selling to one wholesaler limits sales volumes and geographical reach. Given the large number of wholesalers this leads to the practice of horizontal selling where the single wholesaler then sells the manufacturer's products to other wholesalers and then on to subwholesalers and retailers. Sales between wholesalers at the national level often add an additional transaction cost and mark-up to the final retail price.

Even though having additional intermediaries usually leads to higher markups, introducing a prewholesaling operation may help aggregate and organize a highly fragmented wholesaler base. Prewholesalers allow manufacturers to distribute their product to multiple wholesalers and achieve higher volumes of sales, product reach, and market penetration without necessarily adding to the costs of creating a company-owned distribution or commercial entity. A prewholesaler could also reduce markups between national

wholesalers as well as reduce long lead times for orders improving the efficiency and financial stability of wholesalers who often have to find expensive working capital credit to cover lead times. In many instances the benefits (i.e., economies of scale and reduced transaction costs) outweigh the costs (i.e., increased margins) and a prewholesaler model helps improve overall supply chain efficiency.

New Retail Pharmacy Formats

Enhanced supply chain reach would require working with newer retail pharmacy formats. Instead of concentrating on a few hospitals and large pharmacies, growth will come from increasing points of sale. This would require accepting that not all retail points of sale for medicines will have the form, shape, and structure of a developed-country pharmacy. Regulatory hurdles will have to be carefully negotiated in making this change. Also cost for transit will have to be reduced significantly to reach a larger number of outlets without compromising margins. Health microfranchises represent a specific network of retail points of sale, which may be employed in the development of an optimum distribution network. These microfranchises are often developed as a means to improve access and quality of medicines and prescribing practices within emerging markets. Microfranchises are technically a part of the private sector, however, they are often accredited and maintain a certain quality standard regulated by the public sector. Accredited Drug Dispensing Outlets (ADDOs) in Tanzania, CARE shops in Ghana, and Child and Family Wellness (CFW) Shops in Kenya represent three similar microfranchise models that provide extensive sales networks, with a specific emphasis on serving remote communities.

New Models for Supply Chain Information Collection

Information flows in the supply chain where a third party information broker collects information about sales from each point in the supply chain may take years before it develops in many of the emerging markets. New models for collecting supply chain information should be examined for their feasibility. There are many new models that utilize technology to share real-time information throughout distribution networks. Logistimo, a web service run on mobile phones and Internet browsers, offers supply chain management tools specific to emerging markets. Similarly, All Indian Origin Chemists and Distributors Limited (AOICD) offers technology-based logistics services to pharmaceutical companies to improve supply chain and distribution network visibility and efficiency. SMS-for-Life is another example of technology (using SMS text and electronic mapping) that has effectively facilitated comprehensive and accurate stock counts of medicines at health facilities by district-level staff. SMS-for-life is a public-private partnership between Novartis, Vodafone, IBM, Ministry for Health of Tanzania, and the Roll Back Malaria Partnership.

Partnerships with Governments and Other Agencies

Leveraging public-sector resources to reach areas that a company cannot directly influence is another method for

improving reach. The resources required for expanding supply chain reach often are beyond the means of a single firm. Poor infrastructure in rural markets, such as roads, electricity, and telecommunications, create barriers to entry for many large manufacturers. The absence of mass media and communication platforms makes demand creation and awareness building among patients and community members very expensive, and inhibits the growth that can be achieved in rural markets. Partnerships should be formed with the government (at federal, state, and local levels) where common goals can be met through public-private partnerships.

Note that civil society and consumer groups often view new business models with mistrust. Partnering with organizations that have higher trust and confidence of the community ensures that the innovative distribution model can survive the early days of infancy without backlash from the civil society organizations and community groups because of misconceptions about the objectives of the model, etc.

Distribution Strategies of the Generics

Many small and large generic companies have achieved significant rural penetration in emerging markets. Carefully examining their distribution strategies can be a useful exercise while formulating a new distribution strategy. Many generic companies have set up rural-focused distribution channels and developed rural sales forces with locally trained staff. Mankind Pharmaceuticals and Cipla represent two such companies that have increased their product reach both domestically and within other countries through targeted distribution channels. This has given them stronger reach into both rural healthcare providers and rural pharmacies and drug shops. Some innovative pharmaceutical companies have also focused on the rural markets through patient education. The Arogya Parivar program from Novartis involves health educators, usually local women, who are recruited and trained to raise awareness about specific diseases. The initiative utilizes a special sales force to ensure that medicines are available in the most remote locations. The above strategies may not be sustainable for all companies, especially for companies with fewer and more costly products in their portfolio.

Conclusions

Emerging markets now represent a significant portion of the global pharmaceutical market and are growing at much faster rates than the more mature developed-country pharmaceutical markets. Pharmaceutical markets in emerging markets tend to be very different than developed markets with private sector out-of-pocket expenditures leading financing in Asia, some parts of Africa, and Latin America. Additionally, publicly funded medicines tend to be more prominent in other emerging market regions, especially within the African context. The nature of the distribution system used for pharmaceuticals in

emerging markets is different from developed-country pharmaceutical markets in several ways. Successful growth strategies for emerging markets will depend on expanding the reach of supply chains as well as increasing its overall efficiency. This article presents strategies used for achieving those goals.

See also: Pharmaceuticals and National Health Systems. Pharmacies. Pricing and Reimbursement of Biopharmaceuticals and Medical Devices in the USA

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