PGDM- IB (2014-16)
INTERNATIONAL MARKETING
Subject Code: IB-301
Trimester – III, End – Term Examination, April 2015

Time allowed: 2.5 hours . Marks: 50

Roll No. : _____

Instruction: Students are required to write their roll number on every page of the question paper, writing anything except the roll number will be treated as Unfair Means. In case of rough work, please use the answer sheet.

Section A

Attempt only THREE questions. Marks: 5*3=15
Word limit: 200 words

1. Briefly explain the distinction between construct and measurement equivalences.
2. Explain how parallel imports have become a major problem for pharma companies in many international markets?
3. Explain 3 controllable and uncontrollable variables each in pricing for exports.
4. Various stages of economic development of a country affect the demand of industrial goods. Comment on this statement.
5. Explain any two of the following concepts
    a. Transfer Pricing
    b. Dumping
    c. Countertrade

Section B

Attempt only TWO questions. Marks: 10*2=20
Word limit: 350 words

1. Explain the significance of culture and its impact on international marketing decisions.
2. Describe the trends in world trade. Briefly explain the reasons for such changes.
3. Selection of a market entry mode is the key decision companies have to take while expanding into overseas markets because it involves risk and a certain level of control. Explain how risk and control are affected by different entry methods..

Section C

Compulsory Case study Marks: 15

(1)

CASE 12.2

THE PRICE OF LIFE

In a surprising announcement, the world's second largest pharmaceutical company, GlaxoSmithKline (GSK), announced that it would slash prices on the pharmaceuticals it sold in the world's poorest countries. The company challenged other pharmaceutical firms to do the same. Specifically, GSK declared that it would cut prices for all drugs in the 50 least-developed countries to a level no higher than 25 percent of the price charged in the United States. The company also pledged to redirect 20 percent of its profits from poor countries to hospitals, clinics, and medical staff in those countries. In addition to slashing prices in the very poor markets, GSK also noted that it was determined to make drug prices more affordable in what it termed to be middle-income countries, such as Brazil and Mexico.

This was not the first time a global pharmaceutical company had taken such action. Eight years earlier, Merck declared that it would cut prices 40 to 55 percent in African markets on two of its recent AIDS-fighting drugs. Merck's powerful three-drug cocktail would be available in Africa for $1,330 a year, compared to approximately $11,000 in the United States. The company noted that it would be realizing no profits at this new price. Merck also pledged to extend these discounts to poor countries elsewhere in the world. Bristol-Myers followed suit, promising to slice the price of its AIDS drug Zerit to only $54 a year in Africa. At this price, Bristol-Myers claimed to be selling below costs. The company called on donor governments in Europe, Japan, and the United States to join in a vigorous international response to the AIDS crisis in Africa, where more than 26 million people are estimated to be infected with the HIV virus that eventually causes AIDS.

Only a week before, however, 39 major pharmaceutical companies had begun litigation to stop Indian pharmaceutical firms from selling generic versions of their patented drugs, including AIDS drugs, in the South African market. India had long refused to recognize pharmaceutical patents in order to supply its vast poor population with recent pharmaceutical products at much cheaper prices. Indian firms had become adept at reverse-engineering drugs and had become efficient producers and exporters of high-quality generics. When two Indian generic drug firms, Cipla and Hetero, entered a price war in Africa, prices on some key AIDS drugs fell precipitously. India had joined the WTO, and the country consequently agreed to bring its pharmaceutical protection laws more in line with world norms. However, change was not immediate, and patent protection cases were slowly working their way through the Indian legal system.

In the meantime, the fight to keep the prices of AIDS drugs high in Africa eventually failed, resulting in embarrassing public relations missteps for many global pharmaceutical companies. Consumer boycotts had even been threatened in developed markets. Many companies that held patents on AIDS pharmaceuticals lowered their prices to below that of the Indian generics. In some cases, donor organizations, such as the United Nations, helped supplement the low prices, bolstering the margins the pharmaceutical companies made off the sales. But primarily, the global pharmaceutical companies simply agreed to lower their prices. In the years that followed, access to life-saving AIDS treatments increased significantly in Africa, and the growth of Indian generics was somewhat abated.

Nonetheless, the fact that pharmaceutical companies continued to charge different prices in different countries for the same drug fueled controversy. For example, as markets matured in developed countries, many firms were counting on substantial growth among the middle classes in the developing world, especially in middle-income countries such as Mexico. However, they faced pressure to keep prices low in these countries as well. When Abbott Laboratories was told by the Thai government to lower its price on its latest version of the AIDS drug Kaletra, the company threatened to remove it from the Thai market. A consumer boycott of the company ensued, and Abbott agreed to lower the price to $1,000 a year. In another lower-middle-income country, Guatemala, the drug sold for

$2,200. The average salary in Guatemala was $2,400.

Similarly, Bristol-Myers Squibb charged four times as much for two of its AIDS drugs in Mexico as it did in sub-Saharan Africa. An AIDS treatment in middle-income Mexico could cost $6,000 in a country where the per-capita income was only about $7,300. An AIDS organization launched an ad campaign in the United States, specifically in Los Angeles, against Bristol-Myers demanding that the company lower its prices in Mexico.

Of course, consumers in developing countries rarely pay the full price of a drug, because governments often purchase and dispense critical drugs. As major buyers, governments too were concerned with costs. However, Indian generic giant, Aurobindo, sued the South African government when it chose a local producer's bid over Aurobindo's to supply an AIDS drug. Aurobindo claimed that their bid was priced about 30 percent lower than the winner's bid. However, the South African government produced a study showing that the local producer's tax contribution, linkages with local suppliers, and job creation supported the government decision to procure locally. In fact, emerging markets enforced some of the world's highest tariffs on pharmaceuticals. Iran had tariffs of 50 percent, India of 36 percent, and Brazil and Mexico of more than 35 percent.

Controversy was not limited to emerging markets. Even in developed countries, pharmaceutical prices could differ substantially. For example, drug prices were higher in the United States than in Europe, where governments paid for most prescription drugs. Consequently, European governments negotiated prices with pharmaceutical firms. For example, the antipsychotic drug Clozaril could cost $51.94 in Spain, $89.55 in Germany, $271.08 in Canada, and $317.03 in the United States. Ironically, over-the-counter drugs and generic versions of prescription drugs whose patents had expired could be cheaper in the United States than in Europe because of greater competition in the U.S. market.

Discussion Questions

1. What factors might contribute to GlaxoSmithKline's announcement to discount prices in emerging markets? Do you think these reasons are altruistic or self-serving?
2. Should U.S. consumers pay higher prices for pharmaceuticals than Africans? Why or why not?
3. Should Mexican consumers pay higher prices for pharmaceuticals than Africans? Why or why not?
4. Should U.S. consumers pay higher prices than Europeans for pharmaceuticals? Why or why not?
5. Should national governments pay more for locally produced pharmaceuticals?
6. What challenges might pharmaceutical companies face from widely disparate prices?

Sources: Sarah Boseley, "Drug Giant Pledges Cheap Medicine for World's Poor," February 14, 2009, *The Guardian*, p. 1; "The Price of Life," in Kate Gillespie, Jean-Pierre Jeannet, and H. David Hennessey, *Global Marketing* (New York:: Houghton-Mifflin, 2007); Theresa Agovino, "AIDS Group Launches Ad Campaign," *Associated Press Newswires*, February 23, 2007; Nicholas Zamiska and James Hookway, "Abbott's Thai Pact May Augur Pricing Shift," *Wall Street Journal*, April 23, 2007, p. A3; Philip Ngunjiri, "Big Pharma Still Ignoring the Poor," *All Africa*, December 10, 2007; and Mathabo Le Roux, "Indian Firm Sues Over Aids-Drug Tender," *All Africa*, June 29, 2009.