Glaxowellcome

Case 21 • The Headaches of GlaxoWellcome comply with regulations, and selling it to the end users while making a pro? t. In addition, there is a tariff for the import of candelilla wax into Japan of 3. 8 percent; this is for either ? rst or second re? ned candelilla wax. FUTURE OF THE CANDELILLA WAX INDUSTRY ? According to executives of Ceras Deserticas, the future of this market is promising. They expect growth in the future, although they they have not made public the actual estimated growth for the market. They are worried about the best path to take advantage of this growing and competitive market. The industry is consolidating and if Ceras Deserticas does nothing, it will either die or be taken over. As mentioned before, there are several joint ventures in which U. S. companies are investing in Mexico to guarantee a steady supply of candelilla wax. Both Ceras Nacionales de Mexico and • 735 Multiceras have established joint ventures with American companies. They are pursuing research and development to try to create a synthetic wax that can replicate the characteristics of candelilla wax and meet the requirements of end-users.

DISCUSSION QUESTIONS 1. Of the three options options presented at the beginning of ? the case, what should Ceras Deserticas do? 2. Why would Mitsuba Trading Co. be interested in a joint ? venture with Ceras Deserticas? 3. What would be the advantages and disadvantages for Ceras ? Deserticas of a joint venture? ? 4. What strategy must Ceras Deserticas follow in approaching joint venture? C ASE 21 THE HEADACHES OF GLAXOWELLCOME Migraine medicine is a key growth area for Glaxo Wellcome Inc. Glaxo); a Britain-based pharmaceutical company with global operations. 1 Glaxo’s primary business is to market prescription products to physicians and

healthcare providers. Glaxo was the ? rst pharmaceutical company to manufacture and market a revolutionary new class of prescription migraine medications called ‘‘ triptans’’. Triptans, which Glaxo launched in 1993, are a class of medications that work speci? cally on the 5HT-1 receptor sites, which are believed by doctors to be the primary cause of migraine headaches.

In mid May of 1997, Sir Benjamin Palmer, the general manager of Glaxo’s CNS/GI Metabolic division, sat at the head of the conference table in room G-1 of the Glaxo Wellcome global headquarters in Stockley Park West, England. A group of 6 marketers (3 from the ‘‘ Professional’’ team and 3 from the ‘‘ Commercial’’ team) were staged in front of Palmer and two vice presidents of sales (East and West). The three of? cers listened attentively to the ? nal marketing presentation that more than 60 marketing team members had worked on for the past 19 months.

The issue: How to launch Naramig, Glaxo’s new (second generation) prescription migraine medicine, in the U. K. In the back of Palmer’s mind were the following considerations: – Although Naramig was considered by Glaxo to be a better triptan than Imigran, in reality, there were some attributes of Naramig that were inferior to those of Imigran. – It was not as if Imigran had not been successful: Glaxo had captured 91 percent of the prescription medication market share (in ? s) for migraines in the U. K. – Glaxo expected the approval and launch of its competitor, Zeneca’s ? st triptan medication (Zomig) prior to that of Naramig, and likewise, expected Zeneca to market Zomig as a 2nd generation triptan. 8 1 Months Later 2 Early in February of 1998, a similar scene to that of 8 1 months 2 ago, in room G-1 of the U. K. headquarters, was taking place in a conference room

located at the U. S. home of? ce in Research Triangle Park, North Carolina. Mark Glackin, U. S. General Manager of Glaxo’s CNS/GI Metabolic Division, considered several marketing options presented by the team for the U. S. aunch of Amerge, Glaxo’s second-generation triptan that had been marketed in the U. K. as Naramig. 2 Although Glackin had several considerations to keep in mind, various factors and events gave Glackin a much different perspective than 1 that of Palmer 8 2 months earlier: • How would U. K. hospitals and doctors react to Glaxo’s promotion of Naramig? • Glaxo was apprised of the marketing strategy chosen by the U. K. for Naramig and its short-term results. • What was the best product positioning of Naramig withrespectto Imigran? This case was prepared by Jared Fontaine, Aaron C.

Lennon, and Robert Moscato of the Fox School of Business and Management at Temple University under the supervision of Professor Masaaki Kotabe for class discussion rather than to illustrate either effective or ineffective management of a situation described (2001). 1 Today the company is known as GlaxoSmithKline, which was formed in January 2001 as the result of a merger between GlaxoWellcome and SmithKline Beecham. • Zeneca’s Zomig had in fact been approved and launched in the U. K. prior to that of Naramig. The effects of Zomig on the success of Naramig and Imigran were therefore available for analysis by Glackin. Just as in the U. K. , Glaxo U. S. expected the approval and launch of Zomig in the U. S. prior to that of Amerge. 2 Like Amerge/Naramig, Glaxo’s research indicated that the name Imitrex would fare better than Imigran in the U. S. market. 736 • Case 21 • The Headaches of GlaxoWellcome EXHIBIT 1 The Businiess GW Portfolio: 1998 ? 1, 027m (+9%) ? 432m (+5%) ? 1, 971m (+24%) Respiratory Viral Infections CNS ?

688m (? 44%) ? 749m (+1%) ? 1, 209m (? 4%) ? 1, 089m (+31%) (Migraine ? 645m) Migraine Bacterial Infections Gastro-intestinal Oncology Others % of Sales 28 17 15 9 10 10 6 14

Total sales ? 7, 165m increase of 2% • Glaxo U. S. had launched the marketing promotion of Product Lines: MigraineDepressionGastrointestinal Imitrex (the U. S. brand name of U. K. ’s Imigran)3 Nasal Spray 5 months earlier. on pharmaceutical marketing, Glaxo U. S. could use directto-the-consumer (DTC) advertising to promote Amerge. • Unlike the U. K. , which has stricter government regulations • Allergy/Immunology/Respiratory Division Product Lines: Allergy/Immunology Asthma COPD COMPANY BACKGROUND GlaxoWellcome Inc. was formed in 1995 when U. K. based Glaxo Pharmaceuticals, a relatively young company, acquired U. K. pharmaceutical company Burroughs Wellcome in a corporate takeover. The acquisition made Glaxo Wellcome Inc. one of the top three pharmaceutical ? rms in the world with approximately 4 percent of the worldwide prescription pharmaceutical market. International Organization GlaxoWellcome Inc. is based in the U. K. with its Worldwide Headquarters located in Stockley Park West. As of 1997, Glaxo Wellcome Inc. had 22 local operating companies (LOCs) in 9 countries of which Glaxo U. S. was one. Although based in the U.

K. , the U. S. market made up approximately 40 percent of worldwide sales, while the U. K. only accounted for 7 percent. Due to the rigid guidelines of theFoodand Drug Administration (FDA), Glaxo’s products are generally introduced ? rst in one of the other 8 LOCs before gaining approval in the U. S. The majority of R&D and production for Glaxo takes place in the U. S. , U. K. , France, and Italy, each having both an R&D unit and manufacturing

plants. Organizational Structure/Product Lines The organizational structure of Glaxo Wellcome in both the U. K. and the U. S. s based around its 3 divisions and the product lines within each of those divisions: • HIV/Oncology Division Product Lines: HIV Cancer Glaxo sells prescription medications that fall into one of these three product lines. As of 1998, the migraine product line made up just over 9 percent of total Glaxo sales worldwide. The CNS/GI Metabolic division, of which migraine makes up 60 percent, grew 31 percent from 1997 to 1998 (see Exhibit 1). THE PHARMACEUTICAL INDUSTRY Pharmaceuticals are generally classi? ed into two categories: over-the-counter (OTC) and prescription medications.

As of 1998, there were no OTC drugs speci? cally formulated for migraine. After a pharmaceutical medication has been developed, there are two stages: approval and marketing. Approval In order for a pharmaceutical company to market and sell any medication that they have developed, the product must ? rst be approved by the respective regulatory body of each country (FDA in the U. S. , MCA in the U. K.). On average it takes 12 years for an experimental drug to travel from the lab to the medicine chest. Only ? ve in 5, 000 compounds that enter preclinical testing make it to human testing.

One of these ? ve tested in people is approved. Although each country has • Central Nervous System/Gastrointestinal Metabolic Division (CNS/GI) 3 Market research showed that U. S. consumers would be more responsive to the brand name ‘‘ Amerge’’ than that of ‘‘ Naramig. ’’ Case 21 • The Headaches of GlaxoWellcome its own particular set of guidelines and speci? c procedures for approval, new medicines are generally developed and

approved as follows: 1. Preclinical Testing—This is the exploratory process where a pharmaceutical company identi? es compounds through in vitro (test tube) testing.

The deliverable at the end of this process are compounds that can enter Phase One of Clinical Testing. 2. Clinical Trials, Phases—There are three mandatory phases of clinical trials. These clinical trials study the medicine's safety pro? le, how it is absorbed and distributed, the duration of its action, its ef? cacy, and side effects. 3. Application—Following the completion of all three phases of clinical trials, the company analyzes all of the data and applies for approval in the respective country if the data successfully demonstrate safety and effectiveness. The application contains all of the scienti? information that the company has gathered. At this point, the regulatory body may request further information. 4. Approval/Refusal—Once the regulatory body completes the professional assessment of all relevant information, it either approves the application and the new medicine becomes available for physicians to prescribe, or, if unsatis? ed, refuses to grant approval. There is one important distinction between the U. S. and the U. K. in the approval stage of pharmaceuticals. In the U. S. , every medication must be approved by the FDA before it can be marketed and sold.

However, because of the existence of the European Union (EU), it is possible that a medication may be approved in member nations without being professionally assessed and analyzed by each country's respective regulatory body. This means that if one member nation's (e. g. Sweden's) regulatory body approves a medication, the applying pharmaceutical

company can either ask the other EU member nations to ‘‘ recognize’’ Sweden’s approval or apply to each member nation separately. If one member nation approves a medication, then all of the countries in the ‘‘ Mutual Recognition’’ procedure have the same prescribing information.

However, if a medication receives independent approvals, then the prescribing information will be unique in each country. The difference can have an effect if applying in each country separately produces slightly different results in the trial phases (e. g. , perhaps the trials show that a medication is more effective for its desired indication during trials in the U. K. as compared to similar trials performed in Sweden). Marketing In general, products are marketed and advertised solely toward the ? nal consumer. This makes sense since it is the ? al consumer that ordinarily has the ? nal say as to whether he/she will actually purchase the product. However, pharmaceuticals are marketed to physicians and hospitals that in turn decide if they will prescribe the medication to their patients. U. S. vs. U. K Although it is illegal for pharmaceutical companies to advertise their products directly to patient/consumers in the U. K. , • 737 in the U. S. (as of 1997) direct-to-consumer (DTC) advertising is permitted. Research has shown that DTC advertising in the U. S. has a large impact on sales.

The research shows that patient’s requests for speci? c medications marketed by speci? c pharmaceutical companies affect the companies’ sales to physicians and hospitals. The other major difference in the pharmaceutical industry between the U. S. and the U. K. is the extent of governmental coverage. In the U. K. , thehealthcare system is socialized. Doctors are paid by the government with an additional payment per patient. Everyone is

entitled to free medical care under the plan, which is funded by the National Treasury and Health Insurance Tax. The U. S. on the other hand, has not employed socialized medicine, although Medicare and Medicaid cover a signi? cant part of the population. Instead, the U. S. health care system follows an insurance-based coverage scheme whereby individuals buy insurance from a company, which in turn pays for their medical costs. HEADACHES AND MIGRAINES Doctors classify headaches into three main types: • cluster headaches • tension-type headaches • migraines Cluster headaches are the most painful type but also quite rare and hence have not offered pharmaceutical companies a suf? cient market potential to pro? ably develop and market a medication speci? cally focused on curing these headaches. Tension-type headaches, while the most prevalent, are generally capable of being combated with over-the-counter medications such as aspirin and ibuprofen and hence, likewise do not offer Glaxo a pro? table market for which to develop a prescription product. Migraines, on the other hand, are suffered by an estimated 26. 3 million people in the U. S. , 5 million people in the U. K. , and at the time of Glaxo’s launch of Imigran/Imitrex, were not effectively treatable with over-the-counter medications.

Migraines are complicated combinations of intense pain (usually on one side of the head) and neurological symptoms like visual problems, nausea, vomiting, and sensitivity to light and sound, which often reduce the sufferer’s productivity and concentration and in some cases render the sufferer bedridden. In the U. K. about 18 million working days are lost to migraine sufferers a year. In the U. S. approximately 10 million migraine sufferers were bedridden for more than 3 million days per month and

experienced 74. 2 million restricted activity days per year (as of 1989). Such statistics translate to lost workplace productivity ranging from $5. billion to $17 billion annually in the U. S. and sick pay and replacement personnel costs of ? 750 million in the U. K. annually. Hence, in the early 1990s, Glaxo took advantage of the market potential for migraine-speci? c prescription drugs. 4 4 At the time of Glaxo Wellcome Inc. ’s entrance into the market for prescription migraine medicines, although doctors were prescribing drugs for migraines, these drugs were not migraine-speci? c but rather were drugs that were developed for general pain relief. 738 • Case 21 • The Headaches of GlaxoWellcome IMIGRAN/IMITREX In 1993, Glaxo Pharmaceuticals introduced in the U.

K. and the U. S. , the ? rst medication (triptan) speci? cally formulated for the acute treatment of migraine. 6 Imitrex/Imigran when initially launched in March of 1993 was produced in injection form. In 1995 and 1997, Glaxo followed up the marketing of Imitrex/Imigran by introducing line extensions in the forms of tablets and nasal spray, respectively (see Exhibit 2). Imitrex/Imigran5 uncomfortable injecting themselves). Sales of Imitrex/Imigran worldwide grew from less than $350 million in the year of its introduction to more than $1 billion in 1997.

Imigran/Imitrex SWOT Glaxo considered the strengths, weaknesses, opportunities, and threats of Imigran/Imitrex to be the following: Strengths— Imigran/Imitrex was the ? rst medication marketed toward speci? c migraine relief. Hence, Imigran/Imitrex had a strong brand image as the market leader, and in fact played a signi? cant role in the development of the migraine market. Imigran/Imitrex was also a potent medication with a proven

ef? cacy; it was in fact very successful in relieving the pain of migraine headaches. Although there were some side effects associated with the medication, Imigran/Imitrex has a proven safety pro? e. The fact that Imigran/Imitrex is offered in 3 different line extensions offers Glaxo a ‘‘ portfolio’’ of relief to offer to various patients. Weaknesses—The fact that Imigran/Imitrex is a potent medication has its downside as well. The medication proves to be too powerful for some patients, which therefore limits its use. Moreover, Imigran/Imitrex is expensive relative to OTC products that were used to ? ght headaches. This weakness of being expensive is exacerbated by the fact that the medication has a high rate of recurrence (a patient may need to take the drug more than once during a migraine).

Although Imigran/Imitrex is proven to be safe, because of the side effects (e. g. , tightening of the chest), there is a perception by some that the medication is not safe. Opportunities—Glaxo felt that having 3 product line extensions opened up the opportunity to perhaps exploit Imigran/Imitrex as a medication that is right for every kind of migraine sufferer. The biggest opportunity for Glaxo and Imigran/Imitrex is the fact that the migraine market was completely underdeveloped. EXHIBIT 2 Line Extension Injection Tablet Nasal Spray U.

K. 3/1993 5/1995 5/1997 U. S. 3/1993 7/1995 8/1997 These line extensions were spurred by the fact that only a small percentage of the total 26. 3 million migraine sufferers had ever tried Imitrex/Imigran in injection form. Hence, Glaxo, even 2 years after the introduction of Imitrex/Imigran injections, viewed the potential market as wide open. The injection

formulation of the product provides the fastest relief—as early as 10 minutes; the nasal spray—as early as 15 minutes; and the tablet—as early as 30 minutes.

Hence, Glaxo has been successful marketing the injection form of Imitrex/Imigran using a strategy of ‘‘ quick-relief’’ (an aspect that is very important to severe migraine sufferers) and successful marketing the tablet and nasal spray forms of the drug using a strategy of ‘‘ easy and painless administration’’ (an aspect that is important to migraine sufferers who are 5 The launch of Imigran/Imitrex came prior to the Glaxo Pharmaceuticals’ acquisition of Burroughs Wellcome, Inc. 6 Glaxo used the brand name Imitrex in the U. S. nd the brand name Imigran in the U. K. for the same product. Market research showed that the name Imitrex would fare better with U. S. physicians and hospitals. EXHIBIT 3 GlaxoWellcome Worldwide Migraine Franchise $m 1, 200 1, 000 800 600 400 200 0 1993 Injection 1994 1995 Tabs 1996 1997 1998 Nasal Spray Case 21 • The Headaches of GlaxoWellcome Threats—The two main threats to Imigran/Imitrex are that of competition and cannibalization. Glaxo was aware that Zeneca was close to marketing a competitor triptan called Zomig. Since

Imigran/Imitrex had been on the market for over four years, Glaxo felt that Zomig would be marketed as a ‘‘ second-generation’’ triptan (an improved version of Glaxo’s ? rst-generation Imigran/Imitrex). Imigran/Imitrex had also experienced some cannibalization effects between its 3 line extensions (see Exhibit 3). The Underdeveloped Migraine Market As of 1997, the fact of the matter, was that approximately 90 percent of migraine sufferers were not

being medicated with a triptan (see Exhibit 4). This meant that many people were still taking ineffective OTC drugs to combat their migraine pain.

Accordingly, Glaxo considered the market for ‘‘ triptan’’ drugs to have great potential. • 739 Exhibit 5 shows how Naramig/Amerge speci? cally compared to Imigran/Imitrex as a migraine medication. EXHIBIT 5 Imigran vs. Naramig MEASURE Speed of onset Peak efficacy Consistency of response Tolerability Incidence of chest pain Incidence of recurrence ORDER (best first) Imigran > Naramig Imigran > Naramig Imigran > Naramig Naramig > Imigran Naramig < Imigran Naramig < Imigran EXHIBIT 4 Migraine market = underdeveloped 48 million migraine patients 586 million migraine attacks/year

Naramig/Amerge SWOT Glaxo considered the strengths, weaknesses, opportunities, and threats of Naramig/Amerge to be the following: Strengths —Although not as powerful as Imigran/Imitrex, Naramig/Amerge was effective in relieving migraine pain. Its biggest strength, relative to Imigran/Imitrex was its mildness; the side effects caused by Naramig/Amerge were substantially less compared to Imigran/Imitrex, which gave it ‘‘ user friendly’’ image. Its long duration of pain relief gave Naramig/Amerge a low rate of recurrence; 67 percent of patients require only one dose of Naramig/Amerge over a 24-hour period.

Naramig/Amerge was able to be marketed as a true second-generation triptan (an improvement on the ? rst) since Glaxo was the company that had introduced the ? rst triptan medication. Weaknesses—The major weaknesses of Naramig/Amerge were twofold. First, it had a slow onset of action. This of course would turn off patients looking for fast relief. Second, Naramig/Amerge had only been developed in tablet form and therefore

lacked marketability in terms of line extensions. Opportunities—The market opportunity for Naramig/ Amerge was quite obvious.

At the time of Naramig/Amerge's approval, only 10 percent of all migraine attacks were being treated with triptan drugs. This meant that 90 percent of migraine sufferers were either not being treated at all, or treated with relatively ineffective medications. Threats—Like Glaxo's ? rst-generation triptan, Naramig/ Amerge's biggest threat came from Zeneca's Zomig. Although it was unclear how successful Zomig would be in stealing Glaxo's market share and expanding the market through sales to the untapped 90 percent, what was clear was that Zomig was likely to be approved in both the U.

K. and the U. S. prior to Glaxo obtaining approval for Naramig/Amerge. COMPETITION 60 Triptan Rx = 10% 526 Million Attacks Since its introduction in 1993, Imitrex/Imigran had clearly played a role in de? ning patient expectations. However, combining its awareness that Zeneca was in the process of developing Zomig and the fact that Glaxo, as a company, was always looking to bring new medications and improvements to the forefront, Glaxo had worked on developing a secondgeneration triptan of its own.

Company research revealed that for a new triptan product to be successful, patients and doctors would require it to be as effective as Imitrex/Imigran but with a longer duration of pain relief and a lower side effect pro? le. NARAMIG/AMERGE Naramig/Amerge, Glaxo's second-generation triptan, was actually being developed prior to the launch of Imigran/ Imitrex. 7 Amerge/Naramig, only available in tablet form, tested to have both a longer duration and a lower side effect pro? le than Imigran/Imitrex.

Although Naramig/Amerge was considered by Glaxo to be a better triptan than Imigran/Imitrex, in reality, there were attributes of Naramig/ Imigran that were inferior to those of Imigran/Imitrex. 7 Glaxo, as with Imigran/Imitrex, used the brand name Naramig in the U. K. and the brand name Amerge in the U. S. for this new ‘‘ triptan’’ drug. This decision was once again a product of market research. When Glaxo Pharmaceuticals acquired Burroughs Wellcome in 1995, they had already launched Imigran/Imitrex (1993). 740 • Case 21 • The Headaches of GlaxoWellcome However, Burroughs Wellcome was also developing a triptan of its own.

When the takeover took place, the Federal Trade Commission (FTC) forced Glaxo Wellcome to divest one of its triptan formulations because of antitrust implications (i. e. , monopolization). Having already successfully marketed Imigran/Imitrex, Glaxo Wellcome of course chose to divest the triptan that Burroughs Wellcome had developed. (Burroughs only completed about 55 percent of the clinical trials.) Zeneca purchased the rights to this incomplete triptan and ? nished the further development and application process of what came to be Zomig.

Glaxo had the following assumptions about Zomig: powerful means of maximizing market share, Palmer was unsure of the logistics of such an approach and worried about the ethical considerations of focusing the promotion of their product in areas based on factors such as socioeconomic status. Also, Palmer considered the fact that such a strategy may overlook patient needs. 3. An Alternative: Whereby Glaxo would market Naramig as an alternative to Imigran/Imitrex, (e. g. , superior; different; similar). The pros of the ‘‘ Alternative’’ strategy were that it could detract from competitor

noise, and could in fact devalue the image of the econd-generation triptan. This latter aspect may be an effective way to combat Zomig. The biggest drawback of this strategy was the idea that if there were no clear message (in terms of the medication that was best for migraines) it could lead to confusion and hence hurt Glaxo's image. 4. Replacement: Whereby Glaxo would discontinue the marketing of Imigran and focus solely on Naramig. This option ? t well with the overall concept that Naramig was an overall superior drug to Imigran. It would also allow Naramig to gain all the bene? s of a new compound: '' secondgeneration,'' safety, and low recurrence. However, Palmer worried about the confusion that would accompany such an approach and if a '' Replacement'' strategy would devalue Glaxo Wellcome in the eyes of physicians and hospitals. 5. Don't Launch: Whereby Glaxo would only continue to market Imigran and never launch Naramig. Although this strategy might class all triptans as the same, negating Zomig as a second-generation, Palmer had already made up his mind that not launching Naramig was a waste of an opportunity and of resources that went into developing the medication.

There was also the consideration that Zeneca would still be able to accomplish marketing Zomig as a second-generation triptan and leave Zeneca with an open ? eld. Naramig in the U. K. Palmer and his team chose a '' Replacement'' strategy for Naramig. This involved ceasing all promotion of Imigran (except to the extent of sales for patients who were already using Imigran) and positioning Naramig as the recommended starting place for migraine patients. Palmer felt that replacement was the best way to attract triptan-na? atients and ? ve capture the untapped market. Glaxo focused the

promotion around Naramig as a ‘‘ patient-friendly’’ medication providing patients with the best relief on the market. The results showed that the replacement strategy met Glaxo U. K. expectations. Naramig proved to be effective for migraine headaches in the majority of patients. In terms of the 90 percent untapped market, Naramig was preferred by 67 percent of previous non-triptan users. Exhibit 6 shows worldwide sales of Glaxo Wellcome’s two triptan drugs.

It is clear that the replacement strategy thwarted the growth of Imigran, and that Zomig and Naramig were both successful in expanding the market. PRODUCT POSITIONING: U. S Mark Glackin was now faced with the same decision that Palmer was faced with 8 ? months earlier. What was the best strategy to market Amerge with respect to Imitrex in the U. S. • Like Naramig/Amerge, Zomig had a lower recurrence rate than Imigran/Imitrex. • Zeneca would be successful in marketing Zomig as a secondgeneration triptan even though it was the company’s ? rst triptan. This was simply an issue of timing. Zomig’s ef? cacy was comparable to Imigran/Imitrex. • Zomig would be launched in both the U. K. and the U. S. prior to Naramig/Amerge gaining approval in both markets. PRODUCT POSITIONING: U. K Sir Benjamin Palmer sat in his of? ce weighing all the information he had just learned in the marketing meeting. There was only question to be considered; the considerations were complex; the answer to that question was crucial: the success of a major product line of Glaxo Wellcome hung in the balance. How should Glaxo Wellcome U. K. , position its new triptan Naramig?

Palmer wondered how U. K. hospitals and doctors would react to Glaxo’s promotion of Naramig when Imigran had been the ‘‘ gold standard’’ for the past 4 years and had captured 91 percent of the prescription migraine medication market share. Palmer’s bigger concern was how to position Naramig with respect to Imigran in order to capture the 90 percent of the market that was untapped (see Exhibit 4). Although Naramig was considered to be a better triptan than Imigran, perhaps there were new patients who would be partial to the characteristics of Imigran.

Just as important was what positioning strategy would be the most effective in ? ghting off the attack of Zeneca’s Zomig that Palmer expected to be launched in the U. K. prior to that of Naramig. Palmer had been presented by the marketing team with ? ve positioning strategies for Naramig: 1. Based Segment: Whereby Glaxo would target its marketing efforts toward different patient types. (e. g. , adolescents; elderly; chronic migraine; Imigran/Imitrex nonresponders; and patients who do not tolerate Imigran). Using such a strategy would allow Glaxo to promote Naramig where Imigran was weak to increase market share.

At the same time, though, it was not clear as to how the market should be segmented, or how able physicians would be to identify such segments. If in fact physicians had trouble identifying the different patient types, the effect may be to confuse the prescribing process. 2. Distribution Based Segment: Whereby Glaxo would segment the market based on distribution channels. (e. g. , hospitals only; clinics only; private channels; less wealthy areas). Although Glaxo considered this option to be a Case 22 • Benetton • 741 EXHIBIT 6 Sales (? m) 700 600 500 400 300 200 194. 04 100 35 0 8 6054

282. 588 362. 346 539. 451 Triptan Revenue 662. 12 671. 797 would have to consider this difference along with the differences in the respective health care systems. Would Glaxo U. S. be successful in using DTC advertising to offer a portfolio of migraine medication to various types of migraine patients, or should the U. S. follow a similar replacement strategy as the U. K. and position Amerge as the best migraine medication available. Glackin considered the same 5 options for Amerge positioning as Palmer had considered 8 ? months earlier for Naramig: 1.

Clinical/Patient Based Segmentation 2. Distribution Based Segment 3. An Alternative to Imitrex 4. A Replacement for Imitrex 5. Don’t Launch Amerge at All DISCUSSION QUESTIONS 1993 1994 Imigran 1995 1996 Zomig 1997 1998 Naramig market? Glackin had several considerations to keep in mind including the results of the ‘‘ Replacement’’ strategy chosen in the U. K. , and the effect of Zomig as a competitor. As was the case in the U. K. , Imitrex had largely de? ned the market for migraine medication and had been quite successful in capturing customers.

Glackin also expected that Zomig would be launched in the U. S. prior to that of the approval of Amerge. The U. S. had recently legalized DTC advertising. Glackin 1. Why is GlaxoWellcome introducing a second migraine medication? 2. How should GlaxoWellcome position Naramig in the U. K.? 3. Was the actually chosen strategy (option #4) the best decision? 4. How should GlaxoWellcome position Amerge in the U. S.? C ASE 22 BENETTON COMPANY BACKGROUND Benetton was founded as a single shop in Italy in 1965. Three years later the company expanded into France.

Eventually, Benetton spread throughout Europe and by 1979 it was established in the United States. Benetton Group S. p. A is a unique global group that is a part of a larger organization known as the Edizione Holding Group. This is the holding company through which the Benettonfamilyhas ownership in many different businesses including hotels, publishing, and real estate. The Edizione Holding Group as well as the Benetton Group was founded by the Benetton family, which is made up of four siblings: Luciano, Chairman; Gilberto,

Deputy Chairman and Joint Managing Director; Carlo, Director; and Giuliana, Director, who own and run the company as shown in Exhibit 1. Luciano’s son, Alessandro, is also one of the eight Directors. This global Benetton Group specializes in designing and manufacturing of clothing within the textile-apparel sector of industries, and combines this know-how with the strong identity and image of world-leading sports brands that have been incorporated through the acquisition of the Benetton Sportsystem business.

These sports brand names are encompassed under the Playlife label and include Rollerblade, Killer Loop, Prince, and Nordica. The clothing sector includes casual and sportswear, consisting of the Sisley, United Colors of Benetton (UCB), and Undercolors of Benetton brands, which are mainly produced and distributed by the Automated Distribution Center in Castrette, Italy, the factory that produces over 90 million items of clothing each year. There are production facilities in France and Spain as well. These ? ished and packaged products are the dominant production category for the company and are distributed directly to the Benetton Group’s 7, 000 retail stores located in 120 countries, of which only 55 stores are owned by the company,

with the remaining stores independently owned and operated. The second production category for Benetton comprises the sports equipment and performance-wear item and a third category encompasses items such as footwear, bags, and accessories. Benetton’s overall turnover amounts to about 4, 000 billion lire.

Recently, in 2003, the company initiated an effort to diversify away from its main clothing business by moving to acquire Italian highway operator, Autostrade. This case was prepared by Eunjung Jenny Chun, Juliet Freedman, and Nicole Parker and updated by Sonia Ketkar of the Fox School of Business and Management at Temple University under the supervision of Professor Masaaki Kotabe for class discussion rather than to illustrate either effective or ineffective management of a situation described (2003).