

**RESEARCH PAPER****Sales Force Management and Channel Management in Indian Pharmaceutical Distribution: A Qualitative Field Study of Torrent Pharmaceuticals****Pulkit Rathi and Rakesh Kumar Singh**

Institute of Management Technology, Ghaziabad

Email ID: pulkitrathi09@gmail.com**ABSTRACT**

This paper examines the interdependence of sales force management and channel management practices in the Indian pharmaceutical industry, using a single-company qualitative field study of Torrent Pharmaceuticals' gastroenterology division in Delhi. Pharmaceutical selling differs from consumer-goods selling in that demand is created by influencing prescribers rather than end consumers, which places unusual weight on the sales force as a relationship-building asset and on the distribution channel as the mechanism that converts prescriptions into purchases. Using semi-structured interviews with three respondents occupying distinct positions in the sales and distribution hierarchy - a Regional Sales Manager, an Area Sales Manager, and a Medical Representative - the study documents the organizational hierarchy, recruitment and training practices, territory design, performance control systems, channel structure, and sources of channel conflict. Thematic analysis of the interview data is examined against established frameworks in sales force control, span of control, relationship selling, and channel management theory. The findings indicate that Torrent operates a hybrid behavior- and outcome-based control system, a pooled territory model that secures coordination at the cost of individual accountability, and a four-tier distribution channel whose principal vulnerabilities are commission-linked partner disengagement during periods of stagnant growth and unresolved product-expiry disputes. The study also surfaces an informal, relationally embedded market-intelligence mechanism in which retail chemists function as de facto prescription monitors. The paper concludes with practical implications for performance measurement design and channel governance in pharmaceutical sales organizations, and notes the methodological limitations of a small, single-company, interview-only sample.

Keywords: sales force management, channel management, pharmaceutical distribution, territory management, sales force control, relationship selling

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INTRODUCTION

The pharmaceutical industry operates a demand-creation model that is structurally distinct from most consumer goods sectors. In fast-moving consumer goods (FMCG), demand is generated through advertising and direct consumer pull. In pharmaceuticals, by contrast, demand is created indirectly: sales personnel influence prescribers - primarily physicians - who then direct patients toward specific branded medicines. This single structural fact has wide-ranging implications for how pharmaceutical companies organize, train, deploy, and monitor their sales forces, and for how they design and manage the distribution channels that must convert a prescription into an available, dispensed product at the point of sale.

Because the prescriber, not the patient, is the locus of the purchase decision, the pharmaceutical sales force functions less as a transactional selling unit and more as a relationship-management function operating over long, trust-dependent sales cycles. At the same time, the distribution channel - typically structured as a sequence from manufacturing plant to carry-and-forward agent (CFA) to stockist to

retail chemist to patient - must operate with sufficient reliability and speed that a generated prescription is never lost to a stockout. Sales force effectiveness and channel efficiency are therefore not independent management problems; they are interdependent components of the same demand-fulfilment system. A motivated and well-trained sales force that generates prescriptions in a market where the product is not consistently available achieves little, just as an efficient channel cannot compensate for a sales force that fails to build the prescriber relationships on which Indian pharmaceutical demand depends.

Despite this interdependence, sales force management and channel management are frequently treated as separate domains of inquiry - the former drawing on sales force control and relationship-selling theory, the latter on channel-length and channel-conflict theory. There is comparatively less field-level evidence that examines both domains together, within a single organizational account, in a way that traces how control mechanisms at the sales force level interact with coordination mechanisms at the channel level. This paper addresses that gap through a qualitative case examination of one division of one company.

The empirical setting is the gastroenterology division of Torrent Pharmaceuticals Limited, operating in the Delhi market. Torrent Pharmaceuticals is an India-headquartered, research-driven pharmaceutical company with a multi-decade operating history and a broad therapeutic portfolio spanning gastroenterology, cardiology, central nervous system disorders, diabetology, and gynaecology. Its gastroenterology division in Delhi is described, by respondents internal to the organization, as one of the company's more competitive and revenue-significant business lines, deploying a field force of approximately twenty-four to thirty Medical Representatives (MRs) under the supervision of Area Sales Managers (ASMs) and a Regional Sales Manager (RSM).

The objectives of this study are to: (i) document the hierarchical structure of the sales organization and the role responsibilities at each level; (ii) examine recruitment, induction, and training mechanisms for the field sales force; (iii) analyse territory allocation and daily work-planning practices; (iv) study the performance monitoring systems, reporting mechanisms, and review cadences used to control and evaluate the sales force; (v) map the pharmaceutical distribution channel and the roles of channel intermediaries; (vi) examine the nature and resolution of channel conflict; and (vii) interpret these field-level observations against established theoretical frameworks in sales and channel management in order to derive practice-relevant implications.

LITERATURE REVIEW

Sales Force Management and Organizational Structure

A foundational concern in sales force management is the design of the supervisory hierarchy, particularly the span of control - the number of subordinates a manager can effectively supervise. Ingram, LaForge, Avila, Schwepker, and Williams (2015) argue that in complex, relationship-intensive selling environments, spans of control should be kept narrow, typically in the range of four to six direct reports, in order to permit meaningful coaching, joint working, and individualized performance feedback. Wider spans dilute supervisory attention and weaken the manager's ability to intervene in individual performance problems before they compound. This principle is particularly salient in pharmaceutical selling, where the sales process depends on cultivated, long-duration relationships between representatives and prescribers rather than discrete, easily monitored transactions.

Sales organization design in pharmaceutical companies typically reflects a multi-tier hierarchy in which strategic responsibility is concentrated at higher levels (zonal and regional management) while operational execution and relationship-building occur at the field level (medical representatives). The literature on sales organization structure generally holds that the effectiveness of such hierarchies depends on the clarity of role differentiation at each tier and on the extent to which geographic or therapeutic specialization is used to reduce coordination costs.

Territory Design and the Free-Rider Problem

Territory design in sales organizations involves allocating accounts, geography, or customer segments to individual representatives or teams in a manner intended to balance market potential, travel

efficiency, and workload. While individual territory assignment with individually owned targets is the conventional model, some organizations adopt pooled or team-based territory structures, in which a collective target is shared across a group of representatives covering a common geography.

Pooled compensation and target structures introduce a well-documented agency problem: the free-rider problem, as formalized by Holmstrom (1982) in the context of team production and moral hazard. When individual contribution cannot be cleanly disentangled from collective output, each agent's incentive to exert maximal individual effort is weakened, because the cost of reduced effort is partly absorbed by the group rather than borne entirely by the individual. High-performing agents may become demotivated when their incremental contribution goes unrecognized, while low-performing agents can shelter within the average performance of the group. This tension between the coordination benefits of pooled structures and the accountability costs of diminished individual differentiation is a central theoretical concern for any sales organization that adopts team-based territory or target design.

Sales Force Control Systems

Anderson and Oliver's (1987) typology of sales force control systems distinguishes between behavior-based control, in which management monitors and evaluates the activities and processes a salesperson undertakes (such as call frequency, coverage, and reporting compliance), and outcome-based control, in which management evaluates results (such as sales volume or revenue) with comparatively less attention to the process by which those results were achieved. Anderson and Oliver argue that behavior-based control is more appropriate in selling environments characterized by long, non-routine sales cycles in which outcomes are delayed and difficult to attribute to specific behaviors in the short term - a description that closely matches pharmaceutical selling, where a prescription is typically the product of cumulative relationship-building over an extended period rather than a single sales encounter.

In practice, most mature sales organizations operate hybrid control systems that combine behavior-based elements (activity reporting, compliance monitoring, coverage frequency) with outcome-based elements (sales tracking against targets), in proportions calibrated to the nature of the selling task. The robustness of such hybrid systems depends, in part, on the quality of the proxy measures used for behavior-based control: where the behaviors being monitored are easily falsified, gamed, or only loosely correlated with the underlying outcome of interest, the control system's diagnostic value is correspondingly weakened.

Relationship Selling

Relationship selling theory holds that, in selling contexts characterized by repeated interaction, professional judgment, and an intermediary decision-maker acting on behalf of an end consumer, interpersonal trust between the salesperson and the buyer is a significant predictor of purchase loyalty and continued engagement. Palmatier, Dant, Grewal, and Evans (2006), in a meta-analytic review of relationship marketing, demonstrate that relational constructs such as trust and commitment exert a measurable influence on seller performance outcomes, particularly in business and professional contexts where the immediate buyer is not the final beneficiary of the product. This literature is directly relevant to pharmaceutical selling, in which the physician - who does not personally consume the product - exercises a form of agency on behalf of the patient, and where the physician's prescribing choice among largely substitutable branded alternatives is plausibly influenced by the quality of the relationship with the representative promoting the brand, in addition to clinical considerations.

Channel Structure and Channel Length

Channel management theory addresses the question of how many intermediary tiers should exist between a manufacturer and the end consumer, and what functions each tier should perform. Stern and El-Ansary's (1992) classic treatment of marketing channels argues that channel length and structure should be calibrated to the complexity of the product, the geographic dispersion of demand, and the specific intermediary services required (such as inventory holding, credit extension, or last-mile distribution). Channels that carry unnecessary intermediary tiers incur additional margin leakage and coordination cost without a corresponding service benefit, whereas channels that are too lean for the complexity of the product or market may underprovide essential intermediary functions.

In the Indian pharmaceutical distribution context, the channel typically comprises a manufacturing plant, a carry-and-forward agent (CFA) acting as a regional warehousing and distribution point, a stockist (wholesale distributor), and a retail chemist who dispenses the product against a prescription. The absence of a “super stockist” layer - found in some FMCG distribution systems - represents a comparatively lean channel design for an industry in which brand strength and prescription-led pull reduce the need for additional intermediary inventory-holding capacity.

Channel Conflict and Coordination

Channel conflict arises when the interests, incentives, or operational practices of channel members diverge, producing friction that can disrupt the flow of product or information through the channel. In pharmaceutical distribution specifically, two recurring sources of conflict are commonly identified: disputes over the handling of products approaching expiry (which intermediaries are often unwilling to hold as unsellable inventory without compensation) and parallel or “grey market” imports, in which intermediaries source product from other geographic markets at different price points, undermining locally administered pricing. Christopher's (2016) work on logistics and supply chain management emphasizes that responsive, demand-data-driven replenishment - using real-time sales information to trigger restocking rather than relying on fixed periodic ordering cycles - is a defining feature of lean, well-coordinated supply chains, and that digitization of order and billing information is a key enabler of this responsiveness.

Synthesis and Positioning of the Present Study

Taken together, this literature suggests that pharmaceutical sales organizations sit at the intersection of several theoretical concerns that are usually examined separately: the design of sales force hierarchy and control systems (Ingram *et al.*, 2015; Anderson & Oliver, 1987), the agency risks of team-based incentive structures (Holmstrom, 1982), the relational foundations of professional selling (Palmatier *et al.*, 2006), and the structural and conflict-related dynamics of distribution channels (Stern & El-Ansary, 1992; Christopher, 2016). The present study contributes a single, field-grounded account that traces these themes concurrently within one organizational hierarchy and one channel structure, allowing their interdependence - rather than each theme in isolation - to be examined.

RESEARCH METHODOLOGY

Research Design

This study adopts a qualitative, interpretive research design grounded in primary field data. The choice of a qualitative approach follows from the nature of the research objectives: the study seeks to understand complex organizational processes, managerial judgment, and inter-personal dynamics within a single firm's sales and distribution system, rather than to test a quantifiable hypothesis across a sampled population. Processes such as relationship-based selling, informal channel coordination, and the lived experience of territory management involve tacit knowledge and contextual nuance that are not readily captured through structured surveys or secondary data alone. A qualitative, interview-based design allows respondents to describe their operating practices, illustrate them with specific incidents, and articulate challenges in their own professional vocabulary, which is essential for the kind of process-level understanding this study seeks to generate.

Sampling Approach and Respondents

The study employs purposive sampling, in which respondents were deliberately selected to represent distinct, complementary positions within the sales and distribution hierarchy rather than to constitute a statistically representative sample of any single role. Three respondents were interviewed:

- **Respondent 1 (Regional Sales Manager, RSM):** oversees the entire Delhi gastroenterology division, supervising five Area Sales Managers. The RSM was the primary source of insight on regional strategy, territory design philosophy, performance review cadence, and channel-level (CFA and stockist) oversight.

- **Respondent 2 (Area Sales Manager, ASM):** manages a team of approximately six Medical Representatives across North and West Delhi, spanning gastroenterology and adjacent therapeutic responsibilities. The ASM was the primary source of insight on recruitment criteria, compliance monitoring, coverage frequency, and channel-level product rollout strategy.
- **Respondent 3 (Medical Representative, MR):** covers frontline sales activity in West Delhi, managing a defined doctor and chemist base. The MR was the primary source of insight on daily work planning, doctor coverage norms, and chemist-based prescription verification practices.

This purposive design ensures that the data span the full value chain of the sales and distribution system - from strategic and channel-level oversight at the RSM tier to ground-level execution and prescription verification at the MR tier - enabling triangulation of perspectives across organizational levels rather than reliance on a single vantage point.

Data Collection Instrument

Data were collected through semi-structured interviews, conducted using an interview guide developed prior to data collection and organized around two thematic domains: (a) sales force management and (b) channel management. Within the sales force management domain, the guide addressed organizational structure and reporting hierarchy, recruitment and selection criteria, induction and ongoing training, territory design and daily work planning, performance monitoring and key performance indicators, incentive structures, and the handling of underperformance. Within the channel management domain, the guide addressed channel structure and supply chain flow, the selection and management of CFAs and stockists, product availability and inventory monitoring, channel coordination mechanisms, the nature and resolution of channel conflict, and channel partner motivation and evaluation. The semi-structured format was chosen specifically because it combines the discipline of a consistent topic checklist - ensuring comparability of coverage across the three respondents - with sufficient flexibility to probe unanticipated themes that emerged organically during each interview, such as the role of emotional rapport in prescription generation or the staged rollout strategy for new product launches.

Method of Analysis

All interviews were conducted verbally and subsequently transcribed in full. The transcribed data were analysed using thematic analysis, a method appropriate for identifying, organizing, and interpreting recurring patterns of meaning across qualitative data. Themes were derived both deductively, from the structure of the interview guide (sales force management and channel management as a priori domains), and inductively, from patterns that emerged directly from the data and had not been explicitly anticipated in the interview guide (for example, the cultural significance of the pooled territory model and the informal chemist-based intelligence loop).

DATA COLLECTION AND ANALYSIS

Interview Conduct

Interviews were conducted individually with each of the three respondents, as the basis for discussion while allowing departures from the guide where respondents introduced relevant detail. Each interview was conducted verbally and subsequently transcribed for analysis. The use of direct, role-specific respondents - rather than a single informant attempting to describe the entire system - was intended to reduce the risk that any one level of the organization's perspective would dominate the resulting account, and to allow cross-referencing of descriptions of the same process (for example, territory design, or prescription verification) as reported independently by respondents at different levels of the hierarchy.

Coding and Thematic Organization

Following transcription, the interview data were read in full and organized into the two a priori thematic domains established in the interview guide: sales force management and channel

management. Within each domain, sub-themes were identified inductively by grouping related statements and incidents described by respondents. For the sales force management domain, the resulting sub-themes were: organizational hierarchy and span of control; recruitment and induction; territory management and work planning; and performance monitoring systems. For the channel management domain, the resulting sub-themes were: channel structure and distribution flow; chemist relationships and prescription verification; and channel conflict and resolution.

Within each sub-theme, illustrative statements from respondents were retained as supporting evidence, and the analysis proceeded by examining (a) what each respondent described as standard or formal practice, (b) where respondent accounts corroborated or extended one another across hierarchy levels, and (c) where respondents themselves identified limitations, vulnerabilities, or informal workarounds in the system they described. This last category - limitations and vulnerabilities acknowledged by respondents themselves rather than inferred externally - proved particularly valuable, since it surfaced candid assessments (for example, the Area Sales Manager's acknowledgment that prescription claims by doctors are not always corroborated by chemist-level dispensing data, and the Regional Sales Manager's acknowledgment that carry-and-forward agent commitment weakens when divisional sales growth stagnates) that might not have been visible through observational or document-based methods alone.

Analytical Approach to Theory Integration

Having organized the data thematically, the findings were then examined against the theoretical frameworks: sales force control theory (Anderson & Oliver, 1987), span-of-control principles (Ingram *et al.*, 2015), the free-rider problem in team-based incentive structures (Holmstrom, 1982), relationship selling theory (Palmatier *et al.*, 2006), channel length and structure theory (Stern & El-Ansary, 1992), and lean supply chain principles (Christopher, 2016). This step moved the analysis from description (what the respondents reported) to interpretation (how the reported practices align with, depart from, or extend established theoretical expectations), and forms the basis for the Results and Discussion.

RESULTS AND DISCUSSION

Organizational Hierarchy and Span of Control

The Delhi gastroenterology division operates a three-tier field hierarchy: the Regional Sales Manager oversees five Area Sales Managers, each of whom supervises four to five Medical Representatives, for a divisional field strength of approximately twenty-five MRs. The Regional Sales Manager explained the rationale for this structure directly in terms of supervisory feasibility, noting that direct, daily coordination of the full field force by a single manager is not practicable, and that the intermediate Area Sales Manager tier exists specifically to keep each manager's span of direct reports within a coachable range.

This structure is broadly consistent with the span-of-control principle articulated by Ingram *et al.* (2015), which holds that narrow spans (four to six direct reports) are appropriate in relationship-intensive selling environments to permit meaningful coaching and joint field engagement. The geographic clustering of Medical Representatives under each Area Sales Manager - for example, assigning a single ASM to adjoining West and North Delhi zones - further reflects a deliberate effort to minimize travel overhead and enable frequent joint field visits, rather than an arbitrary administrative division.

A notable tension, however, emerges at the Regional Sales Manager's own level: the RSM supervises five Area Sales Managers across a market as large and therapeutically diverse as Delhi, which - by the RSM's own account - leaves limited bandwidth for the kind of strategic, senior-level relationship-building (for example, with key opinion leaders among physicians) that the RSM identifies as an important part of the role. This suggests that the span-of-control discipline applied carefully at the ASM-MR interface is not symmetrically applied at the RSM's own level, a structural inconsistency with implications for how senior managerial time is allocated.

The Pooled Territory Model

A structurally distinctive feature of the Delhi operation is its use of a pooled territory model, in which a collective monthly sales target - in the range of ₹1.2 to ₹1.5 crore - is shared across the division's roughly twenty-four Medical Representatives, rather than being allocated to each representative individually. Respondents at both the Area Sales Manager and Medical Representative levels confirmed this practice and described its coordination benefits: it removes the need to adjudicate territorial boundary disputes between representatives and simplifies the target-setting process for management. This design, however, carries the theoretical risk identified by Holmstrom (1982) as the free-rider problem: when individual output cannot be cleanly separated from a group's collective result, each individual's incentive to maximize personal effort is diluted, because part of the cost of reduced effort is absorbed by the group rather than borne by the individual alone. High-performing representatives may experience reduced motivation if above-average contribution is not separately recognized, while underperforming representatives may be shielded by the group average. The Medical Representative interviewed for this study described a personal activity standard - meeting twelve to fourteen physicians daily - that appeared to function as an internalized discipline independent of the pooled structure, suggesting that individual conscientiousness and close ASM-level activity monitoring may partially offset, without fully resolving, the structural accountability gap inherent in the pooled model. The absence of any individually owned outcome target, however, remains a design feature with limited theoretical justification beyond administrative convenience.

Performance Monitoring as a Hybrid Control System

Torrent's performance monitoring architecture for the sales force combines several mechanisms operating at different time horizons: daily digital activity logging via a proprietary reporting portal; weekly compliance monitoring of physician coverage frequency by the Area Sales Manager; weekly tracking of secondary sales (product movement from stockist to chemist) as a market-pull indicator; and a review cadence that is nominally monthly but which the Regional Sales Manager described advocating, in practice, on a weekly basis.

This combination of activity-based monitoring (calls made, coverage compliance) and outcome-based monitoring (secondary sales trends) corresponds closely to the hybrid control system described by Anderson and Oliver (1987), and is theoretically well-suited to a selling environment - such as pharmaceutical detailing - in which the link between any single sales activity and an eventual prescription outcome is long, indirect, and difficult to attribute in the short term. The presence of behavior-based controls (coverage compliance, call frequency) provides management with an intermediate, near-term signal of effort and discipline that does not require waiting for a delayed outcome measure to surface a performance problem.

The system's most significant gap lies in the quality of the proxy used to verify prescription generation, which is the ultimate outcome of interest. The only verification mechanism available to Medical Representatives is informal feedback solicited directly from chemists regarding how frequently a given physician's prescriptions for the company's brand are being dispensed. The Area Sales Manager explicitly acknowledged that this method is imprecise - that comprehensive, doctor-by-doctor prescription verification across a market as large as Delhi is not feasible - and that physicians' self-reported prescribing claims are not always corroborated by what chemists actually dispense. This represents a measurement validity gap: the behavior-based and intermediate outcome-based controls in place are reasonably robust, but the most consequential outcome metric - actual prescription volume attributable to a specific physician relationship - is measured only indirectly, informally, and with acknowledged unreliability.

Relationship Selling as the Operative Mechanism of Prescription Generation

Across the interview data, a recurring and theoretically significant theme is the centrality of interpersonal, emotionally grounded relationship-building to prescription generation, as distinct from the formal activity metrics (call frequency, coverage) that the organization's control systems primarily measure. The Area Sales Manager articulated this directly, observing that a physician's choice among

substitutable branded products is driven less by the frequency of sales calls and more by the emotional connection established with a specific representative.

This finding aligns closely with relationship selling theory as developed by Palmatier *et al.* (2006), which establishes that interpersonal trust and relational commitment are significant predictors of buyer loyalty in professional and business contexts - particularly where, as in pharmaceutical selling, the immediate decision-maker (the physician) is not the end consumer of the product (the patient) but acts in an agency capacity. The Area Sales Manager's emphasis on consistency - reliable attendance, follow-through on commitments, and professional conduct - as the substrate of physician trust is a practitioner-derived articulation of relationship marketing constructs that is rarely captured directly in the company's formal measurement systems, which monitor activity volume rather than relationship quality.

This finding has a direct organizational implication that the data itself partially surfaces: if relational quality, rather than call volume, is the binding constraint on prescription generation, then a control system built primarily around activity counts is measuring a necessary but insufficient condition for the outcome the organization actually wants. It also offers a theoretical explanation for the strategic importance of territory stability - that is, retaining the same representative in the same territory over time - since frequent reassignment of representatives would reset the relational capital that, on this account, drives prescribing behavior more than any single sales call.

Recruitment, Induction, and Training

Recruitment of Medical Representatives follows criteria combining age (generally under thirty, with limited exceptions for younger high-potential candidates), prior relevant field experience (typically three to four years in the specific territory or therapeutic area), and communication ability. A notable strategic feature of this hiring profile is the explicit preference for candidates with prior experience in the specific territory being staffed, on the rationale that such candidates bring pre-existing relationships with local physicians and chemists, shortening the ramp-up period in a selling context where relational capital is the primary driver of performance.

Induction training covers two domains: product and clinical knowledge, and operational training on the company's reporting portal. Ongoing training thereafter follows a cyclical model, in which Product Managers conduct periodic refresher sessions on specific brands at intervals of roughly ten to fifteen days, ensuring that product knowledge remains current. This training model, however, is narrowly product-focused. None of the respondents described any structured training component addressing consultative selling, negotiation, objection handling, or relationship management - despite the same respondents (the Area Sales Manager, in particular) identifying these relational competencies as the primary determinant of prescription-generation success. This represents a notable misalignment between what the organization's own field managers regard as the critical skill set for performance and what its formal training curriculum actually develops.

Channel Structure and Distribution Flow

The distribution channel follows a four-tier sequence: manufacturing plant to carry-and-forward agent (CFA), CFA to stockist, stockist to retail chemist, and chemist to patient, with no intervening super-stockist layer. The CFA functions as a regional warehousing and distribution node, expected to fulfil stockist orders within forty-eight to seventy-two hours, and is compensated through a sales-volume-linked commission structure that aligns CFA incentives with company revenue growth under normal conditions.

This lean, four-tier structure is broadly consistent with the channel design principle articulated by Stern and El-Ansary (1992), which holds that channel length should be calibrated to product complexity, market geographic spread, and the specific intermediary functions required. For an established pharmaceutical brand with prescription-led demand pull, a direct CFA-to-stockist linkage - without an additional super-stockist tier - is consistent with minimizing margin leakage while retaining the warehousing and credit functions that the CFA and stockist tiers respectively provide.

The CFA's commission-based incentive structure, however, introduces a conditional vulnerability that the Regional Sales Manager identified candidly: CFA commitment to a given division is observed to

correlate with that division's sales growth, such that a CFA may deprioritize a stagnant or declining division in favour of allocating warehousing and distribution attention to more dynamic product lines. This indicates that the CFA relationship, although structurally aligned with company incentives under growth conditions, is fundamentally transactional and comparatively fragile when growth slows - a channel-partner risk that is not addressed by the commission structure itself and would require active relationship management to mitigate.

Technology-Enabled Channel Transparency

The digitization of CFA ordering, billing, and stockist activity monitoring represents a meaningful advance in channel coordination. The Regional Sales Manager receives daily billing data from the CFA and can identify, in near real time, any stockist that has not placed an order within the preceding week, triggering a follow-up field visit. When the CFA reports a shortage, the Regional Sales Manager escalates the matter to the supply chain function for expedited dispatch based on recent monthly sales data.

This responsive, data-triggered replenishment behavior - using current sales information to drive restocking decisions rather than waiting for a fixed periodic ordering cycle - is consistent with the lean supply chain principles described by Christopher (2016), and represents a substantive improvement over the manual, batch-oriented coordination that such systems typically replace. The transparency this digitization provides also appears to have reduced the incidence of one major historical category of channel conflict: disputes arising from short supply or unclear billing, which the Regional Sales Manager indicated have become significantly less frequent as a direct consequence of the digital audit trail.

Channel Conflict: Expiry Disputes and Parallel Imports

Two recurring sources of channel conflict were identified across respondent accounts. The first is product expiry management: industry convention prohibits dispatch of stock with less than six months of remaining shelf life, and stockists holding slower-moving inventory that approaches this threshold may seek a credit note or product return. The Area Sales Manager described instances in which delayed expiry settlement - extending over several months - visibly strained the working relationship between stockists and field sales personnel, with stockists at times adopting an adversarial posture toward representatives over unresolved settlements that were, in fact, a company-level administrative matter rather than a failure of the field force itself.

The second source is parallel or grey-market importation, in which stockists source product from other geographic markets at different price points, creating local pricing inconsistencies. Respondents indicated that this form of conflict is comparatively more difficult to manage than expiry disputes, owing to the fragmented structure of the stockist network and the practical difficulty of policing inter-market product flows.

Both conflict types appear to be structural features of the Indian pharmaceutical distribution system more broadly, rather than failures specific to Torrent's channel management. The expiry-related conflict category, in particular, appears amenable to procedural mitigation (for example, through proactive expiry monitoring and committed credit-note timelines), whereas the parallel-import category is more resistant to firm-level resolution given its dependence on market-wide pricing and distribution fragmentation.

Chemists as an Informal Prescription-Verification Mechanism

A theoretically notable finding, emerging inductively from the data rather than from the a priori interview structure, is the role retail chemists play as an informal market-intelligence mechanism. Medical Representatives routinely query chemists located near a given physician's practice regarding the frequency with which that physician's prescriptions for the company's brand are being dispensed, using this chemist-reported frequency as a working estimate of the physician's actual prescribing behavior and, by extension, of the representative's own territory performance.

This practice positions the retail chemist in a dual role within the channel: a conventional distribution intermediary, and an informal, relationally accessed source of prescription-level market intelligence

that substitutes for the kind of formal prescription-audit data (such as that available through specialized pharmaceutical market-research providers) used in more data-mature pharmaceutical markets. The Area Sales Manager's acknowledgment that comprehensive doctor-by-doctor verification is not feasible across a market the size of Delhi underscores that this informal mechanism, despite its acknowledged imprecision and vulnerability to manipulation, functions as the de facto prescription-verification system in the absence of a structured alternative. This is consistent with the channel-conflict literature's broader observation that information asymmetry between channel tiers - here, between the company and the prescribing physician - creates space for informal, relationally mediated information substitutes to emerge.

Staged Product Availability as a Prescription-Pull Strategy

For new product launches, the Area Sales Manager described a deliberately staged availability strategy: a new product is first made available at the stockist level, then released only to a small number of chemists located near the specific physicians targeted for promotion, with broader chemist-level availability following only after initial prescription traction is observed. This sequencing reflects a prescription-pull, rather than distribution-push, logic - availability follows demonstrated prescribing interest rather than preceding it - and serves to limit inventory risk and the likelihood of stockist returns on unsold product, while also concentrating the Medical Representative's prescription-verification efforts on a manageable, targeted set of chemists during the critical early period of a launch.

Summary of Findings in Relation to Theory

Considered together, the findings indicate that Torrent's Delhi gastroenterology operation exhibits several practices that are well-aligned with established sales and channel management theory - a narrow, coaching-oriented span of control at the ASM-MR interface, a hybrid behavior- and outcome-based control system appropriate to a long-cycle selling environment, a lean channel structure calibrated to an established brand's prescription-pull demand, and a digitally enabled, responsive replenishment mechanism consistent with lean supply chain principles. At the same time, the findings surface specific points of theoretical and practical tension: a pooled territory model that secures coordination benefits at a documented agency cost (the free-rider risk); a measurement system whose most important outcome variable, prescription generation, is tracked only through an informal and admittedly unreliable proxy; a training curriculum that addresses product knowledge comprehensively but leaves the relational selling competencies that respondents themselves identify as decisive almost entirely unaddressed; and a channel partner (the CFA) whose alignment with company objectives is conditional on sustained growth rather than structurally guaranteed. These tensions, rather than representing organizational failures, are more accurately characterized as the natural friction points that arise when control and coordination systems designed for scale and consistency meet a selling and distribution environment that is fundamentally relational, informal, and locally contingent.

CONCLUSION

This study set out to examine, through field-level qualitative interviews, how sales force management and channel management operate - and interact - within one division of one Indian pharmaceutical company. Its contribution is twofold. First, it provides an empirically grounded account of how an established sales force control system, a pooled territory structure, and a lean four-tier distribution channel function together in a relationship-dependent selling environment, drawing on the direct accounts of respondents occupying three distinct positions in the organizational hierarchy. Second, it demonstrates, through this single integrated case, the practical interdependence of sales force effectiveness and channel reliability that is frequently treated separately in the theoretical literature - showing, for instance, how a channel partner's (the CFA's) commitment is conditioned by sales force performance, and how a sales force's prescription-verification capability depends on an informal channel-level relationship (with chemists) rather than on any company-controlled system.

The findings carry several practical implications. Performance measurement systems in pharmaceutical sales organizations that rely primarily on activity counts and informally verified prescription proxies

may be systematically under-measuring the relational competencies that respondents themselves identify as the decisive driver of prescribing behavior; closing this measurement gap - whether through structured chemist-reporting templates, investment in formal prescription-audit data, or more deliberate evaluation of relationship-building skill - represents a concrete opportunity for control-system improvement. Similarly, channel governance that extends beyond commission-based alignment, through periodic structured review of carry-and-forward agent and stockist relationships, may reduce the partner-disengagement risk that becomes visible specifically during periods of stagnant growth, when commission-based alignment alone is least effective.

This study is subject to several limitations that should inform the interpretation of its findings and any subsequent research building on it. The respondent base comprises three individuals, each representing a single position within the organizational hierarchy; while purposive sampling ensured coverage of the principal roles in the system, the small sample size precludes any assessment of variation across multiple individuals occupying the same role (for example, comparing accounts across several Medical Representatives), and the findings should be read as illustrative of the perspectives of these specific respondents rather than as representative of the organization as a whole. The study is further confined to a single therapeutic division (gastroenterology), a single company (Torrent Pharmaceuticals), and a single geographic market (Delhi); pharmaceutical sales and distribution practice is known to vary across therapeutic areas, organizational scale, and regional market structure, and the findings should not be extended to other divisions, companies, or geographies without independent verification. All data were collected through interview self-report, which carries an inherent risk of social desirability bias, particularly given that respondents are current employees of the organization under study describing their own and their organization's practices; the absence of direct field observation in this study (no field accompaniment was conducted) means that reported practices could not be independently cross-checked against observed behavior. Finally, the study does not draw on secondary quantitative data - such as actual sales figures, market share, or distributor performance records - that would have permitted a more rigorous, outcome-based assessment of the effectiveness of the practices described; future research extending this line of inquiry would benefit from triangulating interview-based qualitative findings of this kind with such quantitative performance data, and from broadening the respondent base across multiple companies, divisions, or geographic markets to test the generalizability of the patterns identified here.

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