

**GLAXOSMITHKLINE
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Simon Dingemans
CFO**

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Question and Answer Session

Speaker: As I think you are aware, this is the GSK Q&A and we have Simon Dingemans with us, CFO of GSK. Does anyone have a question they would like to kick off with?

Question: I wasn't in the presentation. Could you repeat what you said about *Breo* and how the launch is going?

Simon Dingemans: I think it's still early days clearly. We only launched in the last couple of months of last year so to date all the measures we are tracking in terms of share of voice, patient receptivity, physician monitoring, all very encouraging and very much in line with what we expected and now what we are beginning to work through is putting in place coverage and reimbursement and as I commented in the room next-door, given the nature of the universe that you are dealing with, that is just going to take some time.

It's one of the reasons we have said these primary care products in particular will build over time and we need to be careful not to rush them if we are not going to undermine the longer-term proposition, so we are going to be quite patient and careful about how we compete that.

But so far we have about 50 million tier two lives in hand, we have about 50% coverage in the commercial space on tier two and tier three lives. We are a little behind in terms of Medicare Part D because the window fell. As you know, there are only a certain number of windows during the year and the timing of launch meant that we were only going to get to that around now, so that's beginning right at the moment and so all of that puts us pretty much on track with where we expected to be. That's the important measure, but it will be something that we will work over the whole of 2014.

Question: Just on the *Breo* and the coverage, are you able to say in terms of the typical co-payor patient on those tier two or tier three would incur for getting *Breo*?

Simon Dingemans: I don't think I can comment on that at the moment as we are still in the detail of what those contracts actually look like. We have outlines in place, but that's getting into commercial territory that I'll keep to myself for the moment.

Question [off-mic]: The one thing that was missing from your description of cost savings going forward ... for the past several years has been sales force reductions and I'm curious as to whether, it seems to me ... to a new model for the sales force, new model for marketing. Is that ... sales force size ... for GSK ... is it stable at this level or is there more of a chance of making it to yet less personal selling maybe with less of some of the risks that come with having that many sales people out there ...?

Simon Dingemans: Look, it's a great question and I can't speak for other companies, but if you look at our history, we downsized our sales force, particularly here in the US very significantly two or three years ago, probably three years ago now, particularly on the back of *Avandia* and we had about 10,500 reps at the time and we took it down to about 5,000.

Arguably on the basis of the business we had at the time, we could have taken it down maybe 1,000-1,500 heads further but we took a very deliberate decision to say that we are going to hold on to that resource so that when we are ready to launch and we have approvals in hand, we have people we know we trained to work our way because at the same time we were also changing our sales model here in the US and we didn't really want to lose a load of people and then hire them back in and not be sure that they would operate the way we wanted to operate.

That's why we keep saying that we don't need to ramp up our SG&A as we put these launches in place. We may have to put a little bit more behind the launches but not significantly. It's one of the sources of leverage going forward that we are anticipating.

From our point of view yes, we probably have seen the sales force reductions play out but we did it three years ago. Now we are holding things steady while trying to put more product through the same network and actually reallocating resources rather than hiring new sources.

In addition as you know before Christmas we announced that we were going to take the Patient First programme we have implemented in the US which deals with how the sales force relates to physicians and healthcare practitioners reduced at the time significantly the amount of speaker fees and engagements and conference spend, etc that has been a

feature of the industry. We have had very, very positive reaction to that here in the US and that's why we have now taken the decision to roll that out globally.

We think it's the way the market is going. It's clearly what our stakeholders, payors, providers, governments want from us. We have decided to get ahead of that. It's up to other companies what they choose to do, but we think that's the right thing to do. It has the side effect of also reducing your selling costs but we still think there is an important role for reps to play in educating, communicating, explaining our products and they are going to be doing it in a different way but they are not going to stop providing that information about our products while doing it.

Question: Is the sales force at the right size in the rest of the world, particularly in the emerging markets or are they likely to grow as the market grows?

Simon Dingemans: They will probably grow as the markets grow but we have been working quite actively over the last 12-24 months to really put a bit more efficiency into the Emerging Market sales footprint because you had a period of big growth, lots of heads going in, coverage being the priority. What we have said is 'Right, okay, let's call a stop to that. Now we need to make the efficiencies and productivity of that footprint work a lot harder', so we have slowed that significantly.

In Europe we have reduced heads again very materially. We took hundreds of heads out, although we have reallocated quite a lot of those behind those core franchise I talked about next-door and we have seen the benefits of that, so Europe has probably played out like the US. It will be an efficiency slowing of growth that you see in the emerging markets, so the pattern is not universally the same but clearly different from where we were two years ago.

Question [off-mic]: Glaxo's been ... in the US and China in 2013. Has that stabilised now?

Simon Dingemans: I think in relation to the inquiry there's not very much more I can say. We have to respect the Chinese process; that will work its way through and they will tell us when they are ready to respond.

I think alongside that what we have been careful to do is to effectively create a very separate team dealing with that inquiry and focus our Commercial organisation on protecting as best we can the footprint that we have in China. We are still very committed to it as a

market. We don't know exactly what sort of shape of business we are going to be able to have afterwards but we want to be ready to rebuild as soon as we are given that opportunity.

We have seen some stabilisation, as I said at the third quarter. In the back half of that quarter it got a little bit better, not dramatically better but a bit better. I don't want to comment on the fourth quarter yet other than to say that trend probably continued.

Question: As well the issue of what your sales are doing in China, are you able to comment in terms of whether hospitals or physicians, where you are in terms of interactions between them and GSK sales people? Are there any interactions at all now?

Simon Dingemans: There are some. There are more than there were but clearly we still appear in the press relatively regularly and the whole system knows it's under scrutiny and our reps in particular are finding it quite difficult to engage which is a little bit why I wouldn't get ahead of yourself in thinking 'Oh, a rebound in that business'. This is going to be a slow grind to put in place the right structures and work our way to an opportunity that we still think is very real. We all think about our portfolio but there is clearly a significant opportunity there and we are not going to give up on that easily.

Question: When you adopted your new marketing approach in the US in terms of the way in which sales people were compensated, did you see significant departures in terms of some sales people not wanting to work in that way and do you envisage that happening in Europe as well?

Simon Dingemans: I think we saw a few. Frankly we weren't that sorry. We always expected there would be some churn. Our model isn't for everyone; that's fine by us and actually what we saw, if you ask Deirdre was quite the reverse; that we actually saw quite a lot of people coming to us who wanted to work in a different model, who liked the access it was providing and we have genuinely seen doors open in some of the PBMs and other healthcare systems in the US that were not open to us before because our reps have focussed in a very different way.

That's paying off now in terms of some of the access for new products and good quality reps wanted to be part of that. I would expect we see some of the same elsewhere.

Question: [*Inaudible*]

Simon Dingemans: Well the *Anoro* launch is being prepared in a pretty similar way to the *Breo* launch. I don't think I want to give you specific sales force numbers, but we will move sales force around quite actively to my point about flexibility of cost.

To give you an example, what we have done to get ready for the *Breo* launch is take probably three-quarters of the central sales teams that were otherwise focussed on *Advair* and put them behind getting the launches up and running for *Breo*. We may move some of that resource back again as clearly *Advair* remains an important product for asthma but the amount of new information that we can deliver to the market on *Advair* is relatively small so in terms of keeping resources available, the priority is getting the new information out there.

Once we have done that, then we can start moving resource around again, so I think the key message is we are much more dynamic from the model of old where we would have left the *Advair* sales force, we would have created a *Breo* sales force, we then would have created an *Anoro* sales force.

We are going to cycle resource across the areas of greatest need and then titrate depending on where we see the information demand being greater, so it's more a question of what is our Respiratory sales force which is clearly the largest part of our overall footprint, given that is a primary care product as opposed to the specialty resources we need for an oncology launch or for the existing oncology portfolios or what we might put behind HIV for instance where you've got a much more concentrated patient base.

Question: [*Inaudible*]

Simon Dingemans: Well I think, as I said in the presentation, we are always looking at the portfolio that we have and we have seen a lot of benefit in clipping off distractions in the Consumer business, so we sold the tail and we sold the drinks business. We are now probably going to be more active on that front on the Pharma side, especially as we have now a significant number of approvals in hand and we have a refresh of the portfolio under way and as that makes more progress and delivers more momentum into the system, I want to make sure that resources are really focussed in supporting those launches and those new products.

One of the reasons we created the Established Products Group was to make the company very, very clear internally about where it should be prioritising its efforts. At the front end of the commercial organisation I want them focussed on the new launches and the core of the existing portfolio, so *Seretide*, *Advair*, urology products, etc.

The Established Products Group is going to focus on that tail maximising value, cash, profitability. That may include selling if we can get good prices, but equally it may include re-engineering supply chain, maximising margin. They don't need a lot of promotion, so drive them for the products they are, allow us to release that resource and reinvest behind the core of the company and if you don't label it clearly, the General Managers in country get a bit – you know, it's very easy to get confused and we are leaving value on the table.

We are going to work that portfolio on a much more piecemeal basis and it may bring disposable proceeds in along the way.

Question [off-mic]: Could you quickly comment on how you seek to deal with a generic *Seretide*? I think a couple of weeks ago it was approved in Denmark and yesterday or the day before in Germany.

Simon Dingemans: Well we have certainly seen generics beginning to make more of a presence in Europe, but that didn't happen yesterday; it has been happening for some time and I think that despite a lot of noise they have not made a huge amount of progress, partly because some of them have very rudimentary devices. In Respiratory, that's an important part of the patient proposition as well as the effectiveness of the medicine so they have not got a lot of traction but we would still recognise they are a growing issue, but probably one more of price than of competitiveness.

We know how to respond if we need to on that. We have been manufacturing *Seretide* for 11 years now and it's one of the reasons that we have been able to optimise the production lines and grow a Respiratory business at double-digit rates in the emerging markets at even lower price points so we can respond if we need to; we are not going to chase them there.

It's quite interesting that when they have come in with their price points it's not a typical generic response. It's a relatively tight price discount so they have significant investments behind the manufacturing and delivering of a device as opposed to a white pill and they need to make a return.

We think this plays out over time rather than overnight and that will give us time to protect our leadership position. Remember we don't have a 180-day exclusivity period, so being in the incumbent position gives you quite a lot of leverage to protect that, so it will produce more price pressure but we think we have a response for that.

Question: A couple of years back you restructured your discovery DPUs to an entrepreneurial, dynamic environment to improve the innovation culture and the outlook. How is that working?

Simon Dingemans: Well I think that you can see from some of the slides I put up yesterday that we are very pleased with the volume of activity that's coming through the late stage and it would be one thing to deliver five or six significant approvals in 12 months, but if that's all you did then you wouldn't really have achieved what we set out to do which was to build a much broader portfolio, one where we could take a bit more risk so that we could go after genuine innovation and differentiation which is clearly what the payers are looking for but you can only do that on a broader base. I believe the five approvals that we put through last year show you we can deliver.

Look at the six files that we have with regulators for this year, we have another six important late stage read outs behind that and then more in Phases II and I and we are generally pretty shy about talking about what's in Phase I as inevitably a lot of those projects fall over, but from the volume of activity and quality of what is coming through to late stage decisions, we feel pretty good about how the DPUs are working.

We are half-way through the second cycle of those and certainly when I go and visit Stevenage or I go up to Upper Merion, the energy has very definitely moved from three years ago when I first went there and I am relatively recent to that.

Question [off-mic]: Two questions, please. One is Express Scripts and how is their decision to ... *Advair* may impact your launch to the next generation ... and the second question is on immuno oncology collaborations; could you give us a little more colour on that?

Simon Dingemans: On Express Scripts, they clearly made a very public statement about a particular product that they were planning to launch. They are targeting for it to cover in their words about a third of their lives. We will see what the take up is of that product and how many they actually deliver. Those products have not necessarily been that successful in the past, but we'll see. Equally they have a significant number of other lives that we are actively in discussions with them about in terms of our contracting strategy. You might also imagine we are talking to some of their competitors and I would expect that this is a very dynamic situation.

That particular contract may not come up for a few months before you can have another discussion about what you can bring to the table, but at that point we then will have

two significant Respiratory new products to add in to the mix as well as potentially others alongside and that's always been our strategy, is bring a portfolio. It's not just about *Advair*. It's about the breadth that we can offer. You can play an awful lot more tunes on the sort of value proposition you can offer to an ESI with that in hand.

We didn't have it in hand when they made their announcement, so clearly disappointing. We are responding, not just with them and we will continue to work that situation, so there is a long way to go get before we reach a conclusion.

On immunotherapeutics, I commented next-door that we are still waiting for some data on the MAGE programme which is an important part of how we think about that space. We expect our existing oncology programmes, particularly the MEK and BRAF to be collaborative with some of those new PD-1s and other candidates but this is a very evolving space and the nature of the market is that compounds get trialled together, sometimes by us, sometimes by others and we also have some very early stage activity which is still pretty preliminary in terms of us talking about it or giving you any more commentary. But I think it's not a space we are absent from; it's a space we are participating in. It will develop in a whole series of ways and we think we have quite a lot of ways of playing it.

Question: [*Inaudible*]

Simon Dingemans: No. Is there a specific question around that?

[*Additional inaudible comment on question from participant*]

Simon Dingemans: No, I think we have been very clear as to where our priority focus areas are for the portfolio that we have today, the pipeline coming through and I think that CNS has been an area that we have de-emphasised.

It doesn't mean that our early stage discovery activities don't occasionally produce interesting CNS assets and that's part of the philosophy is let the early stage science do what the early stage science does and we can then decide do we have enough to build a core franchise around that or should we out-license or partner that asset, share the development with other people. I think until you get to that point you don't know, but most of all what the R&D leadership will tell you is don't constrain those early stage activities because you just become a production line and we all know where that led, so I can't remember the specific of what you are talking about.

Question: I was wondering if you could comment on the targets of the Salford study.

Simon Dingemans: I don't think there is any more I can say at this point. They read out later on this year and they are an important part of reinforcing a real-life proposition that we have always felt was a strong part of the *Breo* presentation to patients and physicians.

Once a day is something that we think is important and indeed the early engagement that we have had with the patients and the physicians here in the US around *Breo* has absolutely borne that out in terms of what are they focussed on most? Once a day, and they see enormous value in protecting their patients, keeping them stable, avoiding future exacerbations and keeping them out of the system.

That is exactly what we expected to have happen. The real life studies that we are working on will hopefully support that, but we will obviously not be able to comment until they read out later this year.

Question: [*Inaudible*]

Simon Dingemans: Salford is end of this year, next year maybe. [*Inaudible comment from participant*] Yes, sorry – you're right. It took a bit longer, didn't it? Apologies - next year. Can you remember what the date is? [2016]

Question [*off-mic*]: Can you talk about your -, any thoughts on your ... Rare Diseases ...?

Simon Dingemans: Well we have clearly had a few disappointments during the course of 2013 but the technologies that we have in that space are important in the overall portfolio that we are managing within R&D and we like the collaborations and access points that that brings us. But I think that Rare Diseases is probably something that you will see us look for more partnerships or ways of collaborating to make the best of what we have while we have so much else going on in the portfolio.

I think that was always part of the set of trade-offs that we were going to have to make. Clearly if some of the products we have been working on had come through more successfully you may have a different answer to that but I don't think that there is anything that's surprising in what's happened given the nature of the R&D process that some things will work and some things won't. Our core franchises have been significantly strengthened

by the delivery of the approvals we have. Rare Diseases has been less successful. Let's see if we can leverage that with other partners or other opportunities down the track, but I think it's a kind of work in progress.

Question: [*Inaudible*]

Simon Dingemans: We still have that under review. We are talking to the FDA – no decision as yet.

Question: Do you have a meeting schedule?

Simon Dingemans: We are still talking to the FDA, so it's not appropriate to comment in any more detail at this point but it's something that we are working through at the moment.

Question: One question I was going to ask is we were talking about the impact of generic *Advair* in Europe or *Seretide*. In terms of the pricing, if there is a discount, if *Advair's* price is lowered in Europe because of the launch of a generic, how does that potentially impact pricing for *Breo* if you haven't yet sorted the *Breo* reimbursement out in some countries? Could that mean that *Breo* has to automatically also have its price reduced, or is it not that straightforward?

Simon Dingemans: No, I don't think it's that straightforward and I certainly don't think it's automatic but remember Europe remains a very challenging market, not just in terms of the broader economic environment but also in terms of access and reimbursement and so our commercial strategy in the different countries across Europe will have to factor in speed of access because you can sit there at a certain price point, you don't get in and that's an NPV of zero.

We are going to have to be very tailored as we have said a number of times in how we think about markets around Europe and we will probably come up with a different answer depending on which markets we go to first, so expect quite a lot of differentiation in terms of the results that we end up with in terms of prices and pricing strategy.

Question: How should we be thinking about growth margins going through 2014?

Simon Dingemans: Well I think as I said in the presentation, remember the strategy is about leveraging the whole of the P&L to drive earnings per share faster than

sales and that may include working different elements of the P&L at different levels and at different stages. In the short-term the top half of the P&L probably requires more investment to make sure those launches come through as we expect and so there will definitely be some pressure as a result, particularly at the cost of goods line where we don't have volumes coming through yet for some of the new products.

We have new manufacturing costs to bear and to amortise, we have royalties to deal with and we are working hard to offset that with some of the restructuring programmes and investments in new technologies that we have been talking about, many of which will also go to improving the cost of goods on the existing products that can contribute to the overall mix.

I think that certainly over the next couple of years you should see continued upward pressure in the cost of goods line which we will be working hard to offset. The building leverage comes from new revenues at the top line and our continued focus on holding R&D and SG&A costs much more steady relative to the growth in the top line and build the leverage that way, but you can see why it takes some time for that to flow through.

Question: Probably a final question from me which would be that we are going to get some guidance soon. When you think about giving guidance, there is the issue of the divestments. Can you give a guidance that does exclude divestments and does such a guidance make sense at the bottom line when the divestments presumably are partly funding a buy-back with an influence at the bottom line?

So when we are thinking about what to look for for 2014, do we need to think with or without divestments?

Simon Dingemans: I think you need to think about the continuing business. We will only make divestments if we see that we are getting good value for them, they release resources that we can reinvest in the business and contribute to the cash flow that as I described next-door is supporting the dividend and the buy-back programme as well as all the investment we are making in the longer term.

But ultimately at the end of the day, they do, by the nature of selling out a portfolio, have an impact on the sales line and the rest of the P&L but if we get good value then we think that's a sensible thing to do, so we will comment on the business and give guidance on an ongoing ex-divestment basis. We will reconcile that to what that looks like on a reported basis but that's how we think about the ongoing company.

Speaker: I think we are out of time, so in that case thanks very much, everyone.

Simon Dingemans: Good. Thank you for your time.

[Ends]