

GLAXOSMITHKLINE

FULL YEAR 2013 RESULTS
INVESTOR and ANALYSTS TELECONFERENCE

Wednesday, 5 February 2014

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Sir Andrew Witty (CEO): Good afternoon everybody and welcome to today's call. With me I have Simon Dingemans, our CFO. I am very pleased to report that GSK has made significant progress during 2013, and presentations, transcripts and our full press release are all available on the website. As you know, we are not doing a face-to-face presentation which with the Tube strike today, has been a lucky call on all of our behalf.

I recognise that you have not all had the chance to look at the video which is on line so I shall make a few comments to ensure you have heard the highlights at least from our perspective.

We delivered the most productive period of R&D output in the company's history, returned £5.2 billion of cash to shareholders through dividends and share buybacks and were the second largest contributor to growth of the FTSE 100 during the year. Reported turnover grew 1% to £26.5 billion and core earnings per share were up 4% to 112.2 pence. This was at the upper end of our guidance and was achieved despite some unexpected challenges, including reduced sales in our Chinese business, the performance of which is now starting to stabilise.

This year we expect core earnings per share growth of 4-8% at constant exchange rates on sales growth of around 2%. This guidance is given on an ex-divestment basis and from a 2013 EPS base of 108.4 pence.

I am particularly delighted with the levels of innovation we are seeing at GSK. Of the six major new medicines profiled at the start of 2013, five have now been approved, and we are expecting a decision on the final asset in this group, our diabetes medicine albiglutide, in the first half of 2014. These new products which are currently being launched will strengthen our existing businesses in the Respiratory and Vaccines area and support new growth in HIV and Oncology.

I am pleased with the early indicators for all of our new launches: *Breo*, *Tivicay*, *Tafinlar* and *Mekinist* and, of course, our quadrivalent flu vaccine that we launched about a year ago. We are also preparing for the launch of *Anoro* in the US in the next few weeks.

Since 2009 GSK has achieved more new molecular entity approvals in the US than any other company and, importantly, we also continue to improve our financial efficiency of research and development and today have announced an estimated rate of return on

investment of 13%. This is good progress and we continue to target 14% as our long run goal.

Our future pipeline opportunity also remains substantial. We have around 40 NMEs in Phase II or III clinical development, and, over the next two years alone, we expect Phase III readouts for six of those NMEs and a further 10 Phase III starts for additional new drugs and vaccines.

The transition and expansion of our Respiratory portfolio is a critical element of this progress: with *Breo* and *Anoro* and with seven other products in development, we expect to maintain our leadership in Respiratory well into the next decade.

Alongside our core focus of innovative product development, we also continue to optimise our portfolio. Last year, we created a new Established Products portfolio and completed divestments worth £2.5 billion of several non-core products to increase focus in our Consumer Healthcare and Pharmaceutical businesses.

At the same time, we invest in key markets such as India to increase our economic exposure to the very successful opportunities we already have there. We also continue to make fundamental changes elsewhere in our business. These build on the many initiatives we have implemented over the last several years. For example, to increase access to our medicines and visibility to our clinical trial data. Over the next two years, we shall be making changes to how we interact with our customers, including implementing our new global salesforce compensation system.

For our new launches, we shall be adopting further innovative pricing approaches to help meet the needs of governments and payors, and we shall continue with our agenda to increase access to healthcare in the world's poorest countries.

Together with the innovation being created at GSK, we believe these changes position the company competitively for the long term to deliver improved financial performance and returns to shareholders, as well as help meet the wider expectations of society.

Question & Answer Session

James Gordon (JP Morgan): I have two respiratory and two financial questions. On respiratory, there was the LAMA/LABA/ICS that could potentially move into Phase III and my question is whether that can work with your existing dual chamber device, or whether that would need a new device? The other respiratory question is about *Advair* in the US, where we have seen an acceleration in the decline in terms of prescription volumes. I believe the volumes are down about 14% year to date, and I wonder whether you see that as a continuing trend this year because of formulary positioning, or whether that is something that you think the *Advair* decline could slow as we go through the year?

On the financials, one question on established product revenues. I have seen the comments about improving this division's profitability, but I can't see what the profitability is. Can you talk about what the profitability is and how the margin would compare with the group?

Also a quick last one, which was on capex outlook. There are comments about increased investment in manufacturing, what capex could look like this year?

Sir Andrew Witty: Okay, James, I am going to let Simon address your two financial points. On the first two respiratory, yes, you are right. One of the programmes we expect move into Phase III over the next year or so is indeed what we would call the "Closed triple" LABA/LAMA/ICS programme; the codename inside the company is "Diamond", so if occasionally you hear us talk about Diamond that is what we are talking about. That is not going to be the brand name, but it is certainly the name we use. Yes, it will be on the *Ellipta* platform and that is quite an important point. If you look now *Anoro*, *Breo*, and in fact all of the advanced inhaled programmes, will all be launched in the *Ellipta* platform. If all goes well, eventually there will be eight products on that platform.

As far as *Advair* in the US, obviously we have known this disruption from ESI was coming; we knew about it back in July/August. What we have seen in the first week or two of January is very much what we have seen with a number of other companies who have had products similarly affected: some share loss in the first week or two with what appears to be the beginnings of a stabilisation; in week three or so that is probably right, certainly the pattern we are seeing with *Advair* is identical to the pattern we are seeing with other products from other companies. My guess is that during the year what we are going to see is a little bit more dynamism around contracting strategy in the US; you have some companies who are being a little bit more aggressive in this space for their own reasons, I suppose. There are going to be some puts and takes and even in the first month of this year

and in this press release today obviously we have seen the effect of the ESI decision, but you have also seen a very significant jump up in our Medicare Part D coverage from 2% at the beginning of January to 25% as of today. That is directly as a result of us winning a very major contract. I think you will see a lot of this go on during the year. I don't think the first few weeks of January are at all representative for what we will see for the rest of the year and not at all unexpected either.

I'll hand over to Simon on the two financial questions.

Simon Dingemans: Thanks Andrew. On EPP, James, we are going to give you and everyone else some more detail during the first quarter, which will include the re-statements and full cost allocations for the businesses. Generally they are slightly more profitable, as you might expect, given the maturity of those products, but we are in the process of still allocating out those costs, so further detail to come.

Then on the capex side, as I said last year, we were expecting it to tick up a little bit in 2013, which indeed it did – a couple of hundred million to £1.7 billion; that is about the level you should be expecting in 2014.

Sir Andrew Witty: Thanks, Simon. If I could make one further comment since established products has come up. If you look at the 2013 and you can see that the established product portfolio had a sales growth rate of -9, so down 9%, I am sure many of you will have already figured out that that means the rest of the business was essentially growing on an ex-divestment basis of +4, so you have about 70% of the business growing at 4%. One of the reasons we have separated this is to give you and everybody else greater clarity on what the fundamental business is doing. Obviously that EPP block of products is going to be an area where we are going to look, as Simon said, to streamline some of the cost base; that is particularly true in terms of SKU complexity, but it is also where we are going to be looking for divestments. Obviously the investment we made last year of *Fraxi* and *Arixtra* is one I would certainly expect us to do some more in that space and as a result concentrate the organisation on what we regard as the sustainable higher growth parts of the business.

Thanks James; next question.

Graham Parry (Bank of America Merrill Lynch): Thanks for taking my questions. If I can just kick off on one on the guidance? Is it fair to assume the top end of your guidance assumes that there is no generic *Lovaza* launched during the year?

Secondly on margins into 2014, if we were thinking about these on a constant exchange rate basis, do you expect to get any operating leverage there at all, but just offset by FX or even on a constant exchange rate basis, do you think we are looking below the operating profit line for leverage?

Thirdly, on the *Breo* launch, what is the main barrier that you are finding to your Medicare part of the coverage? Why the difference between the 66% in commercial and 25% in Medicare Part D? Can that change? To what extent are you waiting for outcomes data in 2015, for example?

Finally, also on *Breo*, could you also just give us a feel for the sampling that you have been doing in the market and the ratio of samples to prescriptions? How much are real volumes that you are seeing go out of the gate at GSK higher than the prescriptions or the sales that we are seeing? Thank you.

Simon Dingemans: Graham, on the guidance, clearly we have given you a wider range than we did last year, reflecting that there are a number of different factors driving us between the top end and the bottom end. *Lovaza* is a significant one, but it is not the only one. That said, clearly to get to the top end of the range we would need *Lovaza* to be with us for a good part of the year, let's say, so I think your direction is right on that one.

On the leverage side, as I have said in the presentation, there are some more details on the Web and I know you have the transcript of that. I think in 2014 we are certainly expecting to have to continue to invest behind the new launches and make sure that we are really building the most sustainable position for these new products that we can, and so we are expecting that the bottom half of the P&L contributes the more significant part of the leverage that we see, but in delivering a range of between four and eight, certainly at the top end of that range we would see a little bit of contribution from the top half of the P&L consistent with what we have said for some time now, that leverage will build as the new pipeline builds material revenues into the system. The top end will certainly reflect that.

Sir Andrew Witty: Thanks, Simon. As far as the *Breo* questions are concerned, Graham, in terms of building the Part D coverage, as you probably know, particularly in the primary care marketplace in the US, things have changed quite a bit over the years.

A lot of the Part D coverage now, decisions are made on a six-monthly or a 12-monthly cycle and the contracting slots aren't open all of the time. That's a little different to Commercial, so there is a substantial amount of the Commercial book of business where essentially immediately, or almost immediately you have access, albeit that might be at a

relatively restricted tier, so it just depends plan by plan. But you pretty much rapidly get that open access in Commercial.

The build on Part D is really just a function of time and of course successful contracting so this is not dependent on data generation.

I would fully expect, if I just look at the last three weeks, Graham, we have essentially gone from 2% to 10% to 25% in the last two-and-a-half weeks. I would fully expect to see that kind of continued progression during the year for a substantial part of the market.

Ultimately it's unrealistic to expect 100%, so you probably end up at something like the 75%, 80%, and that could take a year to get to that top level but the early part of the curve up to the 50% ought to come relatively quickly. But it just takes time to go through the cycle, so there is no big dependency. It's important that we contract competitively obviously. I think we are in a good position on that and things have gone as well as I could have expected in terms of this.

In terms of demand generation, you ask a great question and obviously that's the thing that I am particularly focussed on trying to make sure we properly understand. All the signals we are seeing are very, very encouraging, so if we look at our ability to cover physicians, excellent; if we look at aided recall, excellent; relevance of message that we are delivering, excellent. We really think we have got the message right on this medicine.

Reception to *Ellipta* - excellent; all of those primary areas, very good. Interest to prescribe from physicians, very, very good, and then of course you look at the classic IMS prescriptions and they don't look as good as you would expect. So what's happening in-between ways?

Well, the first thing that's happening is there is clearly a mismatch between the coverage of the physician population and the insurance coverage. Remember, the date that is in the public domain essentially has a Part D coverage which is by the way worth 60% of the patient side of COPD. It has a Part D coverage which has been between 2-10% for the first three or four weeks of January. So you have a significant number of prescriptions being generated, and they are not being filled at the pharmacy because the insurance is not in place. We would estimate that anywhere up to 70% of scripts are being rejected at that stage, so you immediately can start to see much higher numbers of scripts.

Clearly that is going to start to change quite significantly as that Part D gateway begins to open. As I said, the big contracts which open up for the 25% level actually kicked in on Monday of this week, so we should start to see that flow through in the next few weeks.

You are also right, of course, we are sampling competitively in this marketplace and you will know from other companies' history, this is a very heavy sampling marketplace and very rare for a physician to start somebody on a new inhaled device without a sample.

So yes, significant amount of sampling. I would just remind you that our samples are for two weeks' therapy so it is just worth bearing that in mind. It is very hard to say at this point in time how many samples are being used but I am quite impressed by the fact that we are in the situation where there is reordering of samples going on already so we are issuing more samples after the first wave, if you will. That tells me a lot of consumption of samples has gone on.

It is obviously very difficult to estimate what the fundamental volume is because that sample number could be in a very wide range but it's not at all unrealistic to believe that the combination of the rejected prescriptions due to coverage which we are fixing, plus the samples gives you a prescription number several multiples higher than the number you are seeing in the NRx environment.

The last thing I would say is, if you look at a slightly newer leading indicator which we tend to focus on in our product launches which is NBRx, so this is looking at people who are new to the brand in the last 12 months, not just in the last three months, you can see for Breo we already have a 2% market share of NBRx. We think that is also indicative of a good start to the product.

That is why we are confident, given where we are at, clearly the must do priority for us this year is continue the great work of January in building the Part D coverage, but against the backdrop of physician reaction we are feeling very good about the launch of Breo.

Thanks for the question, Graham. Next question.

Alexandra Hauber (UBS): Thank you for taking my questions. To go back to the guidance, apologies for that, my initial thought when I saw that you gave a point guidance on sales and the wide range on the bottom line, I thought that the delta was probably majorly driven to which extent you should be able to identify the restructuring gains that you can book this. Now I have just learnt Lovaza is certainly some of it as well, but can you confirm that the restructuring gains are going to be a key driver of that delta?

Secondly, coming to back to US Advair, it has been that for a number of years your sales have tended to do a lot better than what we would have thought, based on volumes, partly based on price rises, partly due to smart contracting. Do you think there is a chance,

actually, that we will *Advair* growing this year, based on those strategies? I know you have already taken a 9% price rise in January.

Then a quick question on the supply disruptions you mentioned in the press release, both in Consumer and Vaccines. Can you actually give us some colour on what is happening here and how soon you expect those to get fixed? You also mentioned some stock write-offs in the fourth quarter, are those related in any way to those supply disruptions? Thank you.

Sir Andrew Witty: Simon, do you want to pick up on the guidance point and the stock and I will pick up on the supply issues and *Advair*.

Simon Dingemans: On the guidance and the restructuring gains we have indicated in the detail and the press release will be broadly similar in 2014 to what they were in 2013, so they are not actually a major driver. They, obviously, do create some flexibility, in terms of how much leverage we develop during the year, but it is going to be much more driven by the range around the top end, how long *Lovaza* lasts, what the rate of pickup of new product introductions would be, so those are the more important factors in that, but, clearly, there is some variability as to how much we drop to the bottom line, depending on how those top line items develop.

In terms of the stock write-offs, that is really reflecting some ageing inventory, some of the impact out of China in terms of adjusting our position given the shortfall that we have seen in that business in the second half, and then, also, related to the supply disruptions you have just touched on where that has put some of the stock also out of usage zones, so we have had to write that off and then we will rebuild as the supply comes back into place.

Sir Andrew Witty: Thanks, Simon. As far as the supply disruptions are concerned, I would say there is no pattern here. There have been two or three different things in different parts of the supply network, literally Consumer to Vaccines type of situation.

Probably the one that has attracted the most attention has been the vaccine *Varicella*, which has disrupted things in the last few weeks. We have good news on that, that looks like it is going to be a very short-lived disruption, and I do not expect that to have any material impact on the numbers for this year, and I think you will see that resolve itself very quickly.

I will be honest with you, Alexandra, we take a very, very conservative view if we have any question marks on batches, we hold everything, and sometimes, particularly in products where we have short supply lines - and Vaccines are a good example where we do

have short supply lines - then sometimes that hold can reflect through into the system much more quickly than you might think. In this particular case, as I say, I think we have good news for you there.

As far as *Advair*, you are right, we have seen over the years a gentle decline in volume, but we have seen significant benefit, normally in mix - in terms of which they are parts of the strength - grow prescription size, and actually has been a driver of things over the years, and also price realisation. If you look at GSK's contract and position in the US over the last two or three years, it has been extraordinarily disciplined and extraordinarily effective at capturing economic value for the company. Contrast that to one or two of our competitors who have been able to talk gross sales growth, but from what we can see, very limited net sales growth. It really contrasts very differently.

There is no doubt we will continue to apply that kind of mentality. Obviously the growth of *Advair* really depends on how well we do with some of other products as well, because clearly we are bringing a new product into this market place in the shape of *Breo*, then *Anoro* is going to come into the market place, and we have to see how that whole mix starts to play through.

Our overall goal, at a global corporate level, is that we expect to continue to be able to lead the respiratory market place well into the next decade and I fully expect *Advair* to be a very substantial part of that mix, notwithstanding all the new products which we are bringing to the market.

Next question.

Andrew Baum (Citigroup): I have two questions. First, Andrew, you talk about managing the business for the long term. When I look forward at the demographic trends, I guess they point to cancer, Alzheimer's and diabetes as being the three targets for society. Are you happy with your existing pipeline and research competencies in those areas, or do you see a need to engage in M&A to bolster particularly those areas. That is one.

The second one is for Simon on financials. Perhaps you could give us some background into the tax rate guidance for 2013, and also the quite significant working capital improvements that you managed this year. What is driving that?

Finally, I noted that you are taking the PRAME cancer vaccines forward. Is that in isolation or are you going pair it with a checkpoint? To what extent can we read into you're your confidence in your therapeutic cancer vaccine capital?

Sir Andrew Witty: Simon, do you want to go ahead?

Simon Dingemans: Thanks, Andrew. On the tax rate, we indicated 22% for 2014, another point down on the rate we delivered for 2013, and that is reflecting continued benefits from some of the restructuring of the supply line that has been driving the more recent reductions, but also the beginnings of contributions from new products, and therefore the benefits from the patent box. That is certainly starting to make a reasonable difference in delivering the 22% we are targeting. As I said before, we are looking obviously to improve that further in the years ahead.

Our working capital, we have made a lot of progress over the last several years in particular, tightening up receivables, managing our supplier base, and tightening up payables, but we also last year particularly, given end-to-end ownership of the inventory lines to our manufacturing organisations, and that has allowed us to start dropping out a lot of the supply buffers and contingency stocks that we have had in the system where the Commercial business is protecting itself, and making sure that we're much more responsive. That in turn obviously leads to more direct productivity as Andrew's just described, and it tells us how much the visibility of what the end demand really is, and knock out an amount of inventory, even though during 2013, we have also had to put more investment behind the product launches clearly, and getting ready for those and trying overall to improve our service availability in the market, so we have had some offsets there. Therefore, the net inventory number has been more about preventing cash going out rather than bringing cash in. We are expecting a lot more benefit from that in the years ahead, particularly out of the inventory line, so that is where it is coming from.

Sir Andrew Witty: As far as the R&D portfolio on some of those demographically-driven disease areas, Andrew, on cancer I think we are in a good place where we stand today, so with the MEK/BRAF, with *Votrient*, the performance we are seeing there, with *Arzerra*. We have a pretty good positioning for where we stand in the market. We are not the world's biggest Oncology company, that is for sure, but that is why I describe this as kind of a challenger business. It is a little like HIV in that sense. We have some significant innovation, we are not the leaders. We continue to think hard about how we might leverage what we have in this particular field but we are in a good position.

As you look forward, there are clearly some areas of Oncology innovation where we are not present. We do not have a PD1 programme, we are partnering with two or three other companies in PD1, and we believe there is a significant potential opportunity either for PD1 combinations with targeted therapies like our own, or even sequencing, particularly when you look at melanoma. We have something quite interesting to do there and we have

an active strategy there but we shall certainly continue to think about how we might best utilise and maximise the platform we have, recognising who we are in the marketplace. I am proud to be the leader in Respiratory but I am also honest about where we are in Oncology, and we have to be thoughtful about that.

As far as Alzheimer's, to be honest we are all as good as each other and there is a significant obvious unmet medical need. We have a lot of work going on in this field, we have some interesting programmes but I believe this is an open race to go. Who knows whether or not an attractive target surfaces and perhaps you will see something like a Hep C type of situation suddenly break loose? It is not obvious to me that it exists today and, given the very substantial degree of late stage failure, it looks like a high risk strategy but we are certainly vested in being there hopefully at the forefront of research, and we have to see whether we are the ones who get to it.

On diabetes, we are increasingly confident around *albiglutide* and, as we spend more time interrogating the data, we believe we have a very nice positioning for the product assuming it is approved. We expect those regulatory decisions, both in Europe and America, in the next few months. However, rather than being focused on building a diabetes franchise, I am more and more thoughtful about how we can develop a broader cardiovascular metabolic franchise, looking at areas like Lp-PLA2, at the P38 in ACS as well as diabetes. Therefore, we are a little thoughtful about it from that perspective and are not so much minded towards going to a diabetes only focus.

Then you asked a question about PRAME and it is on our list of opportunities to move into Phase III over the next year or two. It is an important programme for us that reflects our optimism and confidence around the antigen-specific cancer immuno-therapeutics. This is an area where we believe we could leap into a new technology field and be quite differentiated from many others. I would also make the point, obviously we still have three more sets of pivotal data to come in on the MAGE-A3 programme; we have co-primaries, we have three more co-primaries to go. Essentially we need one of those to come in for us to be in business and that is an exciting prospect.

We haven't mentioned it previously, but one of the other programmes in Phase II/III is in fact a third ASCI development programme; I promise you this wasn't named after me, but it is called WIT- 1. This is another one which simply adds to the point that we have a very substantial research effort here; much of it has been below the surface – it is now beginning to move above the surface into very late stage development and it reflects our belief that we can bring something of value here. As we look at different tumour types we think we will see potentially different results.

Thanks very much for the question. Next question.

Tim Anderson (Sanford Bernstein): Hi. A couple of questions. On your pipeline of products that are now in Phase III or nearing Phase III, can you just narrow it down what you think are perhaps the two or three compounds that excite you the most or that you think folks like myself might be missing?

Then a second question that I know I have asked you about before, but what is your latest thinking on the likelihood and the timing of potentially seeing substitutable generic *Advair* in the US? Also on *Seretide* in Europe, can you talk about the sale trajectory likely in 2014 as we start to get value brands launching?

Sir Andrew Witty: Thanks, Tim. As far as the second question is concerned, value brands in Europe are not a new concept. We have had two or three non-generic, but clearly positioning themselves as value brands, which has driven an awful lot of the reference pricing, it drove some of the negative price dynamics two years ago in Europe when *Seretide* took some big hits, particularly in Germany. I don't think the generics that we are hearing about and we are seeing at the moment really makes a big difference. We have had generics come into places like Greece and Poland over the last two or three years; we have not seen them have great strides. We understand that in several countries the putative generics are not going to be substitutable. It is also interesting to know, and I'll just make this comment, we are not seeing any low dose generics. For those of you who are on top of what is required to register in America I'll just leave it at that!

I don't feel like there is a massive ground shift going on in Europe, so my expectation is we will continue to see similar trends to what we have seen over the last two or three years in terms of the European *Seretide* position.

As far as the US is concerned, it boils down to the same conversation that we have been having since 2008 when I first got this job, which is that it is a difficult challenge to get to a substitutable generic in America. While, yes, there have been draft guidelines, perhaps that has made things slightly clearer for some people. They still have to be able to do the work, deliver the reproducible performance, cover the range of information that the FDA are asking for and to be able to not just do that in theory, but then to have the manufacturing process, which ensures it can be delivered repeatedly.

We know, everyone who has worked in the respiratory industry, inhaled industry, knows those are not trivial challenges and I have been struck, even in the last two or three months – some of the varying debates which I hear in the generic industry which are about

just how easy or difficult this is. My expectation hasn't really changed very much, Tim, which is that we have a period of time, several years in front of us where we have substantial opportunity remaining with *Advair*. I can't guarantee you any more than I could in 2008 that that period will last forever, but I do believe it will last for several years.

I believe that, unlike previous times, we have in the meantime created a very substantial new pipeline of products. We have two already approved in the US: we have seven more respiratory programmes in Phase III development or in pre-registration; that is nine new product launches into the respiratory market potentially possible in the next two to three years. That all could happen before we get any kind of generic in the States. Then there is the question mark of will that generic, in fact, after all of this, be substitutable or not? Who knows? That is somebody else's job to try and get done.

For me, I know a lot of people get very fixated on this – if I contrast to where we are now versus a few years ago, the one thing, the only thing that has changed is that GSK now has a new respiratory portfolio. Everything else is more or less the same as it has always been, with a similar kind of uncertainties.

If I look then at the first question that you asked around what would I call out for you individually from the pipeline? If I think about the potential filings, or the filings which have already gone in, I would just remind you we have already submitted for registration globally our LAMA monotherapy, *UMEC* or *umeclidinium*. Of course we already have approval in America for a combination of *UMEC* and the LABA, but remember, what *UMEC* monotherapy is is essentially a product to go into the *Spiriva* marketplace. In most situations, if I told you we had a product to compete against *Spiriva*, you would say "That's pretty interesting". Now it actually has slipstreamed in behind the combination products but that one, remember is already filed so just worth mentioning that.

If I think about now some of the Phase IIIs, I just want to pull out one or two of the ones which I am still very interested and excited about. I have obviously seen more information about Lp-PLA2 and darapladib than you have. You will see this at a conference in March. We indicated that we have seen some encouraging signals in there. I believe that the Lp-PLA2 programme is a programme where we have identified a whole series of very potentially interesting opportunities, so I believe that that is an area which you are going to hear a lot more about.

I remain of the view that we still have three of the four opportunities to win in the MAGE-A3 programme. We will see that as we go through the next year or so, so I just would mention those too.

The triple combination in Respiratory, really a fantastic chance for us to develop a product to bring together the three different modes of action. The long-acting integrase inhibitor in HIV, '744 I think is really potentially a revolutionary product there. P38, losmapimod in acute coronary syndrome, obviously potentially very interesting if indeed we can progress with darapladib, so start to build up a cardiovascular business for us; we have a very nice profile there.

If I look at retosiban, very unusual, very, very interesting product for pre-term labour now moving forward towards Phase III and we have already mentioned the other antigen-specific cancer immunotherapeutics PRAME and WIT1, so there is a whole bunch of things there and I have literally only pulled out four or five of the ten that are about to start and I haven't really gone into at all the 40 other new molecular entities.

I am going to take one opportunity to say something here. When I talk about programmes in R&D, I am talking about unique molecules. I am not talking about line extensions and I am not talking about indication extensions, so ten potential Phase III starts means ten unique new molecules or a creation of a new product in the shape of a triple, and 40 NMEs in Phase II/III means 40 discretely different molecules rather than one molecule appearing 14 times in the list.

Take what you will from that comment but I just want to make sure you understand how we define these numbers.

Keyur Parekh (Goldman Sachs): Good afternoon. I have three questions, if I may please. First, Andrew I would be keen to hear your thoughts on how you think the China situation gets resolved and when we should expect additional clarity on that end.

Secondly, I believe you had previously suggested that in the near-term margin progression is likely to be much more muted and yet what we are seeing is 2% top line growth delivery and a 4% to 8% bottom line. If I put those two things together, should we expect incremental margin expansion post-2014 or do you still see a few tens of basis points as the baseline for '15 and '16?

Then lastly perhaps a little bit of clarification. My understanding was that the launch for Breo in the US was delayed for several months to prepare the market and to make sure that when patients went in with a prescription, those weren't rejected. If you are suggesting that 70% of prescriptions are not being filled, can you just help us understand how that gets resolved and what are the steps you need to do incrementally on that end? Thank you.

Sir Andrew Witty: Okay, let me ask Simon first of all to come in on the margin.

Simon Dingemans: Thanks, Andrew. I think as we covered on an earlier question, looking at 2014 specifically we are expecting the significant part of leverage to be delivered through the bottom half of the P&L. There will be the opportunity for some contribution from the top half, depending on how the new products begin to contribute during the year, but as I have said a few times now, what we are really looking for as we target to improve our operating leverage going forward over the next several years is for meaningful contributions from the pipeline to help drive that forward and offset the drag we have from the growth in our lower margin businesses like Consumer and Emerging Markets.

That is going to be a steady progress. It is going to move the margin forward progressively. We are not going to see big step changes and that mix shift is what is really going to achieve that, so that's sort of the trajectory that you should expect over the next several years.

But I think the guidance we have given for 2014 is really more about the bottom half of the P&L and maybe a little bit from the top.

Sir Andrew Witty: Thanks, Simon. As far as China is concerned, the timing of how this all gets resolved is really going to be determined by the Chinese authorities. There is not much more I can add to that.

I would just make the point that (a) we are seeing a stabilisation in the fourth quarter of the sales performance of the business, and (b) actually if you look back over 2013, our China business was down £125 million year-on-year. Obviously that's against a backdrop of the £26.5 billion total turnover of the company. Obviously we are not happy about the situation in China, what happened last year but I just want to make that overall point around context.

As far as the coverage build for *Breo*, as I have said already on this call, it is really a question of getting the contracts negotiated, when the contracts come up for negotiation. Now, unfortunately, *Breo* one or two of the higher profile decision-makers, for their own reasons, made decisions either before *Breo* was even launched or we had even had a chance to talk to them or really right at the very, very beginning of that conversation. There is not much I can do about that, except just, I suspect, given what was going on with lots of other companies at the same time, it had nothing to do with us, it had everything to do with what those companies' strategy may have been with regard to the market place. Therefore the build of the Part D coverage, which is really the key part, is really a function of when these contracts come up for renegotiation. As I have said already, we have made very

substantial progress in the last three weeks, we can see a lot of opportunity in the next couple of months and so I think we are on the right trajectory to open up this part of the coverage platform.

As I said at length today, we are generating substantial interest and prescribing, and I think, actually, welcome to the new world. I think this is what you are going to see more and more in the primary care market place. There have not been all that many big primary care launches, a lot of what is going on in the US is speciality care, a lot of that has very different coverage dynamics. I think you are going to see this as the new normal in the US.

Thanks very much; next question.

Kerry Holford (Credit Suisse): Sorry to go back to *Breo*, Andrew, but just on that, I am just really keen to understand why you are not able to secure better formulary coverage from the beginning of this year, given it was approved back in May last year? With over a six month window to get more of those Medicare Part D formularies signed up, I am just very surprised if it is only 2% at the start of the year. I guess what is more important is whether this then has a read across to *Anoro*, and whether we should expect a similar delay for *Anoro*'s Medicare Part D access to build? Are we looking at another six months before that product really gets going?

Then also on Respiratory, I wonder if you can talk a little bit more about your marketing strategy. As you are launching *Anoro* in the next few weeks, what proportion of your sales force will be having *Breo* versus *Anoro*, or indeed *Advair*, as their number one detail?

Then just a quick follow-up on the net working capital. We talked already about the inflow in 2012 and 2013. Just to be more explicit here, can we expect/should we expect cash in, in 2014 and 2015, or when do you start to, effectively, need to start reinvesting in the business and when does that item reverse? Thank you.

Sir Andrew Witty: Simon, do you want to comment on that?

Simon Dingemans: Yes, I think for 2014, specifically, you should probably expect a pretty neutral position. We are, obviously, having to invest behind some of the launches, but taking working capital out of some of the more mature bits of the portfolios and net/net that is broadly where you should be. I think going forward, as we continue to drive the days down, what we are looking for is to minimise the cash outflows as we invest behind a growing business and improve our overall efficiency. Calling that, at this stage, is probably a little early, but steady progress is what I am targeting.

Sir Andrew Witty: As far as *Breo* and *Anoro* timings, what you tend to see is quite a lot of contracts being done at the early part of the year, so, hopefully, *Anoro* will come in at a better time of the year than we saw for *Breo*.

Secondly, you have to remember nowadays, under the new PDUFA regulations, you have a post approval, you have basically a two month, or so, minimum two months, in terms of going through the various promotional signoffs and all of that with the FDA, which you really need to get done before you start engaging and describing the benefits of the products to the customers. Again, a lot has changed in the US in the last several years, this is no longer 2006/7, a very different set of dynamics at play, very, very different attitude of payers and a very, very, in some cases, different positioning of competitors. My expectation is *Anoro* will build coverage more quickly, but I don't think it will, necessarily, build coverage as quickly as you might have expected four or five years ago from launches back in those days.

I am not going to describe to you, at all, our commercial strategy for *Anoro* and *Breo*, for obvious reasons.

Next question.

Mark Clark (Deutsche Bank): Good afternoon. I just wondered if you could talk us through some of the dynamics that are included in your 2% sales guidance on Vaccines and emerging markets outside of China. For Vaccines, you have had a lot of moving parts in Japan and benefitted from Sanofi's Production problems. Sanofi claim they are in the process of returning their paediatric product to full production by sometime in the first quarter. I wonder if you could tell us whether you are expecting a material pickup on the 2% growth in Vaccines in 2014 relative to 2013? Secondly, in emerging markets, even if we strip out China, I think the figure was 5%, which is below historic levels, where have the shortfalls come relative to prior years and what are your general expectations for 2014 in some of the bigger areas like LATAM and Russia etc.? Thank you.

Simon Dingemans: Mark, just on your Vaccines question, I think we are not expecting a significantly different outcome, the mix will be different in that, clearly as you point out, we are likely to see some drag in the US business although we shouldn't lose sight of the success of the quadrivalent flu launch that we initiated in 2013 that we would certainly expect to see making a material contribution. Japan is the other way around where we shall see some of the drags in 2013 wash out. Therefore, low single digits is probably the right sort of territory to think about.

Sir Andrew Witty: In Emerging Markets, in addition to China, the drags really came out of India where, as you may recall, there were some quite significant price cuts in April/May of the year. Following on from that, a number of big companies suffered a wholesaler boycott with wholesalers wanting to be recompensed for the price cuts. GSK being one of the biggest in the marketplace took some of the brunt of that. We were certainly not the only one but we took some of it, which knocked off quite a bit of the growth. If you look at our Russian business and at our Latina business, there was very strong growth during 2013.

As we look forward, I would expect to see the Emerging Markets pick up this year as we roll through the whole year. It is also worth saying that, like last year, I expect to see some volatility quarter-to-quarter, because, whether it is vaccine tenders in the previous year or in this year, you will see some of the effects of things like the wholesaler boycott drop in and out of the comparators. I would guide you to expect some volatility in quarter-to-quarter growth rates and not to get too hung up if one quarter is a bit down, and I wouldn't get too carried away if one quarter is a bit up, because we are bound to see some of that during the year.

Jeff Holford (Jefferies): Quickly around *Advair* pricing in the US: it looks like you have taken some positive price on *Advair* since the launch or availability of *Breo* in the US. Should we expect a pricing gap to widen between these two products as part of a switching strategy through this year and next year at all? Then, and I know it is a somewhat awkward question, as you weigh options around Theravance, just as you did very cautiously around Human Genome Sciences, can you perhaps talk about some of the pluses or minuses that you think about when considering potentially buying in your interest from this company? Thank you.

Sir Andrew Witty: As a general rule, and I implicitly made reference to that in various things I have said today either in the letter or in the opening comments, we are, generally not exclusively, bringing new products to the marketplace at or even a little below the price of the embedded products. You saw that particularly with the MEK inhibitor, the BRAF inhibitor, *Breo* has come in in a very competitively priced position. We believe that is absolutely the right place to be. Now you could argue that, in the short run, we could command higher prices but we believe that the US marketplace, indeed all marketplaces around the world, are increasingly price-sensitive, and you should expect to see price being used by GSK more than perhaps we have seen in this marketplace historically.

As far as Theravance is concerned, we have a great partnership with Theravance and we have developed together a substantial number of products. I would just remind you, as people often forget this, that we already own 26% or 27% of Theravance, so we own almost a third of the economic interest that flows to them. We book it in a different part of the P&L on the balance sheet but, nonetheless, it is there and often people just think that GSK has a pay-away to Theravance. Yes, we do, but we then own close to a third of that economic share. Beyond that, we have a very healthy relationship with Theravance and it has been a successful partnership thus far.

Dani Saurymer (Barclays): I have two questions if I may. One relates to *albiglutide*: you hinted at a cardiometabolic franchise of some description, but I am trying to understand how you plan to promote that product. You previously indicated that you have been looking at alternative strategies other than perhaps marketing it yourself. Secondly, for Simon, in relation to SG&A, we saw so-called one-off value opportunities in 2013, and I wonder whether there is any assumption of a repeat of that within your 2014 guidance?

Sir Andrew Witty: As far as *albiglutide* is concerned, we have spent a lot of time looking at the various options, and we feel that we have a compelling positioning strategy for the brand. Although we shall expand some of our resource to support it, we believe that we can commercialise it on our own, partly because of the positioning that we feel good about and partly also because of the opportunity for it to be the first of a number of products in the cardiovascular metabolic franchise. When we looked at this around 18 months ago, we were looking at it very much as a stand-alone product but we no longer look at it as a stand-alone product. We look at it more as the first in what could be an emerging therapeutic area for us and, therefore, it made more sense to do that in an unencumbered way, albeit we will have to build some extra resource, probably through our contract partner, at least initially. Simon.

Simon Dingemans: On the structural benefits, just a quick point. They don't all fall in SG&A; they did largely in 2013, but they do contribute to cost of goods and R&D in all parts of the business where our headcounts sits, is how those benefits fall out. For 2014, as we flagged before, we continue to look for these sorts of opportunities and we have a couple that we are working on; one which could potentially build in of around £200 million of up-front benefits and we have factored that into our guidance. That is planned for the fourth quarter of 2014.

Sir Andrew Witty: Thanks very much, Simon. We have time just for one, last question, please.

Steve Scala (Cowen): Thank you. I have a couple of questions. Are there relevant *Advair* patents in the US beyond the 2016 patent so that when a generic files GSK may sue and be reasonably confident in up to an additional 30 months of exclusivity, similar to what we are seeing unfolding with Lantus? Of course, if the generic filings were a way off, exclusivity could exist well beyond 2016.

Secondly, what has FDA said about your rebuttal to the draft guidelines?

Thirdly, this is a bit of a follow-up, but in comparison to *Breo* and all things considered, including and beyond contracting, could you help us create an expectation for *Anoro*, say over the next one to two years? Would you expect a similar level of success, significantly greater success, given the unmet need, or significantly less success, given the novel concept? Thank you.

Sir Andrew Witty: Steve, I am going to be disappointing for you at not giving you any help at all on the first question; probably for obvious reasons. On the second question, first of all, I know everybody thinks they can determine product launch success in the first six weeks; in today's world that is potentially not the case. We'll see; I may be proven wrong, so I don't think we really see what the success of *Breo* is. Certainly from the reaction of the customers, which is, for me, the leading indicator, it feels very encouraging.

Having said that, *Anoro*, as a first-in-class, when we know that bronchodilator benefit is so important to patients, I have always believed and if you talk to people inside the company you will hear that I have always believed that *Anoro* is new, it is different, it speaks very directly to one of the primary needs of the patient population. I have always had very substantial hopes and expectations for that programme. I would say, and I make no apology for saying something I was saying in 2008, and I remember Graham Parry asking me this question at our year-end results in '08 or '09, I am going to reiterate what I said then: our strategy has never, repeat never, been to replace *Advair* one-for-one. Our strategy has been to succeed *Advair* with a portfolio of respiratory products. I described today, we now have two already approved; we have a total of potentially nine, so seven more in the wings. Of those seven the six which are respiratory most of the molecules are now already approved in one form or another and the device they are coming in is already approved. The risk discharge from the inhaled portion of the next wave of respiratory products is significantly reduced.

That portfolio is what will build the continued leadership of GSK in respiratory. We have never had a goal and a dependency to create one product to replace *Advair*. You are much better at the maths than me. If you have nine products what each of them has to do to

in fact cumulatively be remarkably successful; you can see immediately why this strategy has great appeal to me. It diversifies our risk profile; it gives us many opportunities.

Imagine if, within that, two or three or four of them turn out to be substantial products; that is why we are so excited about the respiratory business. Time will show that the *Breo* proposition is appealing and, as we build coverage, we will demonstrate that through performance. *Anoro* is the first of the truly new types of products and hopefully, as we go through the next two or three years, you will see those two supplemented by up to seven more. It is that portfolio, in addition to the continued *Ventolin* performance, which is still selling hundreds of millions of dollars almost 50 years after it was launched, plus *Flovent*, plus *Advair*, that is going to be the respiratory business of the company going forward and that is why we are confident about it.

With that, thank you very much for your attention today; very much appreciated. I know some of you will have some more questions, please feel free to call into the IR team here at GSK and thank you very much for your attention.

[*Conference concluded*]