



BUSINESS PLAN · INDIA

Generic-Medicine Store

Where your price is read as a signal against you, only evidence repairs it

PHARMACY RETAIL & DISTRIBUTION

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August 2026

This document is confidential and prepared for planning purposes. All financial figures are illustrative model assumptions for an Indian MSME context and must be validated against live quotes, local rates and professional advice before any investment or borrowing decision.

1. Executive Summary

This plan sets out a **Generic-Medicine Store** business in India — a chain of 62 small-format generic pharmacies by Year 3 in the Jan Aushadhi mould, dispensing unbranded generics, quality-tested branded generics, a chronic-care refill programme, surgicals and essential OTC lines, filling roughly 1.56 million prescriptions a year.

This plan inherits the pharmacy anchor's rules and confronts a problem no other plan in this library has: **a business whose central proposition is the one thing its customers instinctively read as a warning.**

☐ **THIS SELLER'S PRICE IS HIS BIGGEST OBSTACLE.** A patient told that the ₹340 branded strip he has been buying is available here at ₹28 does not conclude that he has been overcharged for years. He concludes that the ₹28 one must be inferior — because in every other purchase in his life, price signals quality, and the inference has served him well. Here the signal runs backwards, and it runs backwards for the customers least able to afford the mistake. The trade's answer is reassurance — "same salt, same effect, don't worry" — WHICH IS PRECISELY WHAT A SELLER OF SOMETHING INFERIOR WOULD ALSO SAY, and the customer knows it. So this business PUBLISHES THE BATCH TEST: ASSAY AND DISSOLUTION PER BATCH AGAINST THE SAME PHARMACOPOEIAL STANDARD THE BRAND MUST MEET, WITH THE MANUFACTURER NAMED ON THE SHELF LABEL — 214 batches rejected and 9 manufacturers de-listed in Year 3. THE ONLY ANSWER TO "WHY IS IT CHEAP?" IS THE TEST, NOT THE PROMISE. WHERE YOUR PRICE IS READ AS A QUALITY SIGNAL AGAINST YOU, THE ONLY REPAIR IS EVIDENCE THE BUYER CAN CHECK — REASSURANCE IS INDISTINGUISHABLE FROM WHAT A FRAUD WOULD SAY.

☐ **AND GENERIC SHARE OF REVENUE MUST NOT FALL.** The thin generic margin pulls every store in this category towards supplements, cosmetics and counter FMCG, WHICH QUIETLY CONVERTS A GENERIC STORE INTO A GENERAL STORE WITH A GENERIC SIGN — and nothing in the accounts flags the drift, because revenue and margin both improve while it happens. So GENERIC SHARE OF REVENUE IS PUBLISHED AND MUST RISE — 79% to 82% — with non-generic shelf space capped and ANY OUTLET FALLING BELOW 78% INVESTIGATED.

☐ **AND A STOCK-OUT SENDS A PATIENT BACK TO A BRAND PERMANENTLY.** A generic store that does not have the molecule once has usually lost it for good, because the patient's first switch back is also his last. So FILL RATE REACHED 96%, the median restock of a chronic line is two days, and stock-outs are counted and published.

This plan models an operator requiring **₹8.00 crore** (₹3.20 crore investor + ₹2.40 crore term loan + ₹1.60 crore promoter + ₹80 lakh working capital), moving from **₹7.00 crore revenue and an ₹89 lakh loss** to **₹44.00 crore revenue and ₹1.60 crore profit** by Year 3 — a 3.6% net margin and 17.4% return on capital, having delivered ₹54 crore of savings to patients on ₹44 crore of turnover. (Generic retail — figures illustrative.)

2. Business Description, Vision & Legal Structure

Concept: A generic chemist that publishes the test instead of the promise.

Vision: To make "why is it so cheap?" a question with a printed answer.

Mission: Test every batch against the standard the brand must meet and publish it; name the manufacturer on the shelf; keep the generic share rising rather than drifting into supplements; have the molecule in stock so nobody has to go back to a brand; and tell every patient in rupees what he saved.

Legal structure

- **Private Limited** — recommended. Multi-outlet drug licensing, scheme participation, supplier contracts and outside capital all assume it.
- **Proprietorship** — workable for a single Jan Aushadhi kendra, and unworkable across 62 outlets and a testing programme.
- **Quality function with authority to reject a batch and de-list a manufacturer, reporting to the promoter — because a rejected batch in a 3.6%-margin business is a real loss to somebody's target.**

Regulatory anchor: the Drugs and Cosmetics Act 1940 and Rules 1945, with a retail drug licence per outlet; the Pharmacy Act 1948 and registered-pharmacist supervision, which applies to a generic store exactly as it applies to any other; Schedules H, H1 and X with registers maintained per shop; **the Indian Pharmacopoeia, under which a generic must meet the SAME assay, dissolution, impurity and uniformity standards as the branded product containing the same molecule — which is the entire legal basis of the proposition and is almost never shown to a patient;** NPPA and DPCO ceiling prices, and the Jan Aushadhi / PMBJP framework where a kendra is operated under it, including product basket, pricing and margin structure; drug recall and reporting of substandard product; GST; and shops and establishments, EPF/ESI and POSH. **The decisive structural fact is that the pharmacopoeial equivalence which makes generics lawful is a technical document a patient will never see, while the price difference is visible at the counter in one second — so the evidence and the doubt arrive in completely different formats.**

3. Promoter & Ownership

Led by a promoter with pharmacy retail, generic distribution or public-health background. Three competences decide outcomes. *Supply reliability*, because fill rate is the difference between a patient who converts and one who never returns, and generic supply chains are less dependable than branded ones. *Manufacturer selection*, since the whole proposition collapses if a single batch fails publicly. And *resistance to the drift*, which is where this plan's proposition sits and which means declining the easiest available margin every single quarter. Ownership, equity & investor terms are editable inputs; **the quality function reports to the promoter, holds authority to reject and de-list, and no counter staff member is paid on category mix.**

4. Market Analysis — India

Enormous latent demand held back almost entirely by a belief about price.

Demand drivers

- **Out-of-pocket medicine spending**, the largest healthcare cost for most households.
- **Chronic disease** requiring lifelong monthly purchase where the saving compounds.
- **Government policy** promoting generic prescribing and Jan Aushadhi expansion.
- **Price-controlled branded medicines** still costing multiples of the generic equivalent.
- **Rising prescriber willingness** to write molecule names rather than brands.
- **Insurance exclusions** leaving outpatient medicine cost entirely with the patient.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian retail medicine spend addressable by generics	Very large; penetration still low

SAM	Patients who will switch once shown evidence rather than reassurance	Bounded by TRUST, not by price
SOM (Yr 1-3)	Outlets and prescriptions filled	₹7cr → ₹44cr; 62 outlets; 1.56m prescriptions

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and why it is deliberately thin
Unbranded generic medicines	50.0%	22.0% — the proposition; every point of margin is a point of saving lost
Branded generics at published price parity	18.0%	24.0% — where the unbranded is unavailable
Chronic-care generic refill programme	14.0%	23.0% — the retention engine; 74% persistence
Surgicals, consumables & devices	9.0%	28.0% — genuine need, not a margin escape
OTC and essential non-drug items	6.0%	30.0% — capped by shelf space, not by demand
Institutional & clinic supply of generics	3.0%	16.0% — lowest margin, widest reach

Generic share — the first three rows — is 82% of revenue, and the last two rows are the ones that would grow if nobody was watching. OTC and non-drug items carry 30% against unbranded generics' 22%, and a store manager under pressure has an entirely reasonable-sounding argument for stocking more of them: the customer wants them, they turn faster, they subsidise the thin lines, and nobody is harmed. Each step is defensible and the destination is a general store with a generic sign — which is why the constraint is SHELF SPACE rather than exhortation, capped at 15%, and why generic share is published as a metric that must rise. The institutional line at 16% is the lowest margin in the business and is kept because it puts generics into clinics that would otherwise dispense branded, which is the point of the enterprise rather than a contribution to it.

Constraints

- **Patient belief**, which is the binding constraint and responds only to evidence.
- **Supply reliability**, since generic supply chains are thinner than branded ones.
- **Prescriber habit**, where brand-writing remains the default in much of practice.
- **Margin thinness**, which leaves almost no room for operational error.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
Branded-medicine chemists	Prescriber alignment, stock depth, established trust, better margin	Patient pays multiples for identical pharmacopoeial compliance
Other Jan Aushadhi / generic kendras	Scheme pricing, government backing, low rent formats	Reassurance instead of evidence; drift into non-generic lines
E-pharmacies discounting branded	Convenience, delivery, deep discounts, refill reminders	Discount off a brand price still exceeds a generic price

Hospital and clinic dispensing	Captive prescription flow at point of care	Brand-led; no incentive to raise the generic question
This plan	Batch assay published, manufacturer named, generic share rising, 96% fill rate	3.6% net; forgoes more than twice its profit

The positioning is aimed at the specific moment where this business is normally lost: a patient standing at the counter with a branded prescription, hearing a price that is a tenth of what he expected, and going quiet. He is not being difficult — he is doing exactly what a careful person should do when a number does not make sense. So he is handed the batch test rather than a reassurance: assay and dissolution results for the actual batch in his hand, the pharmacopoeial limits beside them, and the manufacturer's name and address on the shelf label. Everything is checkable in the shop in under a minute, which is this library's standing test, and it is the only form of argument that survives the price paradox — because any sentence beginning "don't worry" is a sentence a fraud would also use.

The cost of the honest position is stated in rupees and is more than twice the profit. Holding generic share at 82% rather than filling the shelves with the non-generic lines that turn faster and earn more cost ₹1.64 crore of Year-3 margin — the largest item, and a cost that recurs every quarter because the drift is continuous rather than a single decision. Batch assay and dissolution testing, published, with 214 rejections and 9 manufacturer de-listings, cost ₹86 lakh. Carrying the stock depth and restock speed that hold fill rate at 96% cost ₹78 lakh. Naming the manufacturer to the patient and informing the prescriber of every substitution, with 6% of patients declining once told, cost ₹42 lakh. Total ₹3.70 crore against ₹1.60 crore of profit — so an operator running the same 62 shops on trade-standard practice would earn ₹5.30 crore.

6. The Price That Argues Against You

This is the finding, and it is a problem of inference rather than of honesty.

What the patient is told	What he reasonably infers
"The same medicine costs ₹28 here"	"Then it is not the same medicine"
"Same salt, same strength"	"A cheap seller would say that too"
"It is government approved"	"So is the ₹340 one"
"Doctors recommend generics"	"My doctor wrote the brand"
"Millions of people use it"	"Poorer people, who have no choice"
"Trust us"	The exact sentence he was hoping to avoid

Every line in the right-hand column is a sound inference from ordinary experience. Price signals quality across nearly every purchase a person makes, and a patient applying that rule to medicine is not being ignorant — he is applying a heuristic that has served him well everywhere else, in the one category where it inverts. And the inversion is cruel in its distribution: the people for whom the saving matters most are the people with the least margin for error if the doubt turns out to be right, so **THE MORE A PATIENT NEEDS THE PRICE, THE MORE RATIONAL IT IS FOR HIM TO BE AFRAID OF IT**. The trade's standard answer makes it worse rather than better, because every form of reassurance available — "same salt", "don't worry", "everybody uses it" — is a sentence that a seller of genuinely substandard medicine would deliver in identical words and identical tone. **REASSURANCE CARRIES NO INFORMATION**, because it is available equally to the honest and the dishonest, and

the patient's scepticism is the correct response to a signal that cannot discriminate.

So the evidence is supplied in a form the reassurance cannot imitate. ASSAY AND DISSOLUTION ARE TESTED PER BATCH AGAINST THE SAME PHARMACOPOEIAL LIMITS THE BRANDED PRODUCT MUST MEET, AND THE RESULTS ARE PUBLISHED PER BATCH — on the shelf label by batch number, on the bill, and online — with the pharmacopoeial limit printed beside the measured value so a patient can see the margin rather than take the word "compliant". THE MANUFACTURER IS NAMED ON THE SHELF LABEL, with address and licence number, because an unnamed manufacturer is precisely what a patient is afraid of. 214 BATCHES WERE REJECTED AND 9 MANUFACTURERS DE-LISTED in Year 3, per the vertical rule that de-listing addresses the source while rejecting a batch addresses one consignment. Rejected stock is destroyed rather than returned. WHERE YOUR PRICE IS READ AS A QUALITY SIGNAL AGAINST YOU, THE ONLY REPAIR IS EVIDENCE THE BUYER CAN CHECK — REASSURANCE IS INDISTINGUISHABLE FROM WHAT A FRAUD WOULD SAY.

What a patient can check in sixty seconds, standing at the counter, without taking anybody's word for anything: the BATCH NUMBER on the strip in his hand matches a batch number on the shelf label; the ASSAY RESULT for that batch is printed beside the pharmacopoeial limit, so he can see it is not merely inside the limit but by how much; the DISSOLUTION RESULT is there on the same line, which is the test that actually determines whether the tablet releases its drug in the body; the MANUFACTURER'S NAME, ADDRESS AND LICENCE NUMBER are on the label rather than absent; the BRANDED EQUIVALENT PRICE and his own saving in rupees are printed on the bill; and a REGISTERED PHARMACIST is standing there, whose registration number is displayed. Not one of those requires him to believe us about anything. That is the design constraint the whole plan is built to: in a category where the seller's own assurance is worthless as evidence, every claim must be reducible to something the buyer can verify himself before he pays.

7. The Drift, the Stock-out and the Saving

Three further rules, the first of which is how businesses like this one usually end.

□ **GENERIC SHARE OF REVENUE MUST NOT FALL, AND NOTHING IN THE ACCOUNTS WILL TELL YOU WHEN IT DOES.** A 22% generic margin sits beside a 30% OTC margin and a 45% supplement margin, so every store manager has a rational, well-meant case for a little more of the latter: faster turns, better cash, happier customers, and a subsidy for the thin lines. Nobody proposes abandoning generics; the shelf simply rearranges itself over eighteen months, revenue rises, margin rises, and the business becomes A GENERAL STORE WITH A GENERIC SIGN — with the accounts recording the whole transition as improvement. So **GENERIC SHARE OF REVENUE IS PUBLISHED AS A METRIC THAT MUST RISE — 79%, 81%, 82% — NON-GENERIC SHELF SPACE IS CAPPED AT 15%, and ANY OUTLET FALLING BELOW 78% IS INVESTIGATED** rather than congratulated on its margin. It costs ₹1.64 crore a year, recurring, because the pull is continuous.

□ **A STOCK-OUT SENDS A PATIENT BACK TO A BRAND PERMANENTLY.** A patient who has just been persuaded to try a generic, and finds it unavailable the following month, does not simply buy the brand once — he concludes the whole arrangement is unreliable, and the first switch back is usually the last. The conversion cost is therefore paid twice and recovered never, which makes fill rate the single most valuable operating metric in this business and the one the category most persistently under-resources. So **FILL RATE REACHED 96% from 86%, the MEDIAN RESTOCK OF A CHRONIC LINE IS TWO DAYS from six, and STOCK-OUTS ARE COUNTED AND PUBLISHED — 11,600 in Year 3, falling in absolute terms while prescriptions doubled.**

□ **AND THE DOCTOR WROTE A BRAND.** Every substitution is a decision taken by us about somebody else's prescription, so the **MANUFACTURER IS NAMED TO THE PATIENT, THE PRESCRIBER IS INFORMED — 94% of substitutions in Year 3 — and 6% OF PATIENTS DECLINE ONCE TOLD**, which is the figure proving the disclosure is real. Informing the prescriber is not a courtesy: it is what allows a doctor to intervene if the substitution matters clinically, and it is the mechanism by which brand-writing habits actually change.

□ **AND THE SAVING IS THE REAL OUTPUT OF THIS BUSINESS.** Every prescription shows the branded equivalent price beside ours and the rupee saving — averaging ₹346 — and the aggregate is published: **₹54 CRORE OF PATIENT SAVINGS DELIVERED ON ₹44 CRORE OF TURNOVER.** The saving being larger than the revenue is the honest way to size an enterprise like this one.

8. Operations Plan (test, stock, substitute, disclose)

Quality

- **Assay and dissolution per batch** against the same pharmacopoeial limits the brand must meet.
- **Results published per batch** with the limit printed beside the measured value.
- **Manufacturer named on the shelf label** with address and licence number.
- **Manufacturers de-listed on failure** — 9 in Year 3 — and rejected stock destroyed, not returned.

Range discipline

- **Generic share of revenue published** and expected to rise; 82% in Year 3.
- **Non-generic shelf space capped at 15%**, which constrains the drift structurally.
- **Any outlet below 78% investigated**, not praised for its margin.
- **No counter pay linked to category mix**, per the anchor rule.

Availability

- **Fill rate measured per outlet and published** — 96% in Year 3.
- **Median restock of a chronic line at two days**, with inter-outlet transfer.
- **Stock-outs counted and published** rather than treated as ordinary friction.
- **Chronic refill persistence tracked** at 74%, with missed refills followed up.

At the counter

- **Registered pharmacist present** for all opening hours, 1.5 per outlet.
- **Manufacturer named to the patient on every substitution**; prescriber informed at 94%.
- **Branded equivalent price and rupee saving printed** on every prescription.
- **Refusal rules of the anchor plan applied unchanged** — prescription demanded, refusals logged.

The operational hinge is a district manager's entirely correct observation that eleven outlets are unprofitable, that each of them would clear its rent within two quarters by giving four feet of shelf to protein powders and skin creams, and that nobody anywhere would be worse off. He is right about the arithmetic and right that no patient is harmed, and the proposal arrives as good management rather than as a compromise. So **NON-GENERIC SHELF SPACE IS CAPPED IN THE PLANOGRAM AT 15% AND THE ORDERING SYSTEM WILL NOT ACCEPT A REPLENISHMENT THAT BREACHES IT** — the system refuses rather than warns, because a cap enforced by memory in a thin-margin business lasts about two quarters. An unprofitable outlet is closed or relocated

rather than converted, and **NO STORE MANAGER'S PAY IS AFFECTED BY CATEGORY MIX OR STORE MARGIN**, only by fill rate, generic share and refill persistence.

A second operational point worth stating plainly, because it is where the category's reputation is genuinely at risk rather than merely doubted. This business's proposition is not that generics are cheap — it is that a specific batch met a specific standard — which means **A SINGLE PUBLIC BATCH FAILURE WOULD NOT MERELY DAMAGE THIS COMPANY, IT WOULD CONFIRM THE DOUBT FOR EVERY GENERIC SELLER IN THE COUNTRY IN ONE NEWS CYCLE**. The asymmetry is severe: years of published passing results earn incremental trust, and one failure removes it from an entire category, including from sellers who had nothing to do with it. So testing is at goods-in on **EVERY** batch rather than sampled, manufacturers are selected on inspection history and **DE-LISTED ON A SINGLE FAILURE** rather than warned, retained samples are held so a disputed result can be independently re-tested, and the recall procedure is exercised rather than documented. The quality function reports to the promoter and can reject without reference to anybody, because a rejected batch in a 3.6%-margin business is a real loss to somebody's target and the person carrying that target must not be the person deciding.

9. Licensing, Equivalence & Operating Compliance (India)

- **Drugs and Cosmetics Act 1940 and Rules 1945** — retail drug licence per outlet, with premises, storage and record conditions.
- **Pharmacy Act 1948** — registered-pharmacist supervision, which applies to a generic store exactly as to any other.
- **Schedules H, H1 and X** — registers per shop; the anchor plan's refusal rules apply here unchanged.
- **Indian Pharmacopoeia** — **a generic must meet the SAME assay, dissolution, impurity and uniformity standards as the branded product with the same molecule; this is the entire legal basis of the proposition, and it is almost never shown to a patient.**
- **NPPA and DPCO** ceiling prices, and Jan Aushadhi / PMBJP product basket, pricing and margin structure where operated under it.
- **Recall and reporting** of substandard or spurious product to the licensing authority.
- **Commercial and workforce** — GST, shops and establishments, EPF/ESI, POSH.
- **The structural gap** — **the pharmacopoeial equivalence that makes generics lawful is a technical document a patient will never see, while the price difference is visible at the counter in one second: THE EVIDENCE AND THE DOUBT ARRIVE IN COMPLETELY DIFFERENT FORMATS.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owens the generic-share rule
Counter staff & outlet support	22	118	Nil pay linked to category mix or store margin
Registered pharmacists	18	94	1.5 per outlet; full opening-hours cover
Warehouse, distribution & restock	8	26	Two-day chronic-line restock at 96% fill
Quality — batch assay, dissolution & de-listing	5	14	Reports to promoter; can reject and de-list
Finance, legal, compliance & admin	4	12	Publishes assays, generic share and savings

Total	58	265	Pharmacists at 35% of headcount
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Ninety-four registered pharmacists across 62 outlets applies the anchor plan's rule unchanged, and it matters more here than anywhere else in the vertical: a generic store is exactly the format where the trade assumes a pharmacist is a luxury, because the ticket is small and the customer is poor. That assumption is the reason generic retail has a credibility problem, and reversing it is cheaper than any amount of advertising. Store managers are paid on **FILL RATE, GENERIC SHARE AND REFILL PERSISTENCE** — never on category mix or store margin — because the three things that would improve a manager's bonus under any conventional scheme are precisely the three that would dismantle the business.

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & first outlets	Month 0-6	Incorporation, drug licences, 12 outlets, supply appointments
Batch testing & publication	Month 2-9	Assay and dissolution per batch; results on shelf label by batch
Planogram cap & generic share	Month 4-10	15% non-generic shelf cap enforced in ordering; share published
Fill-rate programme	Month 8-20	86% → 92%; inter-outlet transfer; two-day chronic restock
34 outlets & prescriber liaison	Month 12-26	Substitution notification to prescribers reaching 84%
Scale & publication	Month 24-36	62 outlets; ₹54cr of patient savings published

Training and competence

- **Answering "why is it cheap?"** with the batch sheet rather than a reassurance — the core counter skill.
- **Reading an assay and dissolution result** well enough to explain it to a patient in a minute.
- **Substitution conversation**, including naming the manufacturer and informing the prescriber.
- **Why the shelf cap exists**, taught as the business's survival condition rather than a rule.

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions, not forecasts or guarantees. They exist to show the drivers of a generic retail P&L and how the testing, range and fill-rate disciplines move them. Every input is editable. **The defining economics are a 23.3% blended gross margin producing 3.6% net — thin by design, because every point of margin taken here is a point of saving not delivered, and the saving is the product.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Outlet fit-out & fixtures (62 small-format, phased)	246	Includes batch-result shelf labelling
Opening inventory across outlets & warehouse	218	Depth is what holds fill rate at 96%
Working capital	124	Stock cycle and institutional terms
Batch testing laboratory & sample management	96	Assay and dissolution against pharmacopoeial limits

Technology, fill-rate & disclosure systems	62	Ordering rejects a breach of the 15% shelf cap
Licences, deposits & pre-operative	54	A drug licence per outlet
Total project cost	800	₹320L investor + ₹240L term loan + ₹160L promoter + ₹80L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
ASSAY AND DISSOLUTION PER BATCH against the same pharmacopoeial limits the brand must meet, PUBLISHED per batch with the limit beside the measured value / MANUFACTURER NAMED on the shelf label / batches rejected / manufacturers DE-LISTED	100% / 100% / 46 / 2	100% / 100% / 118 / 5	100% / 100% / 214 / 9
GENERIC SHARE OF REVENUE — published, and MUST RISE / non-generic shelf space (capped at 15%) / outlets falling below 78% and investigated / counter or manager pay linked to category mix	79% / 12% / 100% / NIL	81% / 14% / 100% / NIL	82% / 15% / 100% / NIL
FILL RATE — generic requested and available / stock-outs that sent a patient back to a brand / median days to restock a chronic line	86% / 8,400 / 6	92% / 14,200 / 4	96% / 11,600 / 2
Brand-to-generic substitutions made / manufacturer NAMED to the patient / PRESCRIBER INFORMED of the substitution / patients who declined after disclosure	42,000 / 100% / 68% / 9%	138,000 / 100% / 84% / 7%	286,000 / 100% / 94% / 6%
Branded equivalent price and RUPEE SAVING printed on every prescription / average saving per prescription / total patient savings delivered (₹cr)	100% / ₹284 / 7.0	100% / ₹312 / 24.3	100% / ₹346 / 54.0
Outlets / prescriptions filled / revenue per outlet / registered pharmacists per outlet / chronic refill persistence	12 / 246k / ₹58L / 1.5 / 52%	34 / 780k / ₹65L / 1.5 / 64%	62 / 1,560k / ₹71L / 1.5 / 74%

Row two is the row that keeps this business what it says it is: generic share **RISING** from 79% to 82%, with the cap enforced in shelf space rather than by instruction, and any outlet below 78% investigated rather than praised for its margin. It is an inverted metric of the kind this library has used before — a number a conventional operator would be pleased to see fall. Row three's stock-out count is worth reading carefully: 11,600 in Year 3 against 14,200 in Year 2, an absolute fall while prescriptions doubled, which is the only shape of improvement that counts when each event is a patient lost for good. Row five's total is the honest way to size this enterprise — ₹54 crore of savings delivered to patients on ₹44 crore of turnover, so **THE OUTPUT OF THE BUSINESS IS LARGER THAN THE BUSINESS.**

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Unbranded generic medicines	350	1,100	2,200	22.0%
Branded generics at published price parity	126	396	792	24.0%
Chronic-care generic refill programme	98	308	616	23.0%
Surgicals, consumables & devices	63	198	396	28.0%
OTC and essential non-drug items	42	132	264	30.0%

Institutional & clinic supply of generics	21	66	132	16.0%
Total revenue	700	2,200	4,400	23.3% blended

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	700	2,200	4,400
Cost of goods — incl. rejected batches and destroyed stock	(537)	(1,687)	(3,373)
Gross profit	163	513	1,027
Staff — pharmacists & counter	(96)	(196)	(318)
Outlet rent, utilities & occupancy	(62)	(132)	(218)
Distribution, warehousing & restock	(28)	(52)	(82)
Batch testing — assay & dissolution	(34)	(58)	(86)
Technology, fill-rate & disclosure systems	(22)	(32)	(44)
Admin, legal, compliance & other	(34)	(54)	(78)
EBITDA	(113)	(11)	201
Depreciation & amortisation	(26)	(44)	(62)
Finance cost	(18)	(32)	(44)
Other income — scheme incentives and supplier terms (<i>disclosed</i>)	38	72	118
PBT	(119)	(15)	213
Tax	30	4	(53)
PAT	(89)	(11)	160
Net margin	(12.7%)	(0.5%)	3.6%
ROCE	(17.4%)	(6.9%)	17.4%

3.6% net is the honest number for a generic chain that has not drifted, and the plan states it rather than modelling its way around it — because every point of gross margin taken here is a point of saving not delivered, and the saving is the product rather than a by-product. Batch testing at ₹86 lakh is 2.0% of revenue spent proving something the law already presumes, which no competitor does and which is the entire answer to the price paradox. Other income of ₹1.18 crore is scheme incentives and supplier terms, disclosed as a line and never conditional on the volume of a specific manufacturer, per the anchor's rule. Commitments of ₹3.70 crore against ₹1.60 crore of profit — more than twice — mean an operator running the same 62 shops on trade-standard practice would earn ₹5.30 crore, and most of that gap is four feet of shelf space per store.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹44.0cr	₹1.60cr	As modelled, 3.6% net

Trade-standard practice	₹45.6cr	₹5.30cr	Shelf drift, no testing, reassurance instead
Generic share allowed to fall to 70%	₹44.0cr	₹1.90cr	The drift pays, which is why it happens
Network grows to 90 outlets	₹63.9cr	₹2.42cr	Operating leverage is modest at this margin
Fill rate falls to 88%	₹41.1cr	₹1.11cr	Each stock-out is a patient lost for good
Rent inflation +25%	₹44.0cr	₹1.18cr	62 leases at 3.6% net leaves little room

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	320	Outlet rollout; generic-share and testing covenants
Term loan	240	Fit-out, laboratory and systems; 5-6 years
Promoter contribution	160	Cash and supply relationships
Working capital facility	80	Stock cycle and institutional terms
Total	800	Illustrative structure

A lender should read fill rate, refill persistence and generic share, and should understand that this is a low-margin, high-social-return business whose principal risk is neither credit nor competition but internal drift. Fill rate is the leading indicator of everything: 88% instead of 96% takes profit from ₹1.60 crore to ₹1.11 crore, and the mechanism is not lost sales but lost patients, which does not recover when stock returns. Refill persistence at 74% is the asset — a chronic patient converted and retained is several years of predictable monthly revenue at a saving he can feel. At 3.6% net there is very little tolerance for error, which is why 62 leases and a 25% rent movement is a material sensitivity, and why the generic-share covenant matters: relaxing it is the one lever that would improve every financial line at once and would end the business's reason for existing.

- **Use of funds** — 31% outlet fit-out, 27% opening inventory, 16% working capital, 12% testing laboratory, 8% technology and disclosure systems, 7% licences and deposits.
- **Repayment** — term loan from Year 3 cash flow; working capital revolving against the stock cycle.
- **Investor exit** — sale to a pharmacy chain, a generic manufacturer integrating forward, or a healthcare or impact investor; or promoter buyback. **The generic-share and testing commitments survive change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation
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The price that argues against you	A patient told his ₹340 branded strip is available at ₹28 DOES NOT CONCLUDE HE WAS OVERCHARGED FOR YEARS — HE CONCLUDES THE ₹28 ONE IS INFERIOR, because in every other purchase in his life PRICE SIGNALS QUALITY, and here the signal runs backwards. He is not being ignorant: HE IS APPLYING A HEURISTIC THAT HAS SERVED HIM WELL EVERYWHERE ELSE, IN THE ONE CATEGORY WHERE IT INVERTS. And the inversion is cruel in its distribution — THE MORE A PATIENT NEEDS THE PRICE, THE MORE RATIONAL IT IS FOR HIM TO BE AFRAID OF IT, because he has the least margin for error if the doubt turns out to be right. The trade's answer MAKES IT WORSE: "same salt", "don't worry", "everybody uses it" ARE SENTENCES A SELLER OF GENUINELY SUBSTANDARD MEDICINE WOULD DELIVER IN IDENTICAL WORDS AND IDENTICAL TONE. REASSURANCE CARRIES NO INFORMATION BECAUSE IT IS AVAILABLE EQUALLY TO THE HONEST AND THE DISHONEST, AND THE PATIENT'S SCEPTICISM IS THE CORRECT RESPONSE TO A SIGNAL THAT CANNOT DISCRIMINATE	SUPPLY EVIDENCE THE REASSURANCE CANNOT IMITATE: ASSAY AND DISSOLUTION TESTED PER BATCH AGAINST THE SAME PHARMACOPOEIAL LIMITS THE BRANDED PRODUCT MUST MEET, PUBLISHED PER BATCH on the shelf label by batch number, on the bill and online, WITH THE PHARMACOPOEIAL LIMIT PRINTED BESIDE THE MEASURED VALUE so a patient can SEE THE MARGIN rather than take the word "compliant"; THE MANUFACTURER NAMED ON THE SHELF LABEL with address and licence number, BECAUSE AN UNNAMED MANUFACTURER IS PRECISELY WHAT A PATIENT IS AFRAID OF; 214 BATCHES REJECTED AND 9 MANUFACTURERS DE-LISTED, with rejected stock DESTROYED not returned (₹86L). Everything checkable IN THE SHOP IN UNDER A MINUTE. GENERAL RULE: WHERE YOUR PRICE IS READ AS A QUALITY SIGNAL AGAINST YOU, THE ONLY REPAIR IS EVIDENCE THE BUYER CAN CHECK — REASSURANCE IS INDISTINGUISHABLE FROM WHAT A FRAUD WOULD SAY
The district manager's four feet of shelf	Eleven outlets are unprofitable; EACH WOULD CLEAR ITS RENT WITHIN TWO QUARTERS by giving four feet of shelf to protein powders and skin creams; AND NOBODY ANYWHERE WOULD BE WORSE OFF. He is RIGHT ABOUT THE ARITHMETIC AND RIGHT THAT NO PATIENT IS HARMED, and the proposal arrives AS GOOD MANAGEMENT RATHER THAN AS A COMPROMISE. A 22% generic margin sits beside a 30% OTC and a 45% supplement margin, so nobody ever proposes abandoning generics — THE SHELF SIMPLY REARRANGES ITSELF OVER EIGHTEEN MONTHS, REVENUE RISES, MARGIN RISES, AND THE BUSINESS BECOMES A GENERAL STORE WITH A GENERIC SIGN, WITH THE ACCOUNTS RECORDING THE WHOLE TRANSITION AS IMPROVEMENT	GENERIC SHARE OF REVENUE PUBLISHED AS A METRIC THAT MUST RISE — 79% → 81% → 82% — AN INVERTED METRIC A CONVENTIONAL OPERATOR WOULD BE PLEASED TO SEE FALL; NON-GENERIC SHELF SPACE CAPPED AT 15% IN THE PLANOGRAM, WITH THE ORDERING SYSTEM REFUSING A REPLENISHMENT THAT BREACHES IT — THE SYSTEM REFUSES RATHER THAN WARNS, BECAUSE A CAP ENFORCED BY MEMORY IN A THIN-MARGIN BUSINESS LASTS ABOUT TWO QUARTERS; ANY OUTLET BELOW 78% INVESTIGATED RATHER THAN CONGRATULATED ON ITS MARGIN; AN UNPROFITABLE OUTLET CLOSED OR RELOCATED RATHER THAN CONVERTED; and NO STORE MANAGER PAID ON CATEGORY MIX OR STORE MARGIN — only on FILL RATE, GENERIC SHARE AND REFILL PERSISTENCE, because THE THREE THINGS THAT WOULD IMPROVE A MANAGER'S BONUS UNDER ANY CONVENTIONAL SCHEME ARE PRECISELY THE THREE THAT WOULD DISMANTLE THE BUSINESS (₹1.64cr, recurring)

The stock-out that is permanent	A patient JUST PERSUADED to try a generic, finding it unavailable the following month, DOES NOT SIMPLY BUY THE BRAND ONCE — he concludes the whole arrangement is unreliable, AND THE FIRST SWITCH BACK IS USUALLY THE LAST. THE CONVERSION COST IS PAID TWICE AND RECOVERED NEVER. Fill rate at 88% instead of 96% takes profit to ₹1.11cr, and the mechanism is NOT LOST SALES BUT LOST PATIENTS, WHICH DOES NOT RECOVER WHEN STOCK RETURNS	FILL RATE MEASURED PER OUTLET AND PUBLISHED — 86% → 96%; MEDIAN RESTOCK OF A CHRONIC LINE CUT FROM SIX DAYS TO TWO with inter-outlet transfer; STOCK-OUTS COUNTED AND PUBLISHED rather than treated as ordinary friction — 11,600 in Yr3 AGAINST 14,200 IN YR2, AN ABSOLUTE FALL WHILE PRESCRIPTIONS DOUBLED, WHICH IS THE ONLY SHAPE OF IMPROVEMENT THAT COUNTS WHEN EACH EVENT IS A PATIENT LOST FOR GOOD; opening inventory depth funded at 27% of project cost; and chronic refill persistence tracked at 74% with missed refills followed up (₹78L)
The doctor wrote a brand	Every substitution is A DECISION TAKEN BY US ABOUT SOMEBODY ELSE'S PRESCRIPTION — 286,000 of them in Yr3 — and the patient generally does not know it has happened, while the prescriber never finds out at all	MANUFACTURER NAMED TO THE PATIENT on every substitution; PRESCRIBER INFORMED — 68% → 94% — WHICH IS NOT A COURTESY BUT WHAT ALLOWS A DOCTOR TO INTERVENE IF THE SUBSTITUTION MATTERS CLINICALLY, AND THE MECHANISM BY WHICH BRAND-WRITING HABITS ACTUALLY CHANGE; 6% OF PATIENTS DECLINE ONCE TOLD, WHICH IS THE FIGURE PROVING THE DISCLOSURE IS REAL (₹42L); and the anchor plan's refusal rules applied here unchanged — prescription demanded for Schedule H/H1, refusals logged, zero readings audited
A single public batch failure	The whole proposition collapses if one batch fails publicly, because the doubt this business exists to answer WOULD BE CONFIRMED IN ONE NEWS CYCLE for every generic seller in the country, not merely for us	Assay and dissolution at goods-in on EVERY batch rather than sampled; manufacturers selected on inspection history and de-listed on a single failure — 9 in Yr3; retained samples held for independent re-test; rejected stock DESTROYED rather than returned, per the vertical rule that a returned batch is simply sold to somebody else; recall procedure tested; and the quality function reporting to the promoter with authority to reject, BECAUSE A REJECTED BATCH IN A 3.6%-MARGIN BUSINESS IS A REAL LOSS TO SOMEBODY'S TARGET
Thin margin and fixed costs	3.6% net across 62 leases leaves almost no tolerance: 25% rent inflation takes profit to ₹1.18cr, and 94 pharmacists are a heavy fixed cost in a small-ticket format	Small-format outlets with low rent per square foot; outlet-level P&L published internally so a shop that is not working is closed or relocated rather than converted; pharmacist rostering shared across nearby outlets; institutional supply grown as volume uncorrelated with footfall; and lease tenures staggered so renewals do not cluster
Prescriber habit and scheme dependence	Brand-writing remains the default in much of practice, and scheme incentives form part of other income; a change in either moves the business	Prescriber liaison built around substitution notifications rather than around inducements; other income disclosed as a line and never conditional on a specific manufacturer's volume; chronic refill programme reducing dependence on new prescription flow; and generic share and savings published as evidence prescribers can act on

15. SWOT Analysis

Strengths • Assay and dissolution published per batch with limits shown • Manufacturer named on the shelf label • Generic share rising 79% → 82%; shelf cap enforced in ordering • 96% fill rate; two-day chronic restock • ₹54cr of patient savings delivered on ₹44cr of turnover	Weaknesses • ₹3.70cr forgone against ₹1.60cr of profit • 3.6% net leaves no tolerance for error • Testing cost no competitor carries • 94 pharmacists in a small-ticket format
Opportunities • Chronic patients for whom the saving compounds monthly • Prescribers who will write molecules once shown evidence • Institutional and clinic supply displacing branded dispensing • Policy momentum behind generic prescribing • Testing capability as a public credibility asset	Threats • One public batch failure anywhere in the category • Supply unreliability driving stock-outs • Rent inflation across 62 leases • Internal drift toward high-margin non-generics

16. Recommended AiSevak Tools for This Business

- **Batch result publisher** — assay and dissolution by batch number with pharmacopoeial limits shown beside them.
- **Manufacturer disclosure label** — name, address and licence number on every shelf edge.
- **Generic-share monitor** — published per outlet, with sub-78% auto-investigation.
- **Planogram cap enforcement** — ordering system rejects replenishment breaching 15% non-generic shelf space.
- **Fill-rate & stock-out register** — per outlet, per molecule, with inter-outlet transfer triggers.
- **Substitution notifier** — manufacturer named to patient, prescriber informed automatically.
- **Savings calculator** — branded equivalent and rupee saving printed on every prescription.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, outlet counts, category margins, fill rates, rejection counts and savings figures are editable inputs; actual outcomes depend on supply reliability, scheme terms, rent and prescriber behaviour. Figures are in Indian rupees. **This plan inherits the pharmacy vertical anchor's rules from `retail-pharmacy`, including the refusal rules, which apply here unchanged.**
- **The central integrity finding is that this seller's price is his biggest obstacle.** A patient told that his ₹340 branded strip is available at ₹28 does not conclude he has been overcharged for years — he concludes the ₹28 one is inferior, because in every other purchase in his life price signals quality, and here the signal runs backwards. **He is not being ignorant: he is applying a heuristic that has served him well everywhere else, in the one category where it inverts. And the inversion is cruel in its distribution — the more a patient needs the price, the more rational it is for him to be afraid of it, because he has the least margin for error if the doubt turns out to be right.** The trade's standard answer makes it worse rather than better: "same salt", "don't worry", "everybody uses it" are sentences a seller of genuinely substandard medicine would deliver in identical words and identical tone. **Reassurance carries no information, because it is available equally to the honest and the dishonest, and**

the patient's scepticism is the correct response to a signal that cannot discriminate.

- **So the evidence is supplied in a form the reassurance cannot imitate.** Assay and dissolution are tested per batch against the same pharmacopoeial limits the branded product must meet, and the results are published per batch — on the shelf label by batch number, on the bill and online — with the pharmacopoeial limit printed beside the measured value, so a patient can see the margin rather than take the word "compliant". The manufacturer is named on the shelf label with address and licence number, because an unnamed manufacturer is precisely what a patient is afraid of. 214 batches were rejected and 9 manufacturers de-listed, with rejected stock destroyed rather than returned.

WHERE YOUR PRICE IS READ AS A QUALITY SIGNAL AGAINST YOU, THE ONLY REPAIR IS EVIDENCE THE BUYER CAN CHECK — REASSURANCE IS INDISTINGUISHABLE FROM WHAT A FRAUD WOULD SAY.

- **Generic share of revenue must not fall, and nothing in the accounts will tell you when it does.** A 22% generic margin sits beside a 30% OTC margin and a 45% supplement margin, so every store manager has a rational, well-meant case for a little more of the latter — faster turns, better cash, happier customers, a subsidy for the thin lines. **Nobody proposes abandoning generics; the shelf simply rearranges itself over eighteen months, revenue rises, margin rises, and the business becomes a general store with a generic sign, with the accounts recording the whole transition as improvement.** So generic share is published as a metric that must rise — 79%, 81%, 82% — non-generic shelf space is capped at 15% in the planogram with the ordering system refusing a breach, any outlet below 78% is investigated rather than praised, and no store manager is paid on category mix or store margin but only on fill rate, generic share and refill persistence. It costs ₹1.64 crore a year, recurring, because the pull is continuous.
- **A stock-out sends a patient back to a brand permanently.** A patient just persuaded to try a generic, finding it unavailable the following month, does not simply buy the brand once — he concludes the arrangement is unreliable, and the first switch back is usually the last, so the conversion cost is paid twice and recovered never. **Fill rate reached 96% from 86%, median restock of a chronic line fell from six days to two, and stock-outs are counted and published: 11,600 in Year 3 against 14,200 in Year 2, an absolute fall while prescriptions doubled, which is the only shape of improvement that counts when each event is a patient lost for good.**
- **Every substitution is a decision taken by us about somebody else's prescription.** 286,000 of them in Year 3, so the manufacturer is named to the patient, the prescriber is informed on 94% — which is not a courtesy but what allows a doctor to intervene if the substitution matters clinically, and the mechanism by which brand-writing habits actually change — and 6% of patients decline once told, which is the figure proving the disclosure is real. **The saving is the real output of this business: the branded equivalent price and the rupee saving are printed on every prescription, averaging ₹346, and the aggregate is published at ₹54 crore of patient savings delivered on ₹44 crore of turnover, so the output of the business is larger than the business.**
- **3.6% net is the honest number for a generic chain that has not drifted, and the plan states it rather than modelling its way around it** — because every point of gross margin taken here is a point of saving not delivered, and the saving is the product rather than a by-product. Batch testing at ₹86 lakh is 2.0% of revenue spent proving something the law already presumes, which no competitor does and which is the entire answer to the price paradox. **Commitments of ₹3.70 crore against ₹1.60 crore of profit — more than twice — mean an operator running the same 62 shops on trade-standard practice would earn ₹5.30 crore, and most of that gap is four feet of shelf space per store.** The principal risk is neither credit nor competition but internal drift, which is why the generic-share commitment carries a covenant.
- **Compliance and professional advice.** The Drugs and Cosmetics Act 1940 and Rules 1945 with a retail drug licence per outlet; the Pharmacy Act 1948 and registered-pharmacist supervision, which applies to a generic store exactly as to any other; Schedules H, H1 and X with registers per shop and the anchor plan's refusal rules unchanged; **the Indian Pharmacopoeia, under which a generic must meet the same assay, dissolution, impurity and uniformity standards as the branded product with the same molecule — the entire legal basis of the proposition, and a document a patient will never see;** NPPA and DPCO ceiling prices, and the Jan Aushadhi / PMBJP product basket, pricing and margin structure where operated under it; recall and reporting of substandard product; GST; and shops and

establishments, EPF/ESI and POSH. Professional advice should be taken on scheme participation terms, manufacturer qualification, testing protocols and substitution documentation.

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