
Misplaced marketing

For the drugs we need

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Abstract

Purpose – To delineate confusions and uncertainties of the issues surrounding those criticisms. Critics assert that all marketing of medical products is abusive, while actual impacts are disputed.

Design/methodology/approach – Pulling from past commentaries on pharmaceutical marketing and current criticisms of the practice, to indicate areas of confusion.

Findings – The ills of pharmaceutical marketing are not as great as critics presume, but the practices are not as positive as the companies might wish to assert. With uncertainty on the actual impact of specific practices, the companies are engaging in a certain degree of warfare via ever-increasing budgets of sometimes-questionable value.

Practical implications – Puts criticisms of pharmaceutical marketing in context.

Originality/value – Perspectives for understanding pharmaceutical marketing.

Keywords Pharmaceuticals industry, Drugs, Brand names

Paper type Viewpoint

Regardless of the consumer protection problem described in our term papers, the students in our 1975 graduate marketing and society course mentioned “consumer information” as a major part of the solution. Misprescribed pharmaceuticals, deceptive loan terms, fraudulent car repairs and many other consumer problems would be solved, we often said, if the businesses were required to provide consumers with more detailed and accurate information. Our instructor, Mary Gardiner Jones, had recently completed her service as a member of the Federal Trade Commission, and while she generally agreed with us, I will always remember her lament after one too many presentations on this theme: “I don’t want to be required to be my own expert pharmacist, mechanic, accountant or doctor.” She was a lawyer by education and that, she said, was difficult enough.

Over five decades ago, the US Government changed the relationships among doctors, patients, and pharmacists. Initially, prescriptions were a doctor’s recommendation of a potentially useful drug, but patients did not need the doctor’s permission to make a purchase and pharmacists could also make recommendations. The 1951 Durham-Humphrey Amendment defined the kinds of drugs that cannot be safely used without medical supervision and restricted their sale to prescription by a licensed practitioner. In theory, with

all the new drugs just starting to come out at that time, patients would be forced to have the rational and informed expertise of a doctor involved in their drug-purchasing decisions.

Advertising information or influence

The doctors are the experts, or so we like to believe. And with the medical doctors as the decision makers, for many years the pharmaceutical industry exclusively focused their brand-name promotional practices on physicians. Even with the more recent advent of direct-to-consumer (DTC) advertising, the companies’ sales representatives still have regular and expensive contacts with physicians, spending large sums of money per year promoting brand name drugs by giving doctors various gifts, travel subsidies, and free meals in addition to the arguably more educational, though potentially biased, sponsored teachings and symposia.

The total annual advertising and other promotional spending by US pharmaceutical companies has grown into the billions of dollars, or as some industry critics like to say, well over a thousand dollars per physician per year. And to the critics, that huge sum alone is the basis for asserting a huge and improper influence on prescribing decisions. Some rare doctors refuse any gifts from the drug companies of any kind in an effort to remain free of the taint of being “bought.” Skeptical patients given a brand name prescription look for coffee mugs with that same name around the front office as potential proof that the brand’s company salesperson had recently paid the doctor a visit and generated the direction to buy an expensive product.

It is hard to tell just what influence specific promotional efforts might have on the doctors who honestly assert they have patients’ interests as their prime concern. No one wants to believe that a patient will be prescribed new anti-depressant

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or antihistamine just because the doctor has a pen with that name written on it. To some extent, it is possible that even the drug companies question the sales value of the plethora of special gifts and advertising specialty products with a brand name printed on the side. At the same time, however, the drug manufacturers must feel the competitive pressure to provide the same sales "support" as is done at the competing companies. In a competitive industry, there must be a degree of advertising dollar combat, with the different companies trying to maintain a financial share of advertising voice.

It still must be admitted that like any other consumer-purchased product from cars to house paint, the physician decision-maker's primary source of product information is provided by the manufacturers. Some critics of the pharmaceutical industry assert that the companies abuse this information power and intentionally desire to mislead medical people. Regardless of whether there is intentional malfeasance, one study found that a significant number of statements from the sale representatives contradicted information readily available to them, and that the physicians generally failed to recognize the inaccuracies (Ziegler *et al.*, 1995). While our personal doctors might claim that they derive their information only from research articles, there exists persistent evidence that they may be misled about a brand's value apart from the scientific data on the matter (e.g. Avorn *et al.*, 1982).

Even the medical practitioners do not always know or understand all the information they have available. Research repeatedly finds that once a company starts selling a drug to assist a certain condition, the number of people diagnosed with the problem increases by several times the original rate. Patients must at least wonder about the medical decision when their new prescription is pre-printed on the doctor's note pad (Wazana, 2000).

Questions of brand value

When new pharmaceutical products are first introduced, the primary marketing goal is to generate awareness of a previously-unavailable potential treatment for medical problems. Yet the longer-term desire would be to generate a degree of brand awareness and even brand loyalty among doctors and their patients that extends beyond the time of patent protection to when generic substitutes are available. Such brand loyalty exists for many categories of products, including non-prescription over-the-counter (OTC) drugs B i.e. many consumers pay a premium price for Aleve or Sudafed instead of the chemically identical generic naproxen sodium or pseudophedrine hydrochloride B So it is logical for a pharmaceutical manufacturer to desire such loyalty to their brand names after the patent expires.

Yet even where such loyalty might have a potential to exist, it is discouraged by state laws that encourage pharmacists to substitute the cheaper generic products for prescriptions. In addition, insurance companies have taken brand names, any brand names, as a surrogate indicator of medical profligate spending, and in the process, they also make it more costly for people to use any and all newly developed drugs. Even if is a new product without an available generic version, many frustrated patients discover that their medical coverage either refuses to pay for brand name drugs or requires a higher co-

payment for coverage of brands than for generic products. In theory, when a doctor recommends a brand name, the patient must decide if the specific brand is worth the higher cost. In practice, the patient is forced to pay for a unique treatment that is still under patent protection.

The possible solution that some would like to see at some future time is a designation as all pharmaceutical brand names as unnecessary, or, at least, not serving the needs of doctors or their patients. In those nations that require dispensing of generic forms of prescriptions whenever they are available, this is the *de facto* outcome.

At a more basic level, there is some question as to whether the medical system is served by brand names for any prescription drug product whose patent has expired. Some people retain an unrealistic faith in the power of brand name drugs, but the Food and Drug Association (FDA) repeatedly assures the public that any functional benefit is virtually non-existent. Generic drug manufacturers are subjected to the same standards as their brand name counterparts. But despite these repeated assurances from the government agency charged with regulating the efficacy and purity of prescription drugs, some patients and even doctors retain faith in the brand names.

Logically, the FDA could ban the use of all brand names for pharmaceutical drugs. When a new drug first comes on the market, the pharmaceutical company has a patent. No one else can make it without their permission and they can charge whatever mark-up is deemed necessary, or rather, whatever the market will tolerate. They do not need a brand name to do this. And once the patent expires, they have competition from what are now identical products. The new products' brand name might have had an initial value to make it easier for consumers to recall the name in direct-to-consumer television commercials, but once the product becomes generic, maybe the former brand name could become generic, too.

Of course, no company would ever tolerate such a change in regulations, especially since brand names have a carryover value after the initial patent expiration. Higher dose or time release variations of the product can give new extended life to a brand name, as can new approvals of the original drug in combination with other products. There are also a growing number of prescription brand names that find extended life as the product gains new approval for OTC sales. Without prescribing laws or insurance payments encouraging generic substitutions, potential brand loyalty acquires new strength with consumer purchases.

Over-informed consumers

New Zealand and the USA might be on the leading edge of what could be an international trend as consumers are expected to play a bigger role in their drug decisions as the two nations allow direct to consumers (DTC) advertising for various prescription drugs. Reportedly the physicians in the two countries are skeptical to outright opposed to the practice, and despite similar survey responses from UK physicians, there is pressure to start allowing the practice in UK and the greater European Community (Reast *et al.*, 2004). The a priori presumed benefits and potential problems have been debated ad infinitum in the news media (for a

summary, see Auton, 2004), yet one detailed large-scale consumer study on actual impacts concluded that:

The reality of DTC's effect on consumer behavior and doctor-patient relationship [in the USA] is more benign than its detractors fear and less specifically influential on product sales than many pharmaceutical brand managers would hope (White *et al.*, 2004, p. 65).

In theory, consumers are well informed by the new conduit of information. While the main "promotional" pages of the advertising have many appeals to consumer emotions (Main *et al.*, 2004), the print versions are filled with the same page of print-heavy data on indications, contraindications and precautions found in medical journal advertisements, and the television voiceovers and superimposed print disclaimers themselves provide enough warnings of side effects to make the audience members nauseous. This additional regulatory-required information is the same materials required in the advertising to the expert audience of physicians; if the front makes a emotional sales appeal, the extra two data pages provide all the information needed for an informed rational decision. While there would exist serious doubts that the typical consumer, or any non-expert layperson, would read the data.

A secondary effect of requiring the technical prescribing data in all DTC advertising is that there are fewer such messages. When a prescription drug changes to OTC status, the data pages are no longer required. With the advertising purchases now able to be a single page instead of three, an extensive study of magazine advertising in one product category found a near-immediate tripling of the number of advertisements for the brand when the former DTC prescription product became OTC (Avery *et al.*, 2005). Such an effect of limiting pharmaceutical advertising could be an unspoken regulatory intent of the data requirements, though there does not exist any proof that rule-writers at the FDA considered this as a goal. But it is clearly an effect.

Yet you have to wonder about just what impact all this DTC advertising must have or what the companies hope to accomplish. The products are often brands under exclusive patent rights, so the company is trying to establish strong and broad demand while they still have an exclusive product. And since the ads often make emotional appeals, people are encouraged to rush to doctors for what could be minor non-medical concerns. Not every case of depression, sleep loss, or lowered sex drive should be treated by expensive drugs. Even highly educated medical students tend to spot each new disease studied in their own bodies, and freshman psychology students tend to suddenly find all sorts of neurotic difficulties in themselves or their friends, so these DTC ads can readily play on consumers' uncertainty about their own health.

Food and Drug Administrations officials repeatedly insist that, at least in their view, the medical practitioners are still gatekeepers on the drug purchases. Unfortunately, with the increasingly competitive environment of patient services and medical care, many doctors concentrate on patient satisfaction, satisfying the medical customer's short-term perceived needs even when the therapeutic solution is not so simple. A patient comes to the office wanting a cure or something that looks like a cure, and even without DTC advertising the physicians can make prescriptions that are, at best, useless.

A sizable percentage of patients would probably respond negatively if their physician refused to prescribe the DTC drug the consumer thinks will solve the problem (Bell *et al.*, 1999). Physicians must feel the pressure (Spurgeon, 2000), and a possibly misplaced marketing orientation insists that the customers needs be satisfied. It would be unrealistic to think that many doctors would not give the requested drug, even when the advertised brand might not be the physicians' first choice for treatment, or even when the patient might be better off not taking any drug at all.

Meanwhile at the advertising spending war

Columnists in the advertising trade magazines have questioned the value of DTC advertising. While it might generate some consumer knowledge or inquiries of a newly introduced product, there does not seem to be any long-term effects on brand demand by consumers. In the wake of a scandal over the hidden dangers of a heavily promoted branded pain reliever, the introduction of a different new product included a promise by the company to refrain from any consumer-oriented advertising for one year. It is hard to believe that a company would so quickly give up a promotional tool if it felt it was important for long-term consumer awareness and prescription sales, so it is possible that the company also questioned the actual value of expenditures on consumer advertising. The new scandal-tied criticisms of DTC advertising gave the company an easy way out of expensive spending on a practice of questionable value.

But then, there are so many variables in prescription decisions, every decision on promotional spending is filled with uncertainty, and valid questions exist of each specific practice's pragmatic utility. In a highly competitive business, with a short shelf-life on a prescription brand name, each pharmaceutical manufacturer is encouraged to maintain a loud and strong spending voice. Advertising and promotional spending almost becomes an arms race of sorts, with spending on marketing increasing as fast as successes in research and development on new products. In turn, the expensive marketing becomes added target for blame in the high costs of drugs.

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