
Beyond product brand management

Function and problems of brand name pharmaceuticals

Herbert Jack Rotfeld

Auburn University, Auburn, Alabama, USA

Abstract

Purpose – This paper aims to discuss the problems faced by US consumers as insurance companies use brand names as a heuristic tool to identify medical profligacy, penalizing consumers with higher co-payments or even refusing funding support for new and necessary medications.

Design/method/approach – Anecdotes and descriptive reviews of the literature describe the basis for the problem. The paper looks at the use of brand names in the pharmaceutical industry in comparison with generic versions. It gives a brief history of brand name development.

Findings – The paper finds that, for the pharmaceutical companies, or any company, a brand name allows them to escape from the confines of generic demand with the price and distribution power from brand demand. Furthermore the easier name can speed adoption of a new product. However, the price spread between new brand name drugs and older ones with non-branded competition gives rise to unfounded presumptions on all brand names.

Practical implications – Brand names can have value for both consumers and physicians, but it might be desirable for the US health care system to put an end to a brand's exclusive use beyond the innovation's patent protection.

Originality/value – The paper provides concluding recommendations of a broad regulatory solution that pharmaceutical companies would probably oppose.

Keywords Pharmaceutical products, Generics, Health insurance, United States of America

Paper type Viewpoint

For the most part, pharmacological sleep aids are taken at bedtime. After popping a pill, the person sleeps through the night and (hopefully) does not feel drowsy the next day. However, since they can be habit forming, these drugs are not recommended for continuous ongoing use. For the vexing situation faced by the person who occasionally wakes up in the middle of the night, these products become a tad counterproductive. If taken midway through the night, the pill's effective duration outlasts the remaining sleep period, resulting in a sleepy-style "hangover" well into the next day.

A new drug innovation on the market solves this problem, with research showing quick effects followed by a flushing out of the system within a couple hours. The sufferer with 2 a.m. bed spins gets help falling asleep without morning drowsiness. Having neither sleep apnea nor narcolepsy, the patient suffering from a periodic overly active middle-of-the-night mind would find this new product a long-sought solution. Unfortunately, some US health insurance companies refuse to support payment for the prescription since, as with any new drug innovation, it is an expensive brand name. Categorized broadly as a sleep aid, the insurance company would note other existing sleep aid products with less costly generic versions, thus the decision-making heuristics of the financial

gatekeeper company directs purchase of what it sees as a less expensive alternative. Even if purchase is allowed, the patient's share of the payment increases significantly whenever the prescription is not in generic form to discourage consumers from choosing brand name products.

It is the frustration of many patients that their medical coverage either refuses to pay for any brand name drugs or requires a higher co-payment for their purchase. In the above example, the patient and the doctor spend time arguing with (and cursing at) the insurance company since the generic alternative is really a different product. The brand is a new chemical with clearly different effects that is still under patent protection.

Of course, there are many times that doctors recommend or require a brand name drug despite the existence of generic equivalents, making the patient decide if the specific brand is worth the higher cost. Many consumers do not know that US federal regulations and oversight make certain that the generic manufacturers provide products that are chemically identical to the brand name originals; sometimes the brand name owners use their excess production capacity to provide the generic versions as well as the brand name products. The Food and Drug Association (FDA) repeatedly assures us that any functional benefit of a brand name product is virtually nonexistent since generic drug manufacturers are subjected to the same standards as their brand name counterparts. In some sense, the generic drug could be considered safer since it is less likely to be the target of illegal drug counterfeiters. But then, any patient taking drugs to correct a medical problem or treat a life-threatening condition would not be easily

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convinced that a cheaper version of the familiar brand is “just as good” as the name they know and trust.

Direct to consumer advertising of prescription drugs also can engender a misleading consumer trust in a brand name (Royne and Meyers, 2008). Even before the existence of this new now-ubiquitous promotional tool currently allowed in the USA and New Zealand, there was evidence that patients, and even some doctors, might be misled about a brand’s value apart from the scientific data on the matter (e.g., see: Avorn *et al.*, 1982). And since medical doctors are people, not decision-making machines, they are not always as rational in their prescribing decisions as we might like to presume. A plethora of numerous industry sales contacts with doctors do have an influence (Wazana, 2000), which should be obvious when a new prescription is pre-printed on the doctor’s note pad.

At a more basic level, the seldom-asked question would be whether the medical system is served by existence of brand names for any prescription drug whose patent has expired.

The issue can be better understood in reference to the history of brands and mass demand as both originated in the latter half of the nineteenth century. Many people mistakenly assert that advertising made mass demand possible and that people started branding and advertising so they could sell more products. But such assertions can only be made by not knowing that mass distribution and mass demand existed before any manufacturers started branding their products. And branding came along before the broad image advertising of those products.

Before the US Civil War, any advertising that existed was retail in nature. After the war, with the development of the national railroad system, companies started producing more products for sale outside the local area. But the products were generic in nature. Then, as now, the maker of a commodity would start branding and advertising more out of a desire for power over the channels of distribution. With consumers desiring the company’s brand instead of a generic product, the company had some control over the price with a pull strategy on the brand that forces distribution to the stores. With a brand, the company might actually end up selling less of a product, but at a higher price (e.g., see discussion in Norris (1984)).

This is not to say that the branded products did not initially have a higher value. Food products were in more sanitary packages than would be available in bulk. Ready-made packaged bars of soap were more convenient than a bulk purchase. In addition, manufacturers would need to come up with some innovations to make the branded product stand out. Morton made modern table salt possible when it created a way of granulating the salt so it would not lump together when moist (“When it rains, it pours”), or it could contribute to public health with iodize salt to aid in prevention of disease, advertising in the 1920s “Keep your family goiter free.” Innovations can make the branded product worth the higher cost (Rotfeld and Rotzoll, 1976), that is, until the innovation is imitated by all competitors. Over time, the old claims are not so much a statement of greater value as a tie to an old

image. Today, all salt is iodized and granulated, but the brand still showing trademarked the person in a rain slicker commands a higher price.

Years ago I visited a bakery in Illinois that made a popular brand of enriched white bread. I noticed several bags at the end of the line in the same size but with different writing. The majority of bags were for the primary advertised brand, but many other bags had the names of local store brands. Years later in Pennsylvania, the same thing was seen at a potato chip company, with a half dozen different brand names on different bags all filled with the same product. And at a drug company, the almost-finished pharmaceutical pills went down one conveyor belt to be stamped with the company label, while other pills went down a different belt for generic sales.

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 markup is deemed necessary to regain the costs of development. They do not need a brand name to do this. And once the patent expires, they have competition from identical products. Originally, the new products’ brand name might have had an initial value to make it easier for consumers or their doctors to recall the name spotted in advertising, but once the product becomes generic, maybe the former brand name could become generic, too. This happens indirectly as prescriptions are written saying “generic version of” a brand, but the FDA could make this a requirement where the brand is used by everyone to designate the product itself and there no longer is a distinct brand name product.

The medical insurance companies have taken the pharmaceutical brand names as a surrogate indicator of what they claim are unnecessarily high costs. And in the process, they also make it more costly for people to use any and all newly developed drugs. The probable solution is to see all pharmaceutical brand names as unnecessary, or, at least, not serving the needs of doctors or their patients.

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