

What can the pharmaceutical world learn from consumer branding practice?

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Abstract The world of branding is divided between consumer practices and those employed in the pharmaceutical world. Fast moving consumer good companies focus on a brand creation model while pharmaceutical companies create products. The pharmaceutical brand model does not easily fit into consumer theory and this leads to few people understanding the subject well. Consumer brand architecture theory is reviewed and then related to pharmaceutical practice (current and future). Aspects covered include the consumer work of Kapferer and Aaker in the area of brand architecture, examining how their work can be translated to pharmaceuticals. Recommendations for pharmaceutical brand management in the future conclude that, although there are many examples of excellent brand building in pharmaceuticals, the discipline has not yet reached a strategic level.

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DIFFERENCES BETWEEN CONSUMER AND PHARMACEUTICAL BRAND BUILDING

Consumer brands appear to have a different longevity to the brands that exist within the pharmaceutical world. Fast moving consumer good (FMCG) brands can last decades and even centuries while pharmaceutical brands are thought to last only a very short period of time (Figure 1). When looking at a typical consumer product category, for example, cereals, soap or toothpaste, it can be seen that within

the US marketplace, the leading brands in 1925 still led the category 60 years later (Kellogg, Ivory and Colgate). Similarly when assessing the longevity of the most known brands in America, over 25 per cent are older than 50 years, another 25 per cent have been around for more than 75 and a further 10 per cent are over 100 years of age. Consumer brands therefore not only last a very long time but continue to compete within their given category if enough attention is given to them. In relative terms, consumer brands also have short research and development (R&D) cycles, as well as

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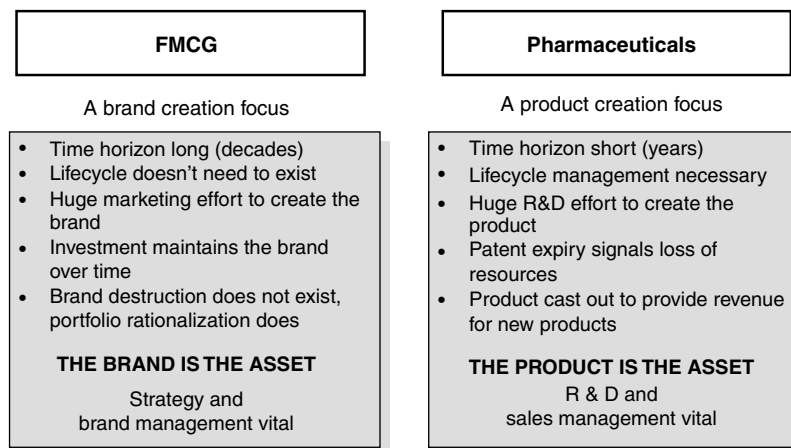


Figure 1: Differences in attitude to brand building
 Source: Giles D. Moss, *Pharmaceuticals — Where's the brand Logic?*

short pre-marketing cycles, which can then be followed by decades of profitable brand building. The traditional product brand lifecycle does not need to exist as the brand is treated as the asset and strategy and brand management are seen as vital to ensure the brand creation focus permeates the whole organisation.

In contrast, within the pharmaceutical world of brands the R&D cycle is long, risky and extremely expensive. Product and patent creation can take at least a decade and this is then followed by a one or two year pre-marketing window before the product brand is launched. What traditionally then follows is massive investment in sales force coverage and frequency of target physicians and approximately 10–15 years of sales. As patent expiry approaches, some attempts to manage the lifecycle of the product brand occur through galenical development but as soon as the expiry date is reached, the product is cast out and treated as a cash cow for the next molecule coming through the pipeline.¹

Brand destruction occurs when corporate resources are withdrawn internationally even though, perhaps, patent expiry only affects the US in the immediate near future. In essence, the product is the asset (rather than the brand)

and R&D and sales management are the vital ingredients to success rather than brand expertise. What is little known, however, is that some pharmaceutical brands do have staying power, for example, Premarin from Wyeth was launched in 1942 and did not reach peak sales until 2001, a full 59 years later while both Augmentin and Sandimmun reached their peak sales more than 20 years post launch.

SO WHY THE DIFFERENCE?

Apart from the attitudinal differences to brand building, a major reason is that the pharmaceutical industry has missed its opportunities to move out of the product attribute trap; a problem that is common in high-tech and data-driven industry sectors. A focus on the efficacy, safety and side effects of a product brand fails to leverage the advantages possible from the management of the brand identity and its resultant brand image with customers. This understanding is not helped by the fact that the pharmaceutical brand model does not fit in easily with the established consumer brand theory that has developed over the last three decades.

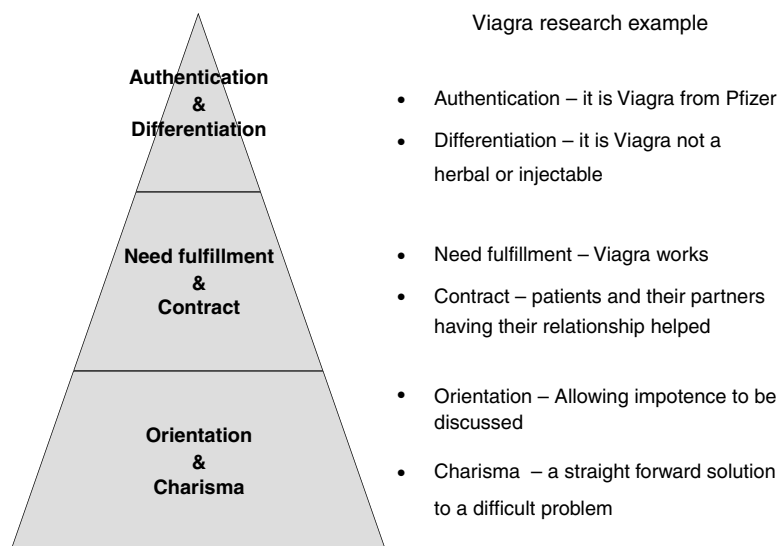


Figure 2: Brand function hierarchy
 Source: Giles D. Moss, *Pharmaceuticals — Where's the brand Logic?*

Pharmaceuticals cannot easily be explained by consumer brand theory or business to business brand models — the multiple stakeholder complexity means it just does not fit in.

As a result, few pharmaceutical marketers understand the basics of branding. Brand identity is a synergy of tangible product brand benefits (functional attributes) and intangible (emotional) benefits that are selected and managed by the company in question.

Brand image on the other hand is the consumer (or physician) perceptions of their reality resulting from company communication and product brand usage. Brand image needs to be tracked and monitored vs the chosen identity and continually adjusted to maintain an ideal positioning within the marketplace.

Even fewer pharmaceutical marketers understand the latest thinking on brand building, which is led by neuro cultural research and which highlights the fact that brands become central to our understanding of the product. What a

brand means to an individual is created from memories, emotions, rules and meanings that create a system of understanding; most mental activity is not conscious or immediately accessible, invisible stored memory plays an important role in linking emotion and reason to guide what we do. These memories then have to be put in a cultural context because to live together we need to share common ground, a common ground created by rules and experiences, which when fused together give the brand a central role in understanding the product and how it should be used. A brand function hierarchy is set up, which helps us understand how a brand may work at different levels (Figure 2).

Put simply, if a company can create brand equity with a pharmaceutical product brand it adds value both to the customer and the company. The customer (physician, HMO and government) benefits from a reduced risk in drug choice for the physician, the patient benefits from increased personal

commitment to the therapy and there can even be a post-prescription satisfaction for the prescriber ('I used the best medicine'). For the company, benefits can include the reduced cost of retaining a customer (rather than having to find a new one), improved price in many markets and potentially longer revenue streams post patent expiry due to a reluctance to change.

BRAND ARCHITECTURE

The theory of brand architecture came from simple beginnings — new products could be associated with the first product offered by an enterprise or by association with the company name itself, or be created as an independent brand of its own. Proliferation of brands and the mergers of consumer goods companies in the 1980s and 1990s then made establishing the theory behind brand architecture necessary. There are two main proponents of architecture theory, Jean-Noel Kapferer in Europe and David A. Aaker in America.

To quote David A. Aaker,

'(Brand architecture) specifies the structure of the brand portfolio and the scope, roles, and interrelationships of the portfolio brands. The goals are to create synergy, leverage, and clarity in the portfolio and relevant, differentiated and energized brands'.²

And to paraphrase Kapferer,

'Thought has to be given to the structure of a portfolio to aide buyer recognition and understanding. In this way it will also guide the larger organization to make the right decisions through the use of rules concerning naming, symbols, colors etc'.³

The area of brand architecture is almost never discussed despite the vast merged portfolios that exist in big pharma, the top companies having more than 1,000 brands listed on their websites. This lack of discussion means that the vast majority of brands lack scope, roles and

interrelationships that work synergistically. Little attention is given to the corporate brand, the franchise brand or even most product brands. There is no doubt that good product brand work exists, for example, Novartis UK established Lamisil for fungal nail infection in the minds of the physician and patient via clever healthcare professional and disease awareness campaigns.

As you would expect, mixed models do exist with some companies like Bayer maintaining pharmaceutical, chemical and even crop science divisions. Novartis grows a generics business in direct competition to its branded arm under the name Sandoz. The majority of thinking that has been done in this area has gone into use of the corporate brand is to try and repair damaged reputations due to illegal commercial practices or 'fat cat' pay awards. In short, more thought is required. When taking on board Kapferer brand architecture theory for this purpose, there are six major brand strategies within the consumer world, which are categorised by two easily understood factors, that is, the strength of indicating the origin of the brand and the strength of product differentiation (Figure 3).

Figure 4 shows the pharmaceutical equivalents that can be placed along side their consumer counterparts. Line brand and range brands are very poorly understood in the pharma area but some useful parallels can be drawn for all six of Kapferer's strategic hierarchy. In addition, a seventh strategy exists in pharmaceuticals when the same chemical entity is promoted in different indications in the same geographical market, most commonly with the same product brand name, for example, Neurontin in Epilepsy and Neuropathic pain, or alternatively with different brand names, for example, Bupropion marketed as Wellbutrin in depression and Zyban in smoking cessation.

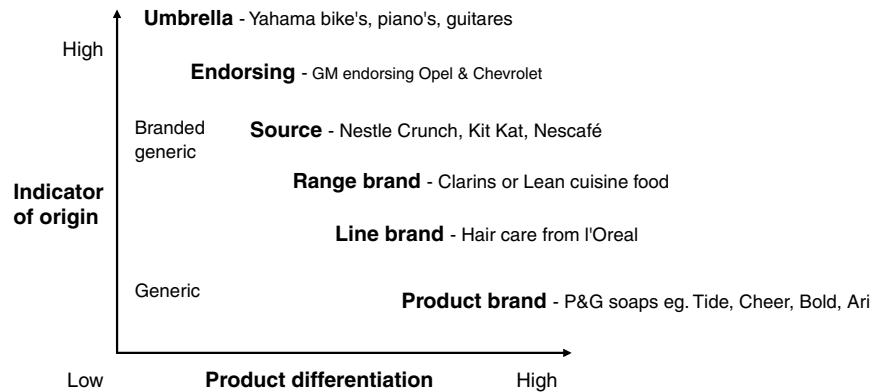


Figure 3: Pharmaceutical brand strategy hierarchy. Adapted from Kapferer, J-N. (2004), *The New Strategic Brand Management*, p 294, Kogan Page, London & Sterling, VA

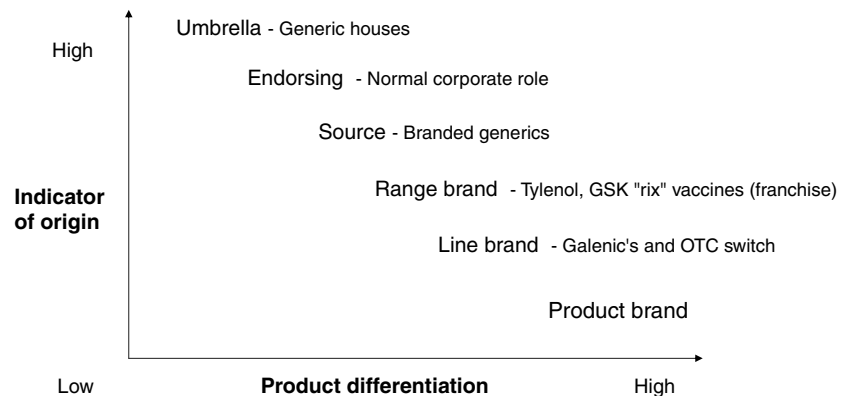


Figure 4: Pharmaceutical brand strategy hierarchy. Adapted from Kapferer, J-N. (2004), *The New Strategic Brand Management*, p 294, Kogan Page, London & Sterling, VA

Moving on to the early Aaker work in respect of brand driver roles within a portfolio of product brands, Aaker identified a number of categories that allow the framework of a portfolio to be understood more easily. He coined the terms strategic brands (pharma blockbusters), energiser brands (Viagra and the National Hockey League in the US), silver bullets (Lipitor for Pfizer — when a co-promotion), flanker brands (authorised generics) and cash cows (the vast majority of pharma portfolios). All of these terms and definitions find a pharmaceutical equivalent and therefore aid in understanding the potential for thinking more in depth about the brand roles.

When Aaker then looked in more depth at brand portfolios, he proposed four corporate brand strategies for consumer companies: House of brands, Branded house, Endorsed brand and the Sub-brand under a master brand as shown in Figure 5.

When drawing parallels to pharmaceutical corporate brand strategy it can be seen that the house of brands is the most commonly used strategy, probably because it is the default option for an industry that has not given the subject much attention over the decades.

When assessing the overall brand architecture subject, it is clear that a strategy taking into account hierarchy

Strategy	FMCG example	Pharmaceutical example
House of brands	P&G, Disney	The vast majority of Big Pharma Companies e.g. Pfizer in epilepsy
Branded house	GE, Virgin	Generic houses
Endorsed brand	3M, Ralph Lauren, Calvin Klein	Lilly corporate
Sub brand under a master	Audi TT, Dodge Viper	Sandoz under Novartis

Figure 5: Aaker corporate brand strategy examples
 Source: Giles D. Moss, *Pharmaceuticals — Where's the brand Logic?*

could have significant impact within pharmaceuticals and could offer synergies of activity (and spending) across a portfolio, leveraging current brand assets more widely, preparing the market for future launches and providing focus for business development activities.

THE FUTURE FOR BRAND MANAGEMENT

The consumer world has seen significant progress made in the evolution of brand management and its role within large and small consumer organisations. That evolution has taken considerable time from when brand management was first championed in the 1930s by Proctor and Gamble. To date there is less evidence that this has yet happened in the field of pharmaceuticals — no pharmaceutical brand logic is currently evident. Although numerous good product brands have been created, for example, Lipitor, Herceptin, Taxol and Nexium, the pharma industry needs to move from tactical to strategic brand management, from a limited focus to a broad portfolio perspective, from a largely sales-driven approach to one that also takes into account brand identity and other sophisticated marketing concepts.

At present, the pharmaceutical industry is not ready for the major changes that have already occurred within the consumer world but cost containment, diminishing pipelines and increasing governmental pressure on prices may well force its hand in the future. We need to formalise brand management and practice it strategically, rationalise our vast portfolios and introduce roles and relationships. In addition, we need to change our mind set and find alternatives to global brand destruction, instead focusing on sustaining a brand over time — especially since far fewer are likely to be available in the future. Marketing should be challenged to manage multiple customer interactions within the context of a strategic brand logic. We need to actively build brands, whether they are corporate, franchise or product.

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References

- 1 Moss, G. D. (2007). *Pharmaceuticals — where's the brand logic?* Branding lessons and strategy, in press, Haworth Inc., Binghamton, NY.
- 2 Aaker, D. A. (2004). *Brand portfolio strategy*, The Free Press, New York, pp. 13–14.
- 3 Kapferer, J. N. (1991). *Strategic Brand Management*, The Free Press, New York, p. 46.