HOW DIFFERENT ARE BRANDING STRATEGIES IN THE PHARMACEUTICAL INDUSTRY VERSUS FAST MOVING CONSUMER GOODS?

Abstract

The objective of this paper is to analyse the branding strategies used currently in the pharmaceutical industry and compare it to the best practices in Fast Moving Consumer goods. First the authors review the differences in the way branding is defined and organised in pharmaceuticals versus FMCG and identify why branding could be leveraged in the pharmaceutical industry to help it return to strong growth in the future. Second, the authors analyse in detail what branding strategies are currently used within pharmaceuticals and FMCG. The choice of brand names strategies, the level of brand globalisation, the use of brand extension and co-branding as well the situation of brand portfolio management are compared. Based on this benchmarking, the authors offer recommendations to guide future branding development successfully in the pharmaceutical industry.

AUTHORS

Isabelle Schuiling

is Professor at the University of Louvain School of Management in Belgium. Prior to her academic experience, she was a former Marketing Director Europe and Belgium at Procter and Gamble. Her research interests are related to branding and international marketing. Isabelle holds a PHD from the University of Louvain and an MBA from the University of Chicago.

Giles Moss

is Regional General Manager of S.E. Asia, Australia and New Zealand at UCB Pharma and has held varied sales and marketing positions at both an affiliate and global level in companies such as BMS, SmithKline Beecham and UCB. Giles is a pharmacist, holds an MBA from Henley and has an interest in brands.

Introduction

The pharmaceutical industry has come relatively late to branding. During the 1980's and 1990's the pharmaceutical industry has enjoyed success over an extended period of time, achieving relatively easy double digit growth on a consistent basis. By in large this was through using traditional methods and there was no apparent urgency to change the way it marketed its products. The success of the industry relied on three factors; strong research and development (R&D), aggressive defence of patents and use of the dominant promotional tool - powerful sales forces. The industry has been therefore product and R&D driven and not market driven. Despite the size of the sales generated, there are over 40 blockbusters or products that generate in excess of $1Bn, drugs were treated as products and not as brands.

The picture has however changed, industry growth has been slowing down and firms have been searching for ways to maintain it. The three traditional success factors of the industry are less evident than in the past. First, it has become much more difficult to identify the blockbuster drugs that can fuel company momentum and additionally product innovation remains costly and more illusive than ever. Second, many of the most successful drugs will soon suffer patent expiry, more than half of the global top 50 best sellers will go off patent in the next 5 years. Moreover, in view of the concentration of sales in fewer big products, the sales at stake are much

larger than in the past. Third, sales efforts are reaching a certain saturation level as the industry consolidates, it will not be possible in the future to base success just on increasing the number of sales representatives promoting a product (Datamonitor 2002).

Combined with this back drop generic competition has also been developing rapidly and constitutes an increasingly real threat for the industry. Generic companies benefit, not only from patent expiration, but also from the cost reduction pressures evident in every healthcare system around the world.

The industry has reacted via consolidation. In a series of significant mergers and acquisitions it has attempted to maximise R&D and reach economies of scale in the sales and marketing area.

Despite this we believe that mergers will not be sufficient in themselves to allow a return to the double digit growth seen during the 1990's.

Branding, however, represents a new competitive advantage that could be leveraged by the industry, in line with the success seen in the FMCG (fast moving consumer goods) area over the last two decades. Branding strategies could then help to maximise return on investment for new products whilst helping to alleviate the inevitable growth of generics in the future.

The objective of this paper is to first investigate what is the current branding situation in the pharmaceutical industry and how it compares versus the FMCG experience; second develop a rationale for branding; third to analyse how pharma's existing branding strategies differ versus current best practise in the FMCG area e.g. in the choice of brand name strategies, global branding, brand extension, co-branding and brand portfolio management and then finally to recommend actions that could make a difference resulting from the lessons learned from successful FMCG branding.

The current branding situation in the pharmaceutical industry

Brand definition

Traditionally when a pharmaceutical product is launched the product positioning is based on the product licence i.e. its indications and the established efficacy, safety and tolerability seen in registration clinical studies. Post launch studies then tend to lead to a broadening of the indications, the development of new dosage forms and the strengthening of claims versus the competition (Moss 2001).

In the recent past, some pharmaceutical firms have been investigating how to develop brands but there is still much confusion in the way brands are defined, thought about and managed. At its simplest some

prescription drug marketers believe that giving a name to a certain product will make it a brand. Others believe that adding a bit of symbolism to a product will be sufficient to create a brand (Chandler and Owen 2002).

One of the factors that has added to the brand debate within pharmaceuticals is the possibility of pull through advertising, direct to the patient communication about prescription only medications. These campaigns termed DTC (direct to consumer) are strictly regulated worldwide and are new in that they became possible only in the 1990's. Previously only OTC's (over the counter pharmacy items) were allowed to be advertised to the public.

The rules vary widely country by country but the biggest difference exists between the US and EU. Europe only allows disease awareness campaigns, not product related campaigns, and even then the types of diseases which can be featured are often restricted. As a result DTC expertise in Europe is less advanced when compared with the US. A few well known European campaigns exist like the Novartis UK Stepwise campaign which has utilised newspaper and television advertising to raise awareness of the fungal nail infection disease area, a therapy class area where the Novartis brand Lamisil (terbinafine) commands a dominant market share.

In the US product name adverts in various media, including television, are allowable assuming they have been approved by the FDA and the

resultant raft of regulatory requirements has been complied with. The early years of DTC have proven difficult with few individual brands hugely benefiting from this type of exposure. Having said that the industry is learning gradually what works and what doesn't, but the huge increases in spend seen at the end of the 1990's have now levelled off and DTC spend accounts for approximately 15% of the budget for prescription drug marketing according to the FDA (The pink sheet 2003). Some therapy areas appear to respond better than others e.g. antihistamines (Claritin, Zyrtec), irritable bowel syndrome (Zelnorm) and erectile dysfunction brands (Viagra, Levitra). In general however, according to a Kaiser Family Foundation study (Erickson 2001) DTC appears to increase the size of the market rather than significantly change an individual brands share of that market. The study focused on antidepressants and suggested that physician detailing still made the difference about which antidepressant was prescribed but more patients identified themselves for consultation as a result of the advertising.

The failure to achieve more concrete results could well be directly related to the generally low level of understanding of brand management within the pharmaceutical industry, DTC being seen as just another tactical approach in marketing.

In FMCG, the brand logic follows a much more thorough and systematic approach. A brand is viewed as a set of tangible and intangible benefits

that are registered in the mind of consumers. The choice of these benefits is based on a thorough analysis of the market, the consumers, the competition and other environmental factors. This analysis permits to identify the right target group and to develop a unique brand identity. This identity will differentiate the brand versus competitors in order to get a competitive advantage in the market.

Brand management organisation

In the pharmaceutical industry, the organisation of brand management is also quite different to that seen in the consumer world. Global marketing people will often come late into the development process, often in phase 3b, close to final registration. Key decisions are taken at a much earlier phase of the products development plan, often years earlier when the product enters phase 2. This has started to change in some of the bigger companies such as AstraZeneca, GlaxoSmithKline, Lilly or Genentech (Erickson 2001) but these are often the exceptions that prove the rule, talking about brand development and actually achieving it are often years apart.

Moreover, Pharmaceutical Marketing people are often more sales driven than marketing driven and therefore pay more attention to the executional elements of marketing rather than developing the strategic thinking that is required to make in-depth analyses of data from the market, the consumers and the competitors. The traditional career route to the top in

the industry is to start as a representative, followed by country specific product management and then back to sales in a management position to allow a career path in the direction of being a country general manager. Operational top management therefore has tended to come from individuals who have experienced big line management careers rather than a specialised marketing background and career. If you then add to this top tier senior R&D management who have only ever worked in that area and necessary finance expertise, this then constitutes the make up many boards. As a result marketing experts are on the periphery at the top level, especially as central or global marketing positions do not hold the same cache of their counterparts in FMCG – a few notable exceptions exists such as Hamad (ex CEO Pharmacia and now of Schering Plough) but they are not the norm.

Early feedback about how to manage both DTC and traditional prescription brand management in the same organisation shows variable results. Where FMCG experienced individuals have been recruited disillusionment sets in quickly, due to the highly restrictive regulatory environment the industry lives in. In addition due to the fragmented DTC geography there are various local structural answers (mostly in the US) and few if any globally coordinated approaches. Even in organisations where consumer healthcare divisions exist i.e. OTC divisions, the transition to DTC has not been easy and few really great campaigns or brands have so far been created, and none rolled out globally.

In FMCG, brands are created very early in the development process and marketing people will work very early with R&D, at the beginning of the product development process. At Procter and Gamble, Marketing people will work with R&D in the beginning of the development of new product ideas. They will test together prototypes and develop brand concepts.

FMCG firms will also dedicate a lot of management attention, investment and effort to manage their brands. These brands are viewed as the key assets of the firms. Branding will be a strategy priority at every level of the organisation. The traditional career path to reach general management is to grow in the marketing function to first become a brand manager, then a category manager and finally a marketing director. The FMCG marketing function is considered as a line job but is sited in the centre of the organisation unlike the pharmaceutical industry where global marketing is a staff function and the sheer size of the sales forces means marketing support is required in the countries. As a result country marketing receives the majority of resourcing in pharma leaving a gap at the centre of the organisation.

Despite the lack of brand focus in the pharmaceutical industry, we consider however that the industry has not realised that it is managing brands and not just products. Indeed, the pharmaceutical product has all the elements that make it a brand. It represents in consumers' mind a set

of tangible and intangible benefits. It does not only deliver a certain efficacy (tangible) but it offers also additional values such as trust (intangible). The brand has an existence in both doctors and patients minds, that goes beyond the product itself. Pharmaceutical companies develop molecules but doctors prescribe brands (Kapferer 1997).

Rationale for branding development

It is clear that the competitive environment is becoming harsher in the pharmaceutical industry and the necessity for health care systems to adopt generics will only accelerate the decline of branded sales post patent expiration, unless the industry manages itself differently. This is why we consider that branding can represent a new competitive advantage.

The creation of brands would enable firms to differentiate the products versus its competition using both tangible and intangible benefits. In view of the increased number of competitors and the relatively lower number of really distinctive products, it is even more important to provide “a reason for being” to each brand.

Branding can help to sustain the brand against generics after patent expiration. A strong brand will benefit from a high consumer loyalty (Aaker 1991, Kapferer 2001). The brand would therefore be in a better position to sustain sales after the patent has expired. For perspective, during the

1980's, a product suffering patent loss could still expect to have 60% of its sales turnover 12 months later. In the 1990's, that figure dropped to 40% and in certain cases it has been further exceeded (Prozac). (IMS Health.com). A strong base of loyal consumers would give additional time to maximise return on investment (Blackett 2001). The maths is relatively straight forward, patent expiry often coincides with peak sales for a product and therefore at its simplest for every month a pharmaceutical brand with annual sales of 1,2 Bn USD is maintained the revenue upside is 100 M USD (using the same logic a six month delay is therefore worth over 0.5 Bn USD)

Some authors have also highlighted the possibility to better protect the brand versus generics from a legal point of view when it is branded (Blackett 2001).

Finally, brands will have also a stronger influence on the behaviour and attitudes of patients and doctors.

It is right that a key difference versus FMCG is the relatively limited life time of pharmaceutical brands. They enjoy only 20 years of exclusivity as a maximum and in general will go off patent after an average of 7 years from when they enter the market. Some authors consider therefore that in view of this short life cycle it is not worth investing in building brand equity (Datamonitor 2002). This is different to FMCG where brands can live for ever, Procter and Gamble management for instance does not believe in

the product life cycle concept. Within the consumer area if they are well managed, brands should last for ever.

We do not believe that this important difference should prevent pharmaceutical firms from building brands. We consider that brand names should be more strongly linked than today to the corporate name (Moss and Schuiling). The latter can be used as a full name or as an umbrella name linked to the product brand name. This would be in line with the current trend in FMCG where companies try to link their product name brands to their strong corporate name and image.

Another important difference seen in contrast to FMCG has been the often highlighted additional layer that exists between the pharmaceutical manufacturer and the patients (consumers). Doctors and pharmacists do inevitably make branding strategies much more complicated.

We do not believe that this represents an insurmountable difference versus FMCG as, contrary to what certain authors highlight, doctors can be convinced by arguments other than the purely rational. They are also influenced by other factors such as trust or the quality image of the manufacturer. In addition they need to be reassured and in similarity to many consumer purchases they operate on a basis of limited information. They also make decisions for emotional reasons, not only rational ones (Chandler and Owen 2002).

We will now review what are the branding strategies currently used by pharmaceutical firms and compare it to the best practise in the FMCG area.

Branding strategies

- Brand name strategies

We need first to highlight that the particularity of pharmaceutical brands is that they have, two names. The brand name and the molecule name. The molecule name is present throughout the development process and will be the one used in scientific publications.

We have identified a series of strategies being used to select brand names in the pharmaceutical industry:

- **Chemical derived names**: The brand name is based on the scientific name of the molecule. This has been the traditional way of naming pharmaceutical products. For example, Cipro for Ciprofloxacin, Capoten for Captopril, Risperdal for risperidone (Erickson 2001). The issue of this strategy is that the brand name is too generic and might speed generic penetration later in the brands life. Moreover, it doesn't give many possibilities to identify a unique name that can be used on all international markets and it is more difficult to protect from a legal point of view.

- **Therapy names**: The name will be indicative of the disease the product treats. We will find for example : Procardia for patient suffering from

heart problems. This strategy represents a risk as the brand name could also be easily imitated and can be more difficult to protect from a legal point of view. Moreover, generics may find it easy to select a name that is close to the therapy and the known pharmaceutical brand.

- **Use or indication name**: The selected name will connote a particular use, indication or characteristic of a brand. For example, we will find : Prilosec, Glucophage, Propulsid, Norvasc, Ventolin, Cardizem. There is also a risk of imitation from the competition.

- **Family name or drug class name**: The family name is a brand name that is similar to other products in the same class and is registered by the same company. For example: Mevacor/Zocor, Zoladex/Nolvadex, Beconase/Vancenase. There is also the possibility of identifying a name that is semi-descriptive of a drug class: Tolinase, Micronase, Orinase (Erickson).

- **Corporate name**: The name will contain an identifiable portion of the corporate name tied to a certain product or product line. For example, Sandimmune (Sandoz), Baycol and Glucobay (Bayer) and Novarapid (Novo Nordisk). This strategy is of course only powerful when the corporate name is well known and has strong positive associations.

- **New invented name**: The name has been created for a specific product. For example: Zocor, Zantac, Zanax, Prozac, Xenical etc. In

the past few years, there has been an overuse of Zs and Xs for first letter. The advantage of this strategy is to identify a unique and distinctive name that can also be used for global expansion. It is also easier to protect from a legal point of view.

Based on these various strategies, we can identify three basic naming strategies: Descriptive brand names (linked to molecules, therapy, indication or use and family or drug product class), corporate brand names and new product brand names.

In FMCG, there is no significant difference in the basic naming strategies but the focus on them is different. We find also three basic brand name strategies: 1) Descriptive brand name (Pampers, Mr Clean, Tonigencyl, Ultra-Bright toothpaste). This name strategy is, however, nowadays, not very frequent as these brand names are not easy to globalise and are viewed as too generic; 2) New brand names (Dash, Ariel, Perrier). This is a strategy that is being used by many multinationals where it is important that each product brand has a distinctive positioning. A company such as Procter and Gamble exist through its brands and not as a corporate entity. Their strategy is to cover a market with a multi-brand approach (Ariel, Dash, Vizir, Bonux, Dreft in the detergent market) ; 3) Corporate brand names. In this case, some elements of the name can be linked to the brand name (Nescafé, Nesquick, Nestea from Nestlé, Dior with Diorissimo, Miss Dior , Diorella) or can be fully in line with the corporate name and

can serve many different products (BMW, Renault, Ford) or product categories (Yamaha, Mitsubishi).

The trend in FMCG is now to use more often corporate names as an "umbrella " name strategy in the current context of globalisation. The trend is indeed to associate a new product to very well known big brands or corporate brand names to benefit from existing awareness and strong image. Nestlé is using its corporate name as an umbrella for all its food products that are linked to a pleasurable experience (Crunch , Galak, Yes, Sundy, Nescafé, Nesquick from Nestlé (Kapferer). This is also in line with the experience of Japanese multinationals that have for a long time given the corporate name to products that belong to different product categories (Honda cars and lawnmowers, Yamaha motorcycles, musical instruments, Canon cameras, printers and copying machines etc).

Based on the FMCG experience, we believe that the descriptive names are not ideal for the creation of pharmaceutical brands. They don't offer the freedom to select the right brand name. There is also a big risk to create a generic association that will benefit to the development of generics and make them more difficult to protect legally. Finally, it will be more difficult to identify names that are suitable for global expansion. Brand names have to be easy to pronounce and, if they are to be memorable, be short, distinctive and difficult to imitate. The brand names have to be identified very early in the process as they are part of the brand equity that will be created.

New invented names are ideal to meet the criteria of uniqueness and memorability. We recommend, however, to favour the association of the corporate names as an “umbrella “name in order not to focus only on the product name that has a limited life time, as indicated earlier.

It is of course necessary to have already created strong corporate brand names that have a very clear and positive meaning in the mind of consumers. This is far from being currently the case in the pharmaceutical area following the number of mergers that have occurred over the past 15 years. It is not unusual to see General Practitioner market research around the world showing that many doctors do not know which companies produce the drugs they prescribe. As far as corporate brand names are concerned if the 2002 Financial Times survey of the world’s most respected companies (Financial times 2003) is anything to go by pharmaceuticals has a long way to go. In a ranking of the top 60 global companies, pharmaceutical companies managed only 4 entries – the highest being GlaxoSmithKline at No 41. Success in the survey probably reflects good branding and respect with integrity and consistency being the most admired qualities. Only one of the top 50 CEO’s was from the pharmaceutical industry Daniel Vassela being placed at No 44.

There is one big risk with this corporate brand naming strategy, and that is the risk of failure of a product in the total portfolio of brands. This risk is similar, but less pronounced, for any global brand in FMCG, particularly in

the Food industry like Coca-Cola, Nestlé or Kraft. The advantages are however bigger than the risks. The company will also evidently have to foresee excellent PR campaigns that would minimise negative reaction from the market if a problem would arise. The most recent example of this was the withdrawal of Baycol (a cholesterol lowerer) from Bayer which has opened the way for acquisition of the parent company brand.

- Global branding strategy

Global branding consists of offering a brand that has standardised a maximum number of elements of its strategy and marketing mix to ideally offer one standardised product to every international market.

Some authors considered that the marketing globalisation was irreversible due to the important economies of scale that it permitted, the emergence of global consumer segments and the rapid diffusion of technology (Levitt 1983, Jain 1989). Other believed, on the contrary that global marketing represented a risk because difference of cultures and consumer habits would remain between markets (Wind 1986, Douglas and Wind 1987). Today, global marketing has been adopted by the majority of FMCG firms. The question is not anymore to globalise brands but rather to see how to do it successfully and what level of globalisation to achieve. It is important to note that the creation of global brands has been more driven by cost considerations than market ones (Kpaferer 1991, Terpstra 1987).

In the pharmaceutical industry, the pressure from the financial community is starting to have en effect on company strategies. Top line growth is becoming more difficult to achieve and therefore there are similar pressures to cut costs to maintain growth in profit. Globalisation of brands is one way to benefit from economies of scale.

Arguments for and against global branding are very similar to the ones that have been given for the FMCG industry. The proponents of brand globalisation consider that 1) consumers (both doctors and patients) are more similar than different in terms of their desires 2) the market dynamics have changed. With regulatory convergence occurring not only in the EU, but between the US, EU and Japan, there is no need to work so often with individual regulatory authorities and the power of local partners is decreasing, 3) the reduction of costs at all levels will improve significantly return on investments, especially if an expensive clinical trial can be leveraged in all markets 4) control can be gained over the local network of partners, 5) one single positioning and image worldwide can be created, 6) more power can be achieved vis a vis doctors with the global organisation communicating one message, and 7) the internet has changed forever the availability of medical information to the patient (being the second most searched web topic), allowing important dialogue about health and drug related issues. Within this context a global brand reduces possible confusion and provides consistent information on a global basis.

A number of truly global brands now exist – Viagra from Pfizer, Vioxx from MSD, Nexium from AstraZeneca, Keppra from UCB – but not everyone thinks the approach ideal.

The opponents to global branding consider that there are inherent risks to this strategy. The arguments are the following : 1) Customers needs vary significantly by markets, 2) regulatory approval systems can still be influenced nationally, 3) identical drug molecules are sold under different names in different countries, 4) pricing remains a major difference and globalisation of brands induces higher risks of parallel importation, 5) the perception of disease and medicine practised might be different country to country, and 6) problems with one product might affect other products of the company very quickly.

In FMCG, the trend towards more globalisation happened earlier and faster, around 10 to 15 years ago. The key driver of the globalisation of brands in FMCG has been the reduction of costs linked to strong economies of scale. The pressure to globalise brands continues to be strong and has even accelerated over the last 5 years. This resulted from 1) the need to find new competitive advantages, 2) the level of industry globalisation and 3) the pressure from the financial community and firms shareholders (Schuiling 2001). Most companies have given priority to global brands, often at the detriment of local brands. This trend had a big impact on brand portfolios. For example, Procter and Gamble has exploited global branding as a competitive weapon since the early 1990's.

A few years later, its key competitor, Unilever, was forced to react and further globalised its brand portfolio despite following in the past their traditional multi-domestic model. As a result, they have announced at the end of 2001 that they would eliminate 1200 brands out of 1600, three quarters of their brand portfolio, to concentrate on 400 brands with international presence or potential.

In global branding, the principle to follow is to look at what is common between markets and minimise or forget the differences between them.

In view of the FMCG experience, we do not believe that the trend will be different in the pharmaceutical industry. We should expect the development of many more global brands and the elimination of many local brands, even successful ones. Indeed, the pressure to reduce costs will be as important as in the FMCG area. It will be key to further increase industry profits and financial analysts and shareholders will continue to increase the pressure.

We may also assume that diseases are much more global than many other needs in FMCG product categories, as a result globalisation pressure will be even stronger. Some important regional differences do exist, such as the problem of malaria in Africa and Asia, but when considering the top seven markets there is little variation (the top seven being US, Japan, Germany, France, UK, Spain and Italy).

Firms will need to further restructure their brand portfolio, especially because of the vast number of smaller brands and products that they have acquired in their recent mergers and acquisitions. Similarly to FMCG, there will be a trend to maintain and further expand global brands while disinvesting in local brands.

- **Brand extension and line extension**

A brand extension is defined in the branding theory as an existing brand name that is being extended to a category of products that is different to the existing one. A line extension consists, on the other hand, in the launch of new products, under the same brand name, in the same product category.

It is difficult to compare strategies in both industries as the vocabulary used and the strategies are quite different.

Brand extension

The FMCG strategy of taking an existing brand name and then extending it to other product categories has been tried on occasion within the pharmaceutical OTC sector (over the counter – free from prescription) but very limited success has been achieved. To some extent this strategy has

worked counter to the training of one of the key influencers in the process, pharmacists. They fear the increasing chances of a dispensing mistake as a major argument to resist this type of brand tactic e.g. Panadol is associated as a paracetamol brand, but adding aspirin components and changing the brand name to a similar sounding brand would be potentially difficult. Many patients, who where for instance aware that they are aspirin allergic, would not spontaneously, check the constituents for such a well known paracetamol based brand.

A relatively new phenomenon could also be seen as brand extension – it is the area where one product is marketed in numerous different diseases at the same time, sometimes with the same brand name sometimes with different brand names -

A limited number of examples exist, where a single prescription only molecular entity (product) is allowed to be marketed under two names in different unrelated indications e.g. bupropion hydrochloride is marketed by GSK as Wellbutrin for depression and as Zyban for smoking cessation. Although this is an extension of a molecular entity it changes the brand name deliberately. In this case, we consider that this does not correspond to a brand extension since two different brand names exist. This is comparable to the P&G experience of marketing two brands Dash and Ariel based on the same chemicals under two different positioning (whiteness and stain removal respectively) under two different names.

A new approach is being pioneered by the biggest companies in the sector, it is the researching, developing and launching of a brand in a number of different indications simultaneously. Pregabalin from Pfizer, an anti-epileptic product, is expected to be launched in the EU (during 2004) with epilepsy and neuropathic pain indications at the same time. In addition it has the potential to be launched in a third simultaneous indication, with the addition of general anxiety disorder (GAD) when US launch occurs subsequently (FDA filing Oct 03). This strategy of trying to achieve launch of multiple indications at the same time is a largely new and direct impact of the need to have bigger and bigger brands to replace sales of products reaching patent expiry over the coming decade. Obviously the resources required to be able to do this are huge and are only really available to a handful of companies in the top 20, who's R&D spends run into the multiple billions of dollars each year. In this case, this strategy is close to the definition of brand extension, as seen in branding theory.

Line extension

This term is similar in pharmaceuticals and FMCG, this connotes an original brand and the later reformulation of it into new dosage forms. This tactic sometimes allows pricing flexibility but more often improves the competitive dynamics a number of years after the original launch. These new dosage forms tend to allow administration to different patient types e.g. an oral solution can greatly ease the difficulty of administration of

large oral dosage forms to the elderly or paediatric populations. Another example constitutes the intravenous forms (IV), which can provide rapid loading of the product in the patients' blood stream in the intensive care setting. Even tablet development can have an impact e.g. melt tablets can provide an acceptable taste mask and ease swallowing of large tablets as well as increasing the chances of compliance with a particular regimen. Reducing the frequency of administration can be highly successful also e.g. allowing the patient to take the product only once a day vs perhaps twice or three times previously.

Within a different context the pharmaceutical industry talks also about "therapy franchises". These are groups of products which work together in a particular area or can be complimentary in that they are used by the same physician speciality to treat the patients of one disease area. As an example in 1999 MSD (Merck Sharpe & Dome) got 52% of its sales from various products in the cardiovascular area. (Moss 2001) At a less analytical level, BMS (Bristol Myers Squibb) is and always has been an oncology house, the old Glaxo has been the asthma powerhouse whilst the old Smithkline Beecham was a specialist in vaccines. All of these are therapy areas which require a particular expertise, for research, development and sales and marketing. We would consider this "therapy" franchise as the development of a certain category or specialised strategic focus of the company but it has nothing to do with brand or line extension.

In FMCG, the use of brand extension has been very frequent and has been developing very fast over the last 10 years. In view of the very high cost of launching new brands and managing them, firms have decided to launch new products behind existing brand names. This builds on the trend to concentrate efforts on big brands only. For example, Procter and Gamble is concentrating on big brands that generate more than $ 1 billion sales e.g they have recently decided to launch two new innovations under existing brand names. New biodegradable wipes, named Kandoo under the Pampers “umbrella” name and a new product for washing cars under the Mr Propre/Clean “umbrella” name. This trend would be seen in both multinationals and local companies

The consequences of extending existing brand names are much more complex in the pharmaceutical industry than in FMCG. There is always the risk of confusion and therefore misuse of drugs. The extension of existing brand names is therefore limited in this industry. However, if the industry leverages more the corporate name as an umbrella strategy, pharmaceutical will be more fully in line with the brand extension concept.

- Co-branding

Co-branding is defined as industrial alliances that are visible by the mentioning of two brand names. All alliances do not lead necessarily to the mentioning of two names (Kpaferer 2001).

In the pharmaceutical industry, due to the fragmented nature of the market place, we have seen more co-R&D development or co-marketing of products than in the FMCG sector. There are numerous examples of this but generally the industry has moved away from its understanding of co-marketing towards co-promotion. During the 1980's and 1990's a lot of products were co-marketed (i.e. the same molecule (chemical entity) promoted under a different brand name by different companies). It was thought that potentially doubling the resources via co-marketing agreements could double the market share for the original owner of the molecule. In reality the hard lesson was that, similar to FMCG, dilution of focus meant poorer in market performance than hoped for. The brand development costs with the different companies and the need to establish two unique brands in the minds of the physicians led to inefficiencies and net net poorer results e.g. despite its heritage with Innovace (Renitec in the US) MSD and its co-marketing partner were never as successful with Zestril and Carace as with the original.

A more common pharmaceutical tactic is co-promotion i.e. the same molecule, with the same brand name, promoted in the same territory by two companies working as separate but strategically connected partners. A good example of this is the UCB and Pfizer relationship for the antihistamine Zyrtec in the US. UCB owns the molecule but both companies promote the brand with their own fieldforces sharing the revenues and profits resulting from their activities – in effect maximising the possible promotional share of voice for the brand within the market place.

Co-promotion is not only used as a brand tactic but has been pioneered by Pfizer as a strategic driver for its acquisitions. Over the years Pfizer has entered into a number of co-promotion deals with third parties e.g. Lipitor with Warner Lambert and Celebrex with Pharmacia, the relationships acted as a form of due diligence before hostile or agreed takeover moves.

In FMCG, the use of alliances has existed for some time but to a lesser degree than in pharmaceuticals. There are different levels of alliances and co-branding is only one of them. The development of co-branding is a new trend in the market and has been adopted by some key companies quite recently. The advantages of these associations are being able to benefit from the awareness of two well known brands, their image, their specific target market or their technical expertise.

The concept is that two known brands will work together in developing or promoting a new product and will visibly link to the two brand names. These co-branding associations can be short term and are more related to co-promotional activities (Disney and Pampers) or long-term where both companies have long term agreements to develop, launch and promote a new product behind both brand names. The idea is to benefit from the awareness, image or technical skills of two equally known brands. For example, Philips and Nivea (Beiersdorf) have decided to develop and market a new product “Philishave Cool Skin with Nivea for men”. Objectives were for each of them to attract new users, enter new distribution channels, reinforce both brand images and share development and launch costs.

Co-branding of ingredients has now become a classical tactic (Iintel, Lycra, Nutrasweet) whilst endorsement campaigns (Ariel and Whirlpool) have been running for decades. All these co-branding agreements are linked to the need to decrease costs of development and of marketing of new products.

Based on FMCG experience at this stage there appear to be very few opportunities for significant successful co-branding within pharmaceuticals due to the weak corporate brand name situation at present,

Conclusions

The pharmaceutical industry has come late to branding and it has not yet received the strategic importance given to it by other industries. After many years of relatively easy double digit growth, the industry is now facing difficulties as it cannot rely, as in the past, on its traditional factors of success: R&D, protection of patents and strong sales force. Moreover, the growth of generics is another threat that the industry has to face, a threat experienced 20 years ago by the FMCG industry.

To return to significant growth, we believe than branding could represent a new competitive edge that the industry should leverage.

The analysis of current branding strategies in the pharmaceutical industry has shown important differences versus FMCG.

In the choice of brand names, the basic naming strategies are the same but focus on them is different. Descriptive branding should not be pursued based on the experience in FMCG. These names are not easy to globalise, are too generic and difficult to protect from a legal point of view. A new name can only be recommended if it is to be used in association with the corporate name in an umbrella strategy. Indeed, investing in a new brand name is not ideal long term as brand names have a limited life time. This is why we recommend following the current FMCG trend -

leverage existing big brand names or corporate names to maximise awareness and benefit from their positive image. This can only be implemented after strong corporate names have been established. Currently, this is not the case, after a series of mergers and acquisitions that have left corporate brand names undifferentiated and at times confused. There is a need first to clearly establish corporate brand identity before leveraging these names.

Branding theory and practise in pharmaceuticals is still 10 years behind the FMCG area.

We expect that continued pressure towards globalisation will continue and this will effect change in the pharmaceutical industry in time. The pressure to reduce costs will become as strong as in FMCG. The companies will need to develop more global brands to benefit from economies of scale that will lead to reduced costs and maintained profit growth. More global brands will be developed and more local brands will be sold or left unsupported. It will be important for the pharmaceutical industry to understand the advantages but also the drawbacks as brand globalisation progresses.

Regarding brand extension strategies, the two areas have big differences. Some attempts of extending an existing brand name have been tried in the OTC sector, but with limited success because of the risks of misuse. Another strategy is being developed which tries to launch a single

chemical entity simultaneously in different indications under the same brand name. The development of brand extension will only be leveraged when the industry focus more on corporate names than product brand names.

For co-branding strategies, different levels of alliances exist between companies. Alliances leading to co-R&D development or co-promotion have been used more often in the pharmaceutical industry, than in the FMCG area. Co-branding, an alliance that associates visibly two FMCG brand names will be more difficult to adopt in the pharmaceutical area.

In conclusion, the difference identified in the branding strategies between both industries are more linked to the fact that the pharmaceutical industry is several years behind FMCG in terms of brand development than to major structural differences. This shows that the pharmaceutical industry will benefit from a good understanding of the FMCG experience to guide future development successfully.

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