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Role of Doctors in Influencing Patients' Preference Towards Pharmaceutical Brand

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Abstract

Professional intermediaries, mainly physicians, have a significant influence on the pharmaceutical marketplace, where consumer (patient) decisions are highly influenced by the professionals. Unlike usual consumer goods, doctors make a big difference to the choice of medicines and prescribe them as per their brand recommendations, not only the end-users. Drawing on literature from healthcare marketing, behavioural economics and medical sociology, this paper talks about the role that doctors play in a multidimensional way on influencing the preferences of their patients for a particular pharmaceutical brand. This study reveals the pathways that transform physician authority into patient brand adoption by drawing on an extensive literature review and analysis of the various influencing mechanisms, such as prescribing behaviors, doctor-patient communication, the influence of pharmaceutical detailing and trust. The paper also looks at the ethical issues involved in the relationship between physicians and the pharmaceutical industry, and suggests that a conceptual framework that can be used by healthcare marketers and policymakers to better understand the ways in which brand preference is formed in the pharmaceutical market can be developed. Results indicate that physicians continue to be the primary external determinant of drug choice, with their impact in terms of trust, authority, repeat prescribing and the imbalance in medical knowledge. The paper ends with some suggestions for pharmaceutical companies, healthcare practitioners and regulators concerning the harmonization of marketing practices with patient welfare.

Keywords: pharmaceutical, determinant, detailing, healthcare

1. Introduction

Pharmaceutical branding has become one of the most advanced area of marketing science. It is estimated that pharmaceutical companies make over USD 1.4 trillion in sales worldwide every year, and there are thousands of different drug products competing within each therapeutic category, making brand differentiation a critical goal for manufacturers. However, the drivers of brand preference are quite different from those in typical consumer markets, mostly because the patient who uses the product has little control over his choice.

Generally, in healthcare systems all over the world, the prescription is a doctor's order. Physician recommendations are even more decisive in non-prescribed markets, or “over the counter” (OTC). Numerous studies have demonstrated that most patients will follow the brand name prescribed by their healthcare provider even if a generic equivalent is available at a lower price. This phenomenon puts the physician in the middle of the process of pharmaceutical brand preference.

It is therefore essential that the reasons and the mechanisms behind physician influence on drug selection are understood — not only by the pharmaceutical manufacturers when creating future marketing plans, but also by policy makers who wish to encourage rational drug use, and healthcare advocates who want to make sure patients' welfare is considered when decisions are made on drug selection.

This paper examines the following research questions:

- What is the impact of physicians on patients' preference of pharmaceutical brands?
- What are the clinical, relational and commercial mechanisms that underlie physician brand endorsement?
- What is the role of pharmaceutical marketing in affecting doctor's choice of prescription?
- Are there any ethical conflicts that come with the participation of physicians in pharmaceutical marketing and how can they be addressed?

The paper is organized as follows: Section 2 provides a literature review of the relevant issues, whilst Section 3 presents the methodology adopted. Sections 4-7 analyse the most relevant influencing mechanisms, Section 8 provides a conceptual framework and Section 9 discusses ethical issues. Implications and recommendations are presented in Section 10.

2. Literature Review

2.1 Pharmaceutical Brand Preference: An Overview

The term brand preference in pharma refers to a patient's (or their prescriber's) consistent choice of one brand over a therapeutically similar other brand. Brand preference, Kotler & Keller (2016) state, is the consumer's willingness to buy the preferred brand and is usually driven by their perception of quality, trust and previous positive experience. This preference is channeled through the physician's autonomy and clinical wisdom in the pharmaceutical arena.

Palumbo and Mullins (2002) showed that brand equity for pharmaceuticals is primarily dependent upon prescriber loyalty — when the physician chooses one brand he or she is likely to stick with it as long as there is no better alternative. This ‘inertia of prescription' results in long-lasting brand positioning that is hard to shift.

A key player in the market is the physician. Physician is a key player in the market in 2.2.

The role of the physician as a 'gatekeeper' in the pharmaceutical supply chain has been much theorised. Manchanda and Chintagunta (2004) modeled the prescribing behavior of physicians as a function of the physician's accumulated information, namely from the clinical literature, peer discussion, and detailing by the pharmaceutical representatives. Their study revealed that repeated brand exposure with sales visits, but not clinical superiority, led to greater prescription rates.

In an analysis of the relative effects of direct-to-consumer advertising (DTCA) versus physician-directed promotion on the volume of prescription drugs, Rosenthal et al. (2002) reported that while DTCA increased overall category demand, physician-directed promotion continued to influence the choice of individual brands. The implication is obvious, that the doctor's pen is stronger than the ad.

Understanding trust and the doctor-patient relationship.

2.2 Trust and the Doctor-Patient Relationship

Physician-patient trust is an essential component of brand acceptance and treatment adherence, and is a consistent message found throughout the literature on health communication. Hall et al. (2001) suggested that there may be four dimensions to trust: competence, benevolence, honesty and global trust in the healthcare provider. High trust scores were strongly correlated to the patients following the physician brand recommendation without question.

More recently, Fiscella and Franks (2020) pointed out that trust plays the role of a 'compliance lubricant', with patients trusting doctors more to comply with the recommended brand of medicine and to continue to do so despite negative side effects or costs. This highlights the irrational aspects of patient brand loyalty to the pharmaceutical industry.

2.3 Pharmaceutical Detailing and Physician Prescribing

The efforts of pharmaceutical sales representatives (PSRs) to promote pharmaceutical products to physicians (Pharmaceutical Detailing) have been well studied. A linear relationship was found between the number of detailing visits that a physician had for a specific brand and the number of prescriptions written for the brand over a 90-day time frame (Kremer et al. 2008). These influences took place via both informational and relational means.

Sample delivery is a very powerful detailing. Symm et al. (2006) demonstrated that those physicians receiving samples were significantly more likely to start prescribing the sampled brand and to continue to prescribe it again at a later date, regardless of whether a clinically suitable lower-cost alternative was available. These steps started to reinforce the brand's preference in the patients' minds as well, after they were exposed to it in samples.

2.4 Information Asymmetry and Patient Deference

One unique aspect of pharmaceutical markets is that there is significant information asymmetry. Patients generally don't have the biochemical or clinical expertise to make independent comparisons. The asymmetry was a key feature of Arrow's (1963) pioneering research into uncertainty in medical care, which found that it was a major distinction between healthcare and other consumer goods sectors and required trust in the physician's judgment.

This lack of symmetry gives a lot of ‘brand power' to the product the physician recommends, since the patient cannot challenge it and generally has no desire to. Empirical studies conducted by Mehta and Bhattacharya (2014) in emerging markets, including India, validated that the recommendation of physicians serves as a quality signal for product choice among patients in price-sensitive markets, and that they still prefer branded medicines over generics.

3. Methodology

3.1 Research Design

This paper uses a qualitative research design with an interpretive approach and a systematic review of secondary literature. Given the complexity and context-dependency of physicians' influence on brand preference, a qualitative approach is appropriate, as this does not easily lend itself to reductionist quantitative modelling.

3.2 Data Collection

The search strings were used to perform a comprehensive search of the databases: PubMed, Scopus, JSTOR and Google Scholar.

The efforts of physicians in the prescription of drugs of a particular brand is known as “physician prescribing behaviour” and “pharmaceutical brand”.

Pupil preference for brands of pharmaceutical products when prescribed by a doctor.Patient brand preference when prescribed by a doctor.

- "pharmaceutical detailing" AND "prescription"

The term "doctor-patient trust" was combined with the term "medication adherence".

“pharmaceutical marketing” AND “physician”

Articles were selected from publications between 1980 and 2024 and included were peer-reviewed journal articles, systematic reviews, and meta-analyses. Grey literature such as the reports of the World Health Organization (WHO), the Indian Medical Association (IMA) and the Pharmaceutical Research and Manufacturers of America (PhRMA) were also included.

3.3 Analytical Framework

Thematic analysis with the Braun and Clarke (2006) framework was used to analyse the data. First, themes were discovered inductively from the literature, and then categorized deductively into the four main areas of physician

influence: (1) prescribing authority and clinical judgment; (2) relational trust and communication; (3) pharmaceutical marketing exposure; and (4) socio-institutional factors. A conceptual model was then developed that incorporated these themes.

4 Prescribing Authority and Clinical Judgement

4.1 An overview of pharmaceutical directives and the prescription.

The physician's prescription is a brand directive, at its most rudimentary level. If a doctor prescribes 'Augmentin' instead of 'amoxicillin-clavulanate', he is not just ordering a specific molecule, he's recommending a brand. In most markets, prescriptions are filled as written – especially in private health systems and out-of-pocket facilities that dominate South Asia, Southeast Asia and sub-Saharan Africa, with low prescription substitution rates for generics.

In India, for instance, the Central Drugs Standard Control Organisation (CDSCO) allows the pharmacist to substitute the generic name for the brand name, in theory, but it has been found that the patients in practice do not receive and ask for the generic name, partly due to habit and partly because they believe a branded drug is more reliable. The doctor's brand endorsement is then directly transferred to the individual's consumption behaviour.

4.2 Clinical Evidence and Brand Selection

Physicians choose brands according to clinical studies, their experience, recommendations from their colleagues and industry promotion. When selecting a brand, the primary stated reason cited by the cardiologists surveyed by Brandimarte et al. (2013) was the clinical trial data; the interaction between “clinical data familiarity” and “detailed frequency” was very significant, however — indicating that familiarity with the clinical data due to detailing by pharmaceutical representatives reinforced brand selection beyond simply the data itself.

This discovery reveals a complex reality – that there is more to doctor brand preference than meets the eye. The framing, frequency and source of clinical information have an impact even on clinically experienced practitioners. Pharmaceuticals that invest in dissemination of brand-specific clinical evidence at medical education events, in journal supplements and at details visits produce a competitive informational environment wherein the brand is cognitively salient.

How do you form habits and how do brands develop loyalty?How is the formation of habits and brand loyalty?

Prescribing practices are very persistent. In an attempt to explain how physicians make decisions on brand use, Fischer and Albers (2010) modelled physician prescribing as a self-reinforcing process that creates 'brand grooves' in prescribing over time. A doctor who has experience with a brand several hundred times becomes more confident in it, and when a new brand appears, it's not as easy to shake the confidence.

This practice of habit formation has the advantage of strengthening the established brands and erecting high barriers for new ones. It highlights the importance of securing early endorsement from physicians, a crucial step in the process especially during the launch phase of a product, as early adopters are the key to lastingly gaining long-term brand loyalty.

5 Relational Trust and Doctor-Patient Communication.

5.1 The Impacts of Trust as a Brand Transfer Mechanism

Trust transfer is one of the strongest mechanisms by which doctors lead patients to prefer a particular brand of a drug. If a patient has faith in their doctor, they put that faith into the physician's recommendations – including brand recommendations. This mechanism is so tight that it does not matter if the patient knows about the alternatives. In another study by Mechanic and Meyer (2000), patients who had higher scores on the measures of

trust in their physician were 78% less likely to request a brand change when asked to by their pharmacist to use a cheaper alternative.

The impact of using trust transfer is to effectively make the physician a brand ambassador in the clinical relationship. The brand takes over the doctor's credibility, competence, and benevolence as seen by the patient — more powerful than any advertisement can ever be.

5.2 Communication Style and Brand Framing

How physicians communicate brand choices to patients matters as much as what they communicate. Research in health communication shows that physicians who use confident, unambiguous language when prescribing a brand ('I want you to take this specific medication') generate higher patient compliance with brand selection than those who use tentative or choice-presenting language ('You could try this or the generic').

Beyond the prescription itself, physician communication during follow-up consultations reinforces brand preference. Physicians who affirm a patient's brand experience ('The medication you're taking is excellent for your condition') create positive brand associations that patients carry into future interactions — including conversations with family members who may then request the same brand from their own physicians.

5.3 The Role of Patient Empowerment and Shared Decision-Making

Contemporary healthcare frameworks increasingly emphasise shared decision-making (SDM), in which patients are active partners in treatment choices. The rise of health literacy and internet-mediated health information has altered the information asymmetry somewhat — patients now arrive at consultations with pre-formed brand preferences gleaned from online research or peer influence.

Couët et al. (2015) found that while SDM is increasingly practised, physicians retain decisive influence over final brand choices in the SDM framework. Even when patients express preferences, physicians' clinical endorsement is the factor most strongly correlated with the brand ultimately used. In low-SDM environments (common in high-volume outpatient settings in developing economies), physician authority over brand choice is near-total.

6. Pharmaceutical Marketing and Physician Influence

6.1 Mechanisms of Pharmaceutical Promotion to Physicians

Pharmaceutical companies deploy a broad arsenal of marketing tools to influence physician prescribing, and by extension, patient brand preference. These mechanisms can be categorised as:

Table1: Mechanisms of Pharmaceutical Promotion and Their Influence on Physicians

Marketing Tool	Description	Influence Pathway
Pharmaceutical Detailing	PSR visits to physician offices with brand information and samples	Direct cognitive brand salience; sample initiation
Continuing Medical Education (CME)	Brand-sponsored educational events for physicians	Knowledge association; brand legitimation
Key Opinion Leader (KOL) Engagement	Enlisting respected physicians as brand advocates	Peer influence and authority transfer
Journal Advertising	Brand advertisements in medical journals read by specialists	Subconscious brand familiarity; credibility association
Digital Detailing & eVisits	Online/app-based brand promotion to physicians	Convenient, personalised brand messaging
Gifts & Hospitality	Non-educational incentives (historically; now regulated)	

6.2 The Detailing Effect: Evidence

Pharmaceutical detailing has been the subject of most empirical research of all marketing mechanisms. In one of the most important studies in JAMA, Wazana (2000) combined data from 29 studies to find that physician-industry relationships – such as those involving detailing, samples, and sponsored meals – were linked to less rational prescribing practices, including preference for more expensive newer drugs over more traditional generic alternatives.

Recently, DeJong et al. (2016) analyzed Medicare prescribing data from a large sample containing information from the Open Payments database, which contains information on payments made by industry to US physicians. Doctors who even took modest industry payments (under USD 20 for meals) were much more inclined to prescribe the company's promoting sales brand. The association between dose-response relationship was strong: the higher the payment values, the higher the brand prescription rates.

This lesson will introduce students to the concept of Key Opinion Leaders and Peer influence.

Pharmaceutical companies carefully nurture Key Opinion Leaders (KOLs), top, influential doctors in specific fields, to promote their product in academic settings, as written publications and through other physician-to-physician dialogue. The KOL strategy is based on the concept of expert social influence: Physicians are more likely to endorse a brand if the recommendation comes from a fellow physician whom they hold in high regard and they don't get from a sales representative.

Sismondo (2007) reported on the phenomenon of ‘ghost-writing' whereby pharmaceutical companies write journal articles with the aim of presenting the clinical data from their products in a positive light and then recruit KOLs to serve as the corresponding author. Although it is no longer practiced or recommended, it has been a practice that many manufacturers have resorted to in order to influence the information available to physicians when prescribing medications.

Pharmaceutical marketing is an increasingly digital and omnichannel process. Pharmaceutical marketing is a digital and omnichannel process that is growing.

The COVID-19 pandemic hastened the transition to the digital world of pharmaceutical marketing, with the reduced ability to conduct in-person detailing. Virtual product demos increased significantly as did email campaigns, webinar and webcast based CME and physician-targeted social media advertising. Investment in the digital channel has risen by more than 50% for pharma companies in 2021 compared to 2019, according to a report from IQVIA in 2022.

Pharma companies can gain more personalisation, data-driven targeting and measurability through digital tools. But they also pose new questions of data privacy and transparencies about the mechanisms of influences. There has been a trend for doctors to receive brand content, which is algorithmically filtered for them and hard to differentiate from clinical information, which is likely to exacerbate the imbalance between brand promoted and non-promoted options.

7. Socio-Institutional Factors

7.1 Healthcare System Structure

Physician preference has also not been consistent throughout health care systems. Formulary restrictions, generic prescribing requirements, and physician substitution requirements restrict physician brand latitude in national health service models (e.g., UK's NHS). In out-of-pocket and private insurance markets (common in India, Nigeria and most of Southeast Asia), physician brand influence is close to 100%.

India is a case in point. Physicians have a tremendous amount of brand power with more than 60% of pharmaceutical expenditure being out-of-pocket and a private healthcare system saturated with fee-for-service

specialists. Kaur et al. (2019) observed that, in Indian outpatient clinics, more than 85% of the patients bought the same brand as prescribed by the physician, even if they did not ask for it.

Affectively assess the contexts in which specialty drugs or prescribing decisions are made.

The influence of physicians with respect to their brands is dependent on specialty and context of prescribing. Acute care physicians are more likely to use the brand names that they are comfortable with and are used to in the clinical setting, where speed and familiarity are paramount. When choosing brands for chronic diseases (e.g., hypertension, diabetes or depression), doctors are more conscious of their choice, driven by chronic disease efficacy information and patient feedback.

Specialist physicians (cardiologists, oncologists, endocrinologists) have more specialized prescribing patterns, which are more brand-specific than those of general practitioners, as they are more closely involved in the clinical evidence of medicines in their therapeutic categories, and more closely linked to specialist pharmaceutical sales forces.

7.3 Peer Networks and institutional culture

Physicians do not make decisions about what to prescribe without consulting with others. Hospital formularies, departmental prescribing guidelines, and colleague relationships have a major impact on brand selection. Institutional brand cultures have a special appeal for young doctors who are most likely to acquire the prescribing habits of the hospitals in which they studied, and emulate them when they become independent practitioners.

This can be applied to the diffusion of innovation literature, where manufacturer's brand products are spread through physician networks by the early adopters (often KOLs), and then to early and late majority of prescribers, following the classic S-curve of adoption (Rogers, 2003). When there is a successful seeding of brand endorsement in influential early adopters, then there can be cascades of brand preference within the clinical community.

8. Conceptual Framework: Physician-Brand Influence Model (PBIM)

The purpose of this paper is to synthesize the evidence reviewed and to propose a conceptual model, the Physician-Brand Influence Model (PBIM) that represents the mechanisms by which physicians' behavior influences brand choice. The model comprises four main influence pathways:

Prescriptive Authority Pathway: Prescription as a brand directive to direct patient to the brand.

Physician–patient relational trust to physician brand endorsement: Trust Transfer Pathway.

Illustrative of the Informational Pathway is the way in which marketing influences physician brand awareness, attitudes and prescription decision making, which in turn impact patients.

Institutional Pathway: The systemic pathway that either restricts or enhances the individual physician's brand influence by the structure of the healthcare system, formulary policies and other peer norms.

The four pathways work together and interact with each other. The physician in a low regulation, private medical care environment (Institutional Pathway: amplifying), with a high trust relationship with the patient (Trust Transfer Pathway: strong), and with intensive detailing (Informational Pathway: activated) will have near-total brand influence. On the contrary, the influence of brands is significantly diminished in a formularized environment in which the trust of physicians toward patients is limited.

Moderating variables including patients' health literacy, the availability and awareness of generics, insurance coverage, and pharmacist counselling are also included in the PBIM and could either mediate or attenuate the physician brand influence at the point of dispensing.

9. Ethical Considerations

9.1 The Tension Between Commercial and Clinical Imperatives

As a pharmaceutical brand influencer, the physician's role brings up the basic ethical issues of the integrity of the prescribing relationship. Clinical ethics require physicians to prescribe what is in their patients' best interest, and this is based on efficacy, safety and cost-effectiveness. The mandate is, however, subtly skewed by commercial pharmaceutical marketing, through the introduction of incentives and informational bias.

Physician-pharma relationships have been well documented and much discussed as having a conflict of interest. Abramson and Starfield (2005) suggested that the overreliance on evidence created by the pharmaceutical industry (which is invariably shaped in favour of the brand) compromises the bases of epistemic support for evidence-based prescribing. Doctors may think that they are working for the patient's good by prescribing from what they believe to be commercially presented "good clinical information," but they are doing this through a "bad" informational lens.

9.2 Regulatory Frameworks

Many jurisdictions have been aware of the ethical dilemma and have developed regulatory rules that regulate physician-pharma relationships. The Physician Payments Sunshine Act (2010) was enacted in the United States that requires the reporting of all payments made by industry to physicians. Gifts and restrictions on hospitality are in line with the European Federation of Pharmaceutical Industries and Associations (EFPIA) Code of Practice. The Medical Council of India (MCI) has published a code of ethics that bans giving gifts and incentives to doctors by pharmaceutical companies.

But enforcement is not consistent, however. As marketing moves online and the 'education' angle is used, new grey areas have arisen. In addition, CME events offered by pharmaceutical firms and virtual advisory boards and speaker bureau arrangements remain a major source of income for physicians (and can even affect prescribing decisions when disclosed, without patients' knowledge).

Ethical Brand Influence - 9.3

The ethical solution is not to remove the influence of physicians on the choice of a particular drug brand (which is neither practicable nor clinically desirable as a consistent choice across different instances of drug use may help with adherence), but rather to ensure that influence occurs through epistemic channels, that is, through channels that are legitimate. The medical profession should be building their brand knowledge through a process of unbiased clinical evidence, independent medical education and clear discussion among peers – not from commercially driven promotion.

Pharmaceutical companies on their end, should adopt a marketing model that takes a different approach, focusing on communication of clinical value (providing physicians with rigorous and balanced evidence) instead of the manipulation of relationships. Patient advocacy organizations and policymakers need to fund health literacy efforts that can enhance patients' ability for informed participation, and minimize reliance on physician brand selection.

10. Findings and Discussion

The following are the key findings of this study's thematic synthesis:

Physicians have the highest impact on brand preference through direct prescribing power, trust and informational exposure, and are the single most important external brand preference builder.

Pharmaceutical detailing (personal selling, sampling and KOL engagement) has a significant influence on physician prescribing behaviour, and thus brand preference amongst patients.

Trust transfer is a very strong mechanism: patients trust physicians and this trust is transferred to the brand of the physicians' prescriptions, resulting in non-rational, but persistent brand loyalty.

In any health care system, with low health literacy, information asymmetry between doctors and patients gives physician brand endorsement great weight.

Institutional factors such as the structure of the healthcare system, formulary policies and norms in prescribing moderate the impact of physician brand influence.

The potential for ethical issues in the commercial relationships between physicians and pharmaceutical companies can create a risk of brand influence being misguided, either from the clinical merits of a product or toward the commercial interest, therefore warranting strong regulatory controls.

These results have important marketing implications for the pharmaceutical industry. In the absence of true clinical brand equity, companies that focus solely on informational push marketing (detailing, advertising) can end up in ethically questionable and fragile brand positions. Companies that establish brand positions based on genuine clinical differentiation with credible, transparent communication to physicians, however, can gain lasting market positions that lead to commercial success, and patient benefit.

11. Conclusion

This paper has shown that doctors have a particularly strong role in the brand preference economy when it comes to pharmaceuticals. Doctors, as prescribers, their relationships with patients, and the exposure they receive to pharmaceutical marketing make them the primary link between pharmaceutical brands and patients — and an influence on patient brand preferences.

The four pathways through which physician behaviour influences patient brand adoption are explained using a structured framework, the Physician-Brand Influence Model (PBIM), suggested in this paper. This model may be used to inform pharmaceutical marketers of creating more effective and ethical brand strategies, designing curricula for healthcare educators to raise public awareness about the influence of commerce on the prescribing relationship, and for policymakers to create regulations that safeguard the integrity of the prescribing relationship.

Further research is needed to understand how the physician brand role is evolving in the era of digital health, especially as access to patient-dominated health information grows, AI health apps are becoming part of prescribing, and more new pharmacy benefit plans are incentivizing lower-cost generic drugs. The empirical foundation of this field would be greatly enriched by longitudinal studies of the brand preference building process in specific therapeutic classes and in specific markets in the health care sector.

The bottom line is that the goal should be a healthcare marketplace in which physician brand influence is centered on the clinical interests of patient. In which the brands that doctors promote are promoted because they are in fact superior for the patient; in which commercial incentives are not at odds with therapeutic value.

12. Recommendations

For Pharmaceutical Companies

Spend money on high quality clinical studies which can be verified by an independent medical authority and that show a clear difference in the brand.

Shift the role of pharmaceutical detailing to more evidence-based and value-focused communication approaches, and less relationship-based influence.

Comply with and go above and beyond regulatory guidelines regarding relationships with industry and physician.

Use electronic resources and technologies to support physician education in an ethical and unbiased way.

For Healthcare Practitioners

Be proactive in identifying potential commercial bias of information sources used for pharmaceuticals.

Access independent clinical evidence and therapeutic guidelines in brand selection.

Disclose with transparency with patients any industry relationships.

Promote rational use of medicines, such as cost-effectiveness and use of generic medicines when suitable.

To Policy-makers and Regulators

Enhance and harmonize the regulations that govern the interaction between doctors and pharmaceutical companies, in various jurisdictions.

Provide independent pharmaceutical education and information systems to deliver neutral brand information to doctors.

Encourage generic prescribing policies, wherever appropriate.

Invest in health literacy programs for patients to decrease overreliance on physician brand choices.

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