Chapter 6

The Branded Prescription Problem

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Introduction: The Power of a Signature

In India, **doctors rarely write prescriptions using generic drug names**. Instead, they almost always prescribe **branded generics**—commercial brand versions of off-patent molecules. This single decision shapes the patient's entire treatment cost, access, and outcome.

India's pharmaceutical market has over **60,000 brands for about 60,000 drugs**, leading to confusion, profit-driven prescribing, and inflated pricing. This chapter explores the reasons behind doctors' **reluctance to prescribe generics**, the **influence of pharma marketing**, and the **systemic problems caused by brand-centric prescribing**.

1. What Is a Branded Generic?

A **branded generic** is a drug whose molecule is off-patent but is sold under a **trade name** rather than its **generic name**.

| Example: Branded vs Generic Drug |

Molecule Name	Atorvastatin
Branded Generic A	Lipicure (Cipla)
Branded Generic B	Atorlip (Zydus)
Generic Version	Atorvastatin (INN)

Unlike in countries like the UK or US, **generic versions in India are not the default choice**, and **chemists cannot substitute a brand with a cheaper generic** without doctor approval.

2. The Scale of Brand Dominance

More than **82% of prescriptions** in India are for **branded drugs**.

In contrast, only **2% of doctors routinely prescribe using International Nonproprietary Names (INNs)** [1].

| Table 1: Market Share by Drug Type (2023) |

Category	Market Share (%)
Branded Generics	82%
Patented Drugs	2%
Pure Generics (INN)	16%

Source: IQVIA India Pharma Audit, 2023 [2]

This results in **huge price variations** between brands for the **same molecule**—sometimes as high as 1000%—with **no difference in efficacy**, assuming quality is maintained.

3. Why Doctors Don't Prescribe Generics

a) Perceived Quality Issues

Many doctors cite concerns about the **quality and bioavailability** of generics, especially those from **Jan Aushadhi** or lesser-known manufacturers.

"I don't know where that generic was made. I trust the brand I know." – Senior cardiologist, Kolkata [3]

b) Brand Familiarity and Habit

Doctors are introduced to brands via medical representatives during internships and training. Over time, this becomes **habitual**—especially for high-frequency prescriptions like painkillers, antibiotics, and anti-diabetics.

c) Incentives from Pharma Companies

Brand loyalty is often reinforced by **financial or indirect incentives**, as detailed in Chapter 5. Doctors may be rewarded for consistently prescribing specific brands.

d) Lack of Regulatory Push

There is **no national law mandating generic-only prescriptions**, although some state governments (e.g., Rajasthan, Tamil Nadu) encourage it in public hospitals.

4. The Jan Aushadhi Paradox

The **Pradhan Mantri Bhartiya Jan Aushadhi Pariyojana (PMBJP)** aims to offer **low-cost generics** through a network of over **9,200 stores**.

| Table 2: Price Comparison – Jan Aushadhi vs Branded Drugs (2023) |

Drug (Dose)	Jan Aushadhi Price	Top Brand Price	% Cost Saving
Telmisartan (40 mg)	?2.60	?13.40	81%
Metformin (500 mg)	?1.50	?9.90	85%
Pantoprazole (40 mg)	?2.20	?8.80	75%

Source: PMBJP & NPPA Price List 2023 [4]

Despite this, **most doctors do not prescribe Jan Aushadhi products** due to:

- Brand unfamiliarity
- No pharma engagement or incentive
- Perceived lower quality

A 2022 survey across 8 Indian cities found that **only 18% of doctors had ever prescribed a Jan Aushadhi medicine** [5].

5. Patient Impact: Affordability Crisis

The brand-heavy prescription system leads to **significant financial burden** on patients.

A 2021 study by the National Health Systems Resource Centre (NHSRC) found that **42% of Indian households reported delaying treatment due to drug costs** [6].

| Table 3: Drug Cost Burden by Income Group (2021) |

Income Level	% Monthly Income on Medicines
Low-income (bottom 40%)	18–25%
Middle-income	8–12%

High-income	2–4%

Source: NHSRC Survey, 2021 [6]

Patients are often unaware that cheaper alternatives exist—and even when they are, **chemists refuse to substitute brands** without explicit permission from the doctor.

6. Brand Manipulation and Me-Too Drugs

Many Indian pharma companies launch **multiple brands of the same drug**, creating **brand confusion** and **artificial demand**.

For example, one company may sell:

- Atorvastatin as Lipicure
- Lipicure-D (with diltiazem)
- Lipicure-A (with aspirin)
- Lipicure-EZ (with ezetimibe)

This **floods the market** and **discourages rational prescribing**, especially when doctors prescribe **combinations** without evidence-based indication.

7. Global Comparisons: Where India Stands

| Table 4: Prescription Norms by Country |

Country	Generic-Only Prescribing Mandated	Pharmacist Substitution Allowed
UK	Yes (NHS system)	Yes
USA	Encouraged but not mandatory	Yes (State dependent)
France	Yes	Yes
India	No	No (Substitution not allowed)

Source: WHO Global Medicines Policy Survey, 2022 [7]

India's **lack of generic substitution rights** puts **price control power in the hands of prescribers**, rather than systems.

8. Policy Efforts to Change Prescribing Habits

a) NMC Guidelines (2023)

Mandated doctors to prescribe using **generic names**. **Challenge:** Faced opposition from Indian Medical Association (IMA) citing "poor-quality generics".

b) State-Level Generic Mandates

- Rajasthan and Tamil Nadu mandate generics in public hospitals
- Maharashtra proposes **electronic prescription audits**

c) eSanjeevani Platform

The government's telemedicine portal includes **generic prescribing defaults**, but uptake remains limited.

d) Public Pressure Campaigns

Some NGOs and RTI activists have demanded that **doctors disclose cost of prescribed medicines**, but this is not legally enforced.

9. Proposed Reforms to Break Brand Monopoly

| Table 5: Reform Proposals for Generic Prescribing |

Reform Proposal	Status / Feasibility
Make INN prescribing mandatory	NMC guideline (not enforceable)
Empower pharmacists to substitute	Pending amendment
Audit prescriptions electronically	Piloted in Tamil Nadu
Incentivize Jan Aushadhi use	Not widely implemented
Disclose brand vs generic price	No policy yet

Until these reforms are implemented **nationwide and enforced**, doctors will continue prescribing brands—not based on evidence, but often on perception, loyalty, and incentives.

10. Ethical Dilemmas and Medical Responsibility

Doctors argue that **quality cannot be compromised**, and that not all generics are reliable. While valid, this concern is often **selectively applied**. In reality:

- Many **branded generics are made by the same contract manufacturers** that supply Jan Aushadhi
- Indian brands do not disclose **bioequivalence data publicly**
- Doctors rarely take the time to educate patients on **drug cost options**

In this silence, **trust is replaced by habit**, and patient welfare is **replaced by commercial comfort**.

Conclusion: The Signature That Costs a Nation

A doctor's signature can mean the difference between **treatment and neglect**, **affordability and bankruptcy**, or **healing and harm**. In India, that signature is more often attached to a **brand name**, not a molecule name—and that choice shapes **one of the most inefficient drug markets in the world**.

Unless brand-first prescribing is reversed through **legal mandates, system audits, and ethical renewal**, India will continue to manufacture cheap drugs while denying its own citizens the benefit of cost-effective treatment.

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