Inditech Health Solutions

Publishing No. 2026 01 60

FIXING THE WET COUGH BRAND CHOICE DRIFT

A clinic-embedded case study playbook to win brand choice at the prescription desk

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Executive Summary

THE DRIFT DEFINITION

In pediatric wet cough with bronchospasm, the decision to prescribe a levosalbutamol syrup is well established. The molecule is familiar, the indication is clear, and doctors are clinically comfortable with its use. This is not a space marked by diagnostic uncertainty or therapeutic debate.

On the surface, this should favour all brands in the category equally. In practice, it does not.

Prescribing behaviour in this segment is highly habitual. Once the clinical decision to use levosalbutamol is made, brand selection happens almost automatically. The pen moves toward the brand that is most familiar, most repeatedly written, and most deeply embedded in the doctor's muscle memory. In a crowded market with a dominant leader, this habit exerts a powerful pull.

Brand UMI operates in precisely this environment.

The brand is not rejected, questioned, or doubted. It simply fails to surface at the decisive moment. When the category decision is complete, brand choice defaults to memory rather than reconsideration. As a result, Brand UMI loses not on science, not on safety, and not on suitability - but on absence at the prescription moment.

Importantly, this makes traditional responses ineffective. Additional molecule education, cough awareness initiatives, or generic reminders would raise confidence in levosalbutamol as a category, but would primarily benefit the category leader. The problem is not insufficient knowledge; it is where brand visibility sits in the doctor's workflow.

The strategic question, therefore, is narrow and specific:

How can Brand UMI enter the doctor's line of sight at the exact moment a wet cough syrup is chosen - without lifting the category or strengthening the leader's default?

This is not a molecule problem or a messaging problem. It is a brand choice problem at the prescription desk, driven by habit, speed, and workflow - and it requires a solution that operates at that same level.

*Brand name used for illustration.

Market Reality

THE GUIDELINE-REALITY GAP

Cough is one of the most frequent reasons for consultation. Decisions are made quickly, often within minutes, and under pressure from parental anxiety and high patient volumes. In this setting, once the doctor concludes that a wet cough with bronchospasm is present, the therapeutic decision is effectively complete. What remains is a rapid execution step: writing a brand.

At this point, clinical guidelines offer little assistance. They define what to prescribe, but not which brand to choose. As a result, brand selection is driven not by differentiation or re-evaluation, but by habit, recall, and ease.

This creates a structural gap between guideline intent and real-world behaviour. Evidence informs the category decision, but brand choice is resolved through workflow shortcuts, not through conscious comparison.

Brands that are not visible within this execution flow struggle to be selected, regardless of their clinical suitability.

Importantly, attempts to close this gap through additional education often have the opposite effect. Category-level teaching strengthens confidence in levosalbutamol use overall, disproportionately reinforcing the dominant brand's position. Without a mechanism to surface an alternative at the point of prescription, educational efforts tend to consolidate existing habits rather than change them.

The guideline-reality gap, therefore, is not about knowledge deficits or inappropriate prescribing. It is about where brand choice is decided - in a narrow, time-compressed moment that sits outside formal guidance and is governed by habit rather than deliberation.

Problem Framework

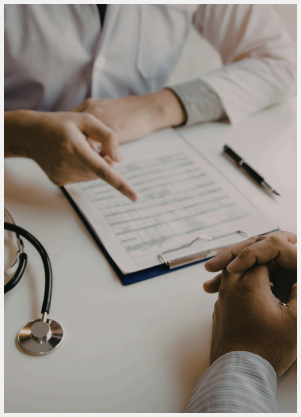
For Brand UMI, once a wet cough with bronchospasm is identified, brand choice is resolved in seconds. In that compressed moment, there is no active comparison, no re-evaluation of options, and no incentive to switch away from habit. The dominant brand benefits not because it is reconsidered each time, but because it is remembered first and written fastest.

Creating three specific points of brand pain.

Habit overrides merit

In a mature, commoditised category, brand choice is no longer a rational exercise. It is a behavioural shortcut. Doctors default to the brand they have written most often, not the one they have most recently heard about.

For Brand UMI, this means that incremental improvements in messaging, packaging, or flavour do not translate into prescriptions. Merit is irrelevant if the brand is not mentally available at the moment of writing.



Investment leakage to the category leader

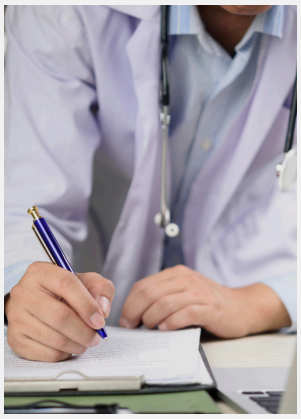
Any activity that improves confidence in levosalbutamol as a therapy - education, guideline reinforcement, cough awareness - lifts the entire category. In such scenarios, the strongest incumbent captures a disproportionate share of the benefit.

For Brand UMI, this creates a structural disadvantage: the brand pays for category lift, while the leader converts it into volume.

Absence at the execution node

Brand UMI does not currently appear inside the doctor's decision flow. It is not embedded in the logic that moves from diagnosis to prescription. As a result, the brand is not rejected - it is simply bypassed.

This absence is the most damaging form of loss. There is no objection to overcome, no misconception to correct, and no conversation to influence. The choice has already been made by the time the brand could be recalled.



THE BRAND PAIN

THE COMMERCIAL CONSEQUENCE

Brand performance in wet cough is not decided by how convincingly a brand is positioned. It is decided by whether the brand is visible at the exact moment the prescription is executed. Until Brand UMI is structurally present at that moment, growth efforts will continue to face diminishing returns - regardless of field strength or creative quality.

WHY THIS PROBLEM MUST BE SOLVED DIFFERENTLY

This is not a problem that can be fixed with louder messaging or broader education. It requires re-engineering where and how brand choice is surfaced - so that Brand UMI becomes part of the doctor's automatic execution pattern, not an afterthought.

The Behavioural Moment Map

Moment 1

PARENT ANXIETY BEFORE THE CONSULT

Parents arrive worried, often after self-medication or internet advice. The doctor's priority becomes reassurance and safety.

Moment 3

POST-CONSULT VALIDATION

Parents may revisit advice through pharmacists or peers - but the brand is already written.

Correction must happen at Moment 2 - not before, not after.

Moment 2

THE CLINICAL SORTING MOMENT (CRITICAL)

Dry vs wet cough. Presence of wheeze. Need for bronchodilator.
-This is where levosalbutamol is chosen.
-This is where brand choice is silently decided.

The Clinic-Centred Solution Framework

SURFACE → ANCHOR → EXECUTE

The objective is not to change how doctors think about cough, levosalbutamol, or treatment guidelines. It is to change what they see at the exact moment a wet cough syrup is written. The solution therefore operates only at the execution window, where brand choice is silently finalised.

SURFACE
(Enter the execution flow)

Brand UMI must appear inside the doctor's clinical sorting process, not before it and not after it.This is achieved by introducing a clinic-owned cough service that doctors already rely on to manage high-volume cough cases safely. The service produces a concise, doctor-facing cough summary and algorithm as part of routine clinic use.

Brand UMI is surfaced only at the precise clinical node where levosalbutamol syrup is appropriate:

- wet cough
- bronchospasm
- no red flags requiring escalation

At no other point does the brand appear.

Result:
Brand UMI is not recalled from memory. It is seen in context.

ANCHOR
(Make the brand feel clinically correct)

Visibility alone is not enough. The brand must feel right in that slot.

Anchoring is achieved by ensuring that:

- the algorithm is guideline-aligned and specialist-approved,
- the brand appears alongside clinical criteria, not marketing language,
- dosing is clearly shown within the same frame.

This positions Brand UMI as the default execution choice, not an alternative option.

Result:
The brand inherits the authority of the clinical logic that precedes it.

EXECUTE
(Reduce friction to zero)

At the execution window, the doctor’s tolerance for effort is minimal.
The framework ensures that when Brand UMI appears:

- the dose is immediately visible,
- no additional material is needed,
- no explanation is required.

The doctor moves directly from decision to writing.

Result:
Brand choice becomes the path of least resistance.

This framework avoids education, promotion, and patient messaging - and focuses influence only where it works: the moment of prescription.

Replication Blueprint

IMPLEMENTATION MODULES

Module	What is implemented	How it works in practice	Brand UMI impact (Brand Choice)
Clinic-Owned "Cough Assistant"	Clinic-branded QR/link service for cough cases	Parents complete a short, guideline-approved cough screen; red flags identified; no medicine or brand shown	Routes every cough case into a consistent doctor-facing execution flow
Doctor-Facing Cough Algorithm	One-page, specialist-approved algorithm	Auto-appears with each cough report; dry vs wet logic shown; Brand UMI visible only at levosalbutamol node with dose	Places Brand UMI directly at the prescription decision moment
Doctor Education Sheets	Short academic sheets mirroring the algorithm	Used in academic calls; reinforces identical logic; Brand UMI appears only in the therapy box	Builds recognition consistency and default formation
Clinic Visibility Cues	Clinic-branded poster + desk QR card	Staff use for every cough case; functional, non-promotional	Increases frequency of exposure to the execution algorithm
Field Enablement	One-time setup + light upkeep	Field ensures setup and continuity; no repeated detailing	Brand choice shifts via workflow presence, not rep pressure

BRAND CHOICE EXECUTION

1. ***Clinic-owned tools in place***

   Do the tools fit seamlessly into clinic routines and invite natural adoption without resistance?

2. ***Guideline-aligned clinical logic***

   Is all decision logic clearly evidence-based and clinically defensible?

3. ***Doctor-only brand visibility***

   Is the brand visible only at the prescription moment, with no patient-facing promotion?

4. ***High-frequency usage built in***

   Will the solution be used repeatedly across cases to enable habit and default formation?

5. ***Low field-force dependency***

   Can the system run at scale without continuous or heavy rep involvement?

Brand Outcome

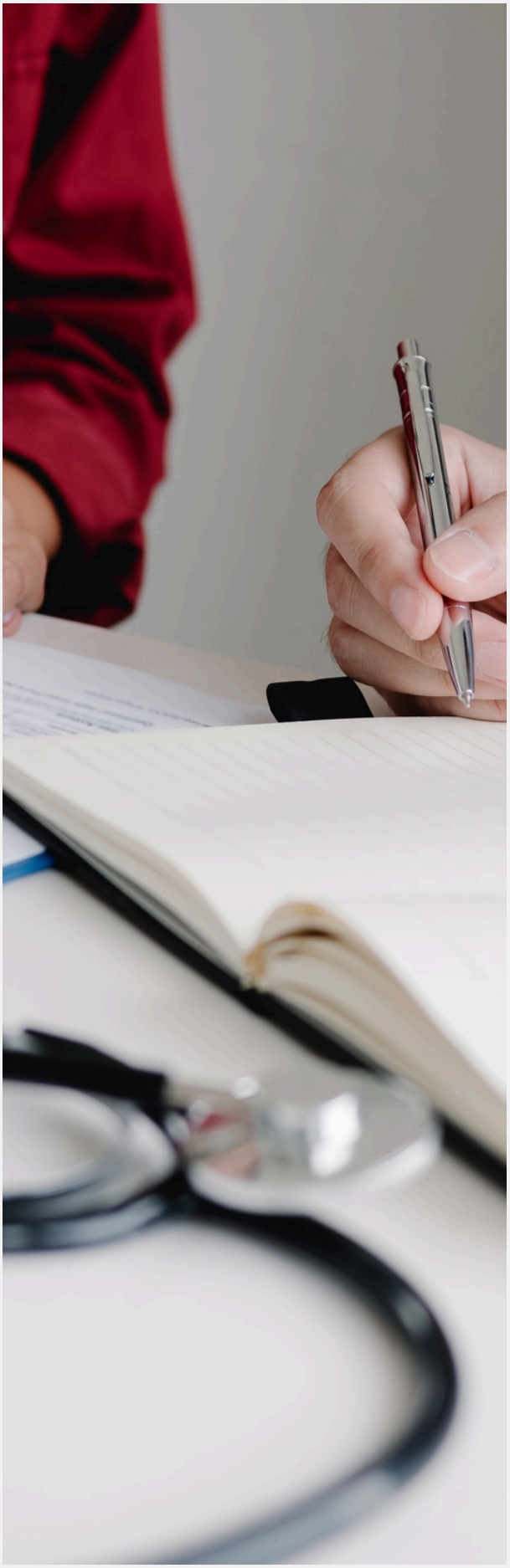
Brand choice in a commoditised cough market cannot be measured directly at scale.

It must be inferred through behavioural and structural proxies that correlate tightly with prescription behaviour.

This measurement framework is therefore designed to answer three questions:

1. Is the solution being used as intended inside clinics?
2. Is Brand UMI being surfaced repeatedly at the execution window?
3. Is this translating into a measurable shift in brand choice over time?

Measurement Layer	What is Tracked	What it Indicates for Brand UMI
Clinic Adoption	Number of clinics live with Cough AssistantConsistency of weekly usage per clinic	Whether the solution has achieved structural presence inside clinics
Workflow Utilisation	Number of cough screening forms completedRepeat usage by the same clinic	Whether the service is embedded into routine cough handling
Execution-Window Exposure	Number of doctor reports generatedNumber of cough algorithm views	Frequency with which Brand UMI appears at the prescription decision moment
Engagement Quality	Time spent on algorithm page/Repeat algorithm access by the same doctor	Strength of exposure and likelihood of recall consolidation
Brand Choice Proxy	Share of Brand Umi among levosalbutamol prescriptions in participating clinics (vs matched controls)	Whether execution-window exposure is translating into brand choice shift
Sustainability Signal	Continued usage without rep interventionStable usage over multiple months	Whether brand choice influence is habit-based, not rep-driven



HOW THIS DIFFERS FROM TRADITIONAL MEASUREMENT

- Tracks where the brand appears, not how often it is promoted
- Focuses on decision-moment exposure, not reach or impressions
- Uses clinic-level comparisons to isolate impact
- Avoids patient-identifiable data entirely

WHY THIS MEASUREMENT IS DEFENSIBLE

This framework does not claim causality through messaging.

It demonstrates structural influence on brand choice, which is the only lever that matters in a habit-driven category.

STRATEGIC OPPORTUNITY & CTA

BRAND UMI CANNOT WIN BY SHOUTING LOUDER IN A CROWDED COUGH MARKET. IT CAN WIN BY OWNING THE COUGH DECISION MOMENT ITSELF.

By building and running the Cough Assistant inside clinics, Brand Umi becomes the brand doctors see exactly when levosalbutamol is appropriate - not as a reminder, but as part of clinical logic.

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The next step is not more promotion. It is structural presence at the prescription desk