Industry funded patient information and the slippery slope to New Zealand

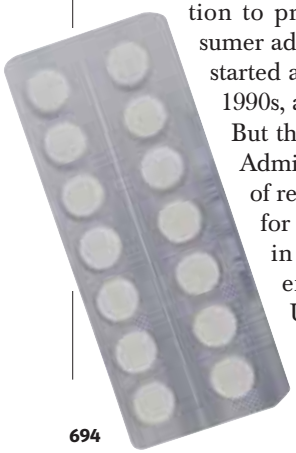
Industry funded health information campaigns could become common on our screens if European Commission proposals are passed. **Les Toop** and **Dee Mangin** warn that Europe could end up with similar problems to those in their country

The European parliament is considering allowing the drug industry to have a much greater role in providing information to patients, with no restriction on the type of media. After direct to consumer advertising was rejected in 2002, industry and the commercial arm of the European Commission submitted a new proposal to allow communication between industry and patients that deliberately leaves out the word advertising and replaces the term independence (freedom from commercial influence) with objective. Information can be entirely objective and yet still mislead through incompleteness or lack of balance and context. Opponents believe that industry will not, and cannot be expected to, provide balanced, comparative, and comprehensive information, and that the proposals amount to advertising by stealth.

In New Zealand and the US, the only two developed countries that allow direct to consumer advertising of prescription medicines, opposition has grown steadily from both the public and doctors. New Zealand's health system is much closer to those in Europe than the US system. So what can we learn from its experience?

Rise of advertising

Unlike most other developed countries, New Zealand never enacted pre-emptive legislation to prevent direct to consumer advertising. The adverts started appearing in the early 1990s, and steadily increased. But the US Food and Drug Administration's relaxation of regulatory requirements for broadcast advertising in 1997, unleashed an explosion in both the US and New Zealand. Last year drug companies spent over $5bn (£2.5bn; €3.6bn) on direct to consumer advertising in the US and tens of millions of dollars in New Zealand.



Opposition grew alongside the advertising, particularly in the women's movement as many of the promoted products were fertility and hormonal preparations. By 2000 New Zealand and US health watchdog groups were becoming more vocal. Doctors were slower to react, probably because initially there was not enough advertising to have a great impact on them.

A limited review of advertisements in 2000 showed poor compliance with the guidelines. The rising concern led the New Zealand Ministry of Health to start a public consultation in the same year. The responses were predictable: independent consumer groups against, those with a vested interest supporting its continuation. But because the analysis was based purely on numbers—and there were many more submissions from advertisers and drug companies than from consumer voices—the advertising was allowed to continue with self regulation. This comprised industry pre-vetting of adverts for format and style and a complaints systems that could recommend withdrawal of objectionable or misleading advertisements. The central regulator Medsafe effectively distanced itself from day to day monitoring with no responsibility and at no cost to the state. A promised further review of compliance with the rules never took place.

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Adverts are not independently assessed for balance or the scientific validity of the claims unless someone complains. There are few complaints because most consumers do not have enough technical knowledge to know they are being misled and the process of making a complaint is time consuming. The advert's run is often finished before decisions on complaints are made and there are no effective deterrent penalties.

In this context advertising became more widespread and proved extremely effective. As an example, a few brief television commercials for the antifungal terbinafine (promoted for onychomycosis) resulted in a doubling of national prescriptions. Refecoxib and celecoxib were heavily and effectively promoted to the public in New Zealand, despite the awareness of their cardiac risks. The adverts were targeted specifically at elderly people with osteoarthritis. As it turned out, this was the group most at risk of the harmful cardiac adverse effects that eventually led to the withdrawal of refecoxib.

In 2002 the marketing arm of Glaxo ran a major television campaign which "informed" people taking the popular branded beclometasone inhalers that the medicine was to be withdrawn and they should visit their doctors to ask to switch to fluticasone. Doctors and New Zealand's health funding agency (PHARMAC) thought that the campaign contained several misleading elements and distressed many patients. The unnecessary additional workload and difficult consultations infuriated many general practitioners. Nevertheless, the campaign was highly effective and sales of the more expensive fluticasone skyrocketed. An unintended consequence was an almost twofold increase in the doses of inhaled steroids prescribed.

Spurred by the professional outcry, a group of academic general practitioners assessed the literature on the public health effects of direct to consumer advertising. It presented the conclusions to government, with a further call for a ban on advertising. As part of this advocacy the report's authors also canvassed the views of all New Zealand general practitioners on direct to consumer advertising. Such was the strength of feeling that within 10 days, half of

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The birth control drug mifepristone is advertised on the New York subway

them had responded to a single mailing. Four fifths of the 1600 respondents were critical of consumer advertising, believing it harmed the doctor-patient relationship and public health. The report drew a swift and forceful reaction from the drug and advertising industries, resulting in several complaints to ethics committees and to the host university. None of these complaints were upheld.

Between 2002 and 2004 almost all health professional groups in New Zealand (including academic pharmacy) issued position statements calling for a ban of direct to consumer advertising and the provision of centrally funded independent consumer health information. But while the New Zealand government was considering its position, a war of surveys broke out, with marketing academics producing evidence that consumers and doctors liked the advertising and opponents producing evidence to the contrary. As always these surveys triggered criticism and counter criticism of sample sizes and response rates and accusations of bias. An almost identical debate has played out in the US, where successive consumer surveys by the FDA show an increasingly negative attitude to drug advertising. The surveys all show that consumers prefer to get information from health professionals and that they dislike being misled. Worryingly, although consumers mistrust advertising, they still act on it. A survey in the US showed many erroneously assume that some state agency ensures that information in advertisements is balanced, accurate, and truthful and that only medicines that are 100% safe are allowed to be advertised.

Even some prominent New Zealand marketing academics who have studied the effects of advertising on consumer knowledge have moved from initial support to opposition: "The advertising and pharmaceutical industries' failure to respond to well-documented concerns about DTCA raises serious questions about the power of policy refinements to control advertisers' conduct."

Back tracking

In response to evidence of mounting concern from the public and the professions, the New Zealand government resolved to ban direct to consumer advertising in late 2003. The easiest mechanism seemed to be to include a ban in the omnibus legislation being drafted to set up a joint Australia-New Zealand Trans Tasman agency for the regulation of all therapeutic goods. Advertising of drugs to the public is prohibited by law in Australia. To date the government has been unable to pass the necessary legislation.

In early 2006 the New Zealand Ministry of Health decided to run a further round of public consultation canvassing the views of consumers and other stakeholders. Analysis of the individual submissions obtained under the official information act shows the political mandate for a ban on direct to consumer advertising was clearer than ever. There is almost complete (90%) opposition from independent consumer and patient organisations. Nearly two thirds of all submissions oppose advertising. And two thirds of the supporting submissions were from groups who profit from drug sales (drug companies, pharmacists, advertisers, marketers) while an additional 5% were from groups that have publicly declared receiving funding from the drug industry.

The lesson from the New Zealand experience for Europe is clear. Pandora's irresistible jar contained within it the misfortunes of mankind. Europe is staring at the lid of pharma's jar and, once opened, hope alone will not be enough to undo the damage. Having seen what lies inside, Europe should find nothing in there to tempt it to take this risk. Allowing industry funded objective information will serve only to manipulate consumer choices. It will not help consumers make better decisions about medicines but will increase the pharmaceuticalisation of health and will expose more of the population to new medicines (many of which offer little benefit over existing medicines) at a time when long term safety is unknown. It will also rapidly drive up drug costs with major implications for already stretched health budgets—all of which will be of net harm to the overall public health.

If the driver for the European legislation was truly the information needs of patients, rather than the needs of industry to boost sales, the recommendations might have been different. The goal should be a global collaborative commitment to facilitate access to the independent information prescribers and consumers need to be able to make decisions about medicines.

Les Toop professor, **Dee Mangin** senior lecturer
Department of Public Health and General Practice, University of Otago, Christchurch, New Zealand

Correspondence to: L Toop les.toop@otago.ac.nz

Competing interests: LT and DM have both received funding from PHARMAC and from general practitioner organisations for organising and speaking at seminars on rational prescribing and innovative models of extended primary care. LT has received funding for speaking on DTCA to the National Prescribing Service in Australia. DM is a member of the Healthy Skepticism management group. Both have actively campaigned for the provision of independent consumer health information and the banning of direct to consumer advertising in New Zealand.