New Zealand deserves better. Direct-to-consumer advertising (DTCA) of prescription medicines in New Zealand: for health or for profit?

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Direct-to-consumer advertising (DTCA) of prescription medicines is legal only in the US and in New Zealand (by default). In both countries the growth in this form of drug promotion has been spectacular. Why is this, and does it matter? The answer to the first question is simple – it is very effective both at increasing total market size and in encouraging widespread switching to advertised brands, which are usually new and more expensive. The answer to the second question depends upon perspective. It clearly matters to many in the pharmaceutical, advertising and print-media industries. The strength and nature of the response by these groups to try to prevent a call from Academic General Practice to the Minister of Health to reconsider banning DTCA shows how important a marketing strategy it has become. It should also matter to us as health professionals, as it has important consequences for public health.

All the evidence from studies in both countries suggests that when patients ask for a particular drug more often than not they will receive it, even when the prescribing doctor feels pressured and or uncomfortable in so doing. It is naive to suggest that doctors should simply resist the pressure to prescribe. ‘Inappropriate prescribing’ is not limited to the prescription of a medicine that is completely unsuitable for the patient. It can also mean the prescription of an equivalent yet more expensive medication than the one already used, which the consumer has been misled into believing is superior, or prescription of a new medication that is no more effective in treating the condition than older medications, but for which less is known about long-term unwanted effects. Clinicians, far from being paternalistic, struggle with the tension of practising evidence-based medicine whilst remaining patient centred and incorporating patient preferences in a shared decision about treatment options. The use of patients as de facto salespeople for a particular brand-name product is as effective as it is obvious.

Many of the reasons why DTCA is, on balance, harmful to the public health are set out in a report submitted to the Minister of Health in February (summarised in Table 1). The main conclusions and recommendations of the report are shown in Table 2.
Table 1. Characteristics of direct-to-consumer advertising (DTCA)

- It is a very effective marketing strategy for brand promotion and is increasing rapidly.
- It does not provide objective information on risks, benefits and options to assist patients to participate in informed healthcare decisions.
- It has a negative effect on health funding, which may create inequity in resource allocation.
- It has a negative effect upon the patient–clinician relationship.
- There are numerous examples where it has compromised patient safety.
- It promotes the medicalisation of normal health and ageing processes.
- There is increasing international opposition to DTCA amongst consumer and professional groups.
- There is increasing opposition to DTCA in New Zealand amongst consumer and professional groups.
- Neither central nor self-regulation has been able to effectively control DTCA.

Table 2. Conclusions and recommendations of report to the Minister of Health

**Conclusions**

- There is convincing evidence, supported by public and professional opinion, to justify a ban of direct-to-consumer advertising of prescription-only medicines in New Zealand.
- There is an urgent need for increased provision of comprehensive and readily accessible, independent consumer information.

**Recommendations**

- That the New Zealand Government introduces regulations and/or legislation to prohibit the advertising of prescription medicines directly to the public, through print and broadcast media or any other means.
- That the Government establishes an independent medicine and health information service free of commercial interest.

There are two crucial issues that are at the heart of the heated and often ill-tempered debate about the net worth of this form of advertising. First, does (or indeed can) DTCA provide information that is educational and of more use than harm? Second, is it possible to regulate DTCA effectively to prevent the public from being misled?

Unfortunately, the advertising/marketing and the health paradigms are so very far apart that dialogue and compromise are far from easy. The language of the marketing and advertising arms of industry is characterised by ‘bottom lines’, ‘market share’, ‘brand loyalty’ and ‘disease creation’. These are concepts foreign to most health professionals, whose framework is the care of individuals in patient-centred and evidence-based paradigms. Most clinicians are well aware of their additional wider responsibility to use finite individual and public resources wisely in a health system in which demand will always outstrip supply. It is, therefore, understandable if disappointing that senior representatives of the advertising and pharmaceutical industries have become frustrated and angry at those who dare to suggest that the diet of misinformation that is advertising is harmful to the public health and should be stopped.

Claims that DTCA provides useful and balanced information are at odds with the industry’s lamentable track record both here in New Zealand and in the US. Many pharmaceutical companies have been taken to task repeatedly for misleading the public and prescribers. Given the purpose of brand advertising, it is perhaps not
surprising that efficacy is generally overemphasised, side effects and lack of long-term safety data are minimised, and cost is rarely mentioned. There is usually no comparison with other available treatments, which in many cases involve non-pharmaceutical solutions. Studies that have systematically assessed the usefulness and understandability of DTCA have uniformly found their educational value to range from minimal to misleading.¹⁰–¹³

Proponents of DTCA in New Zealand claim that advertisers operating under a tighter regulatory framework and with appropriate penalties would provide ‘fair balance’. However, this seems unlikely given the profit-driven need for the industry to produce global blockbusters out of new drugs, the vast majority of which offer little if any advantage over existing products and are pseudo innovations.¹⁴–¹⁶ It is also hard to imagine what level of penalty would provide an ‘appropriate’ disincentive rather than being regarded simply as another necessary business cost for a multibillion-dollar global corporation. For example, how likely is it that the manufacturers of COX 2 inhibitors would want to advertise the facts about their products in a fair and balanced way? Do they advertise that their products, at several times the cost, are at best no more effective than traditional anti-inflammatories? That they may have marginally better gastrointestinal tolerance but, for reasons that are unclear, a possible pro-thrombotic effect, and increased rate of myocardial infarction?¹⁷,¹⁸ No, instead these drugs have huge marketing budgets funding advertising campaigns that have repeatedly been found to be misleading and unbalanced.¹⁷

The European Union Council of Health Ministers recently reaffirmed last year’s decision by the combined European Parliament to reject the proposal by the European Commission to allow DTCA to start in Europe. The right to advertise in this manner has once again been overridden by the need to protect the public health.

New Zealand has a self-regulatory system that clearly has not prevented public exposure to misleading advertisements.⁷,¹⁹ The US has a central monitoring system that has no teeth and cannot cope.¹ Provision of centrally funded comprehensive and independent consumer health information to replace DTCA would represent a much more rational use of New Zealand’s scarce health resources than setting up another expensive, central regulatory framework that would almost certainly be ineffective at controlling DTCA.

In these very columns we have been reminded repeatedly over the last few years that competitiveness, commercialism and marketing are not compatible with a health system focused on the care of individuals and the wise use of finite resources.

It is time that we recognised DTCA for what it is. It has nothing to do with education and all to do with profit. New Zealand often leads the world in social innovation. We have that opportunity to do so again by legislating to replace this pernicious influence with world-class, independent and comparative consumer health information that is free of commercial influence.

Now is the time to make your views known to the politicians.

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References:


Response

The title of Professor Toop’s article ‘For health or for profit’ accurately sums it up, but offers a false proposition – that health and profit are inconsistent with each other.

Manufacturers of medicines, along with suppliers of high-tech medical equipment are part of a market economy, which, along with good government, has delivered major improvements to public health over the past 200 years. These include clean water, modern sewerage systems, and more efficient food production methods, as well as the new medicines and medical technology that have all helped make our lives longer, healthier and more interesting.

Making profit is an essential element in the mix. It is the prospect of making better than average profits that stimulates pharmaceutical manufacturers to spend hundreds of millions of dollars on researching possible new and better products. Sometimes the expenditure yields nothing of real value – that is the risk the companies must take.

The fact that pharmaceutical companies may be driven substantially by profit in no way diminishes the magnificent contribution they make to the health of our society. The fact that, through DTCA, they also hope to sell more of their products should not be seen as negative. There are enough checks and balances in the system to ensure no damage is done to the health budget or consumers.

First, a prescription is necessary and I am not inclined to believe GPs are so weak they will yield to any pressure from their patients. If that were the case we would have to be concerned about their response to non-DTCA-created requests also. Second, through its various programmes and iron grip over the availability of medicines, PHARMAC has effective control over the cost of their usage.

Professor Toop labours the point about the pharmaceutical companies’ profit motive, but seems oblivious to the fact that doctors, specialists and even medical academics all in their own way have vested interests as well, and have been effective lobbyists for their interests over the years.

However, the group that is most important, the consumers, receive little attention in his report to the Minister and the article above. Consumers are not demanding a ban on DTCA and many appreciate the information and stimulus DTCA gives them to seek medical advice.

The advertisements are often criticised because they do not contain all the information that is necessary to make an informed decision. This criticism can be made of most advertisements, particularly those on television. As a consequence, consumers have become discerning about claims made by any advertiser. However, there is scope for
pharmaceutical companies to improve the quality of information made available in their advertisements, and this issue could be addressed by the industry voluntarily upgrading its codes of practice, which it has been doing, or through a revision of the existing government regulations.

In summary, the Government plays a key role in ensuring that safe medicines are available to New Zealanders, that only qualified people can permit access to them, and that subsidies are available to ensure that no one is deprived of medicines through lack of income.

The real health issues are obesity, lack of exercise, and other lifestyle-created medical problems. None of these are susceptible to a quick fix, but they deserve far more attention than a non-problem like DTCA.

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