

Direct-to-consumer advertising is bad medicine

Hamilton Spectator and Straight Goods, February 7, 2003,

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(Spectator headline: Drug ads present rash of problems)

Everyone is worried about health care costs. Spending on prescription drugs really is exploding. And yet, Canada's government is considering a policy change that will increase drug costs without clear benefits, and with substantial risks.

As patients, Canadians can buy a limited set of drugs "over the counter" without a doctor's prescription. For other drugs, the government restricts access through doctors.

Why? Because physicians' knowledge of benefits and risks is necessary for wise decisions about most medication use.

In Canada, drug companies cannot advertise prescription-only medication directly to the public. In the U.S., however, direct-to-consumer advertising, or DTCA, has been feasible since the American Food and Drug Administration (FDA) eased regulations in 1997.

DTCA advocates suggest that advertisements educate patients, encourage discussions with physicians, and encourage patients to take their medications.

The pharmaceutical industry is sold on DTCA. Industry spending on DTCA tripled between 1996 and 2000, when it reached almost \$2.5 billion, about 15% of industry expenditures on drug promotion.

Marketing studies suggest the companies are making a wise investment. Drugs advertised by DTCA get a big sales boost.

So, are we cautious Canadians just slow to get with the latest health care innovation?

Not at all. The U.S. and New Zealand are the only industrialized countries that allow DTCA. In 2000, Australia conducted a legislative review that

recommended against legalizing DTCA. In October 2002, members of the European parliament overwhelmingly rejected a proposal that would ease the Europe-wide ban on DTCA.

Why is the rest of the world so reluctant to adopt the American policy?

First, it is unreasonable to expect the industry to present objective information. Their job is to sell drugs. If advertisements really were unbiased, company marketing departments should be fired.

There is plenty of evidence that industry ads are a poor way to educate the public. In the U.S., companies must submit their ads to the FDA at the time they present them to the public. During the last five years, the FDA has issued 88 letters to drug companies for misleading DTCA.

Furthermore, a review by the General Accounting Office, a US government agency, found that FDA regulation had limited effects. Some ads never get submitted to the FDA in the first place. When companies do get warnings, by the time they pull their ads the campaigns may be over, and the damage done.

The industry spends about 65% of their DTCA money on television ads. Automobile ads don't provide us with statistics about a car's fuel consumption and safety record. Instead, we get a racy sound track and sleek, speedy images.

Sales success, whether for cars or drugs, is based on emotional appeal. DTCA typically presents the happy, carefree people we would all like to be. Alternatively, the ads play on worries and anxieties. This is a long way from the objective presentation of information that patients need to make the right decisions.

The problem is worse because the pharmaceutical industry concentrates DTCA on a small number of new, expensive drugs for common, chronic conditions.

This focus creates two problems. First, the drugs typically have small and often trivial benefits over existing alternatives, benefits that may not justify the additional cost.

Second, of new drugs introduced into the market, 25% will eventually turn

out to cause serious reactions that were not suspected when the drugs were released. Over 5% of Americans have taken medications later pulled from the market because they proved unsafe.

You won't ever see these facts in drug company ads.

A Canadian health researcher, Barbara Mintzes, has conducted the best research showing what is happening in American doctors' offices. Mintzes found that 7.3% of 683 Sacramento patients visiting their family doctor requested advertised drugs. In 80% of these patients, the physician handed out the requested prescription. In 50% of the same patients, the physicians expressed doubts about whether they would use that drug for another similar patient.

Mintzes' results suggest that physicians are, as a result of patient pressure generated by DTCA, prescribing drugs about which they have significant doubts. The finding is consistent with other research showing that demand from patients is the most common reason for inappropriate drug prescribing.

While the pharmaceutical industry is delighted with the results of DTCA, other businesses are not. For instance, the Employer Committee on Health Care – Ontario (ECHCO), which represents over 30 of Ontario's largest employers including Stelco, Dofasco, and the Bank of Nova Scotia, has spoken out against bringing DTCA to Canada.

Barry Noble, an ECHCO spokesperson, has said that DTCA would "compound an already serious problem in runaway drug-plan costs." Through drug benefit employment packages, large companies bear a much of those costs. With the prospect of 7% of people coming to doctors' offices requesting an advertised drug, employers have good reason to be worried.

Would DTCA in Canada encourage some patients to discuss problems with their doctor, and take needed medication?

Maybe.

Would DTCA increase prescriptions for expensive new drugs with marginal benefits and the possibility of hidden toxic effects? Would DTCA

create the need for expensive and often ineffective monitoring of misleading drug industry claims?

For sure.

Not a good deal for Canadian health care.