



Direct-to-consumer advertising – where does the public interest lie?

Barrie Saunders

In debating the merits of direct-to-consumer advertising (DTCA), the key questions to ask are:

- Does DTCA have a negative or positive effect on health funding?
- Does DTCA compromise or improve patient health?
- Does DTCA have a negative or positive effect upon the patient–clinician relationship, and if so to what extent?

Before dealing with these questions I will make some general observations. Whether DTCA should be banned or more tightly regulated is not an issue to be determined by opinion polls of doctors, medical academics or the public, or by policies adopted by other countries.

Governments are elected to make wise decisions having regard for the interests and views of its constituents – not simply respond to interest groups, no matter how important or vocal.

Thus, the fact that a significant number of doctors (probably a minority) want DTCA banned, and, depending on the questions asked, that the public appears to have a degree of ambivalence, does not remotely make a case for banning DTCA.

DTCA is not a privilege. The right to freedom of expression is protected by the New Zealand Bill of Rights Act 1990, and should only be constrained when there is a compelling case, based on a rigorous analysis of the public interest. While there may be good reason to update the regulations, the case for a ban on DTCA is very weak.

The report by Professor Toop et al to the Minister of Health is a contribution to the debate about DTCA but it should not be seen as an academic exercise just because four professors of medicine authored it.¹ This conclusion was also reached by Professor Donald Evans (Director, Bioethics Centre, University of Otago) who investigated a complaint about the research methods used by Toop. He concluded ‘that this proposed report did not convey the impression the survey was a research project but rather clearly demonstrated that it was an explicit gathering of evidence to support a protest to Government about DTCA.’²

Other issues raised by the Toop paper are dealt with in my report sent to the Government on behalf of the Advertising Standards Authority.³

Does DTCA have a negative or positive effect on health funding?

It has been claimed that DTCA leads to ‘unnecessary’ doctor visits, an increase in dispensing, and switches to expensive medicines that are not much more effective than lower-cost alternatives.

Whether a visit is ‘unnecessary’ or not is very much in the eyes of the beholder. If the result is a patient reassured that nothing is wrong, they may consider that result worth the time and cost. If it leads to a prescription, one must assume that this is necessary because doctors would be acting unprofessionally to prescribe otherwise.

No doubt some visits to GPs could be classified as ‘unnecessary’ for many reasons, not just DTCA. However, there are likely to be far more occasions when a visit is appropriate and does not take place. This is an area where the medical fraternity might focus some of its energies, because the anecdotal evidence is that far too many New Zealanders ignore symptoms until there is a serious problem.

The claim that DTCA can lead to pressure to switch to more expensive medicines would be a serious one if it were not for the fact that PHARMAC wields enormous power, and that doctors are professional about decisions relating to different medicines.

I asked Wayne McNee, CEO of PHARMAC for evidence the about impact of DTCA on the pharmacy budget and the issue of patients switching to more expensive medicines. The response arrived after (30 April 2003) my report was completed. DTCA gives them some concerns, but the letter said that PHARMAC manages the financial risks though negotiations with pharmaceutical companies about price and quantity, and through its education programmes for health professionals. As a consequence, prescription numbers involving DTCA medicines usually increase at a faster rate than costs to PHARMAC.

Of interest is PHARMAC’s 2002 annual review, which shows that since 1993 the pharmacy vote has been held to an average annual increase of less than 3% compared with 14% in Australia over the same period.⁴ Through its tendering system PHARMAC has been able to lower the cost of medicines thereby widening their availability. PHARMAC’s achievement is remarkable considering the population increase and the arrival of new medicines during that time.

The most significant comment in the PHARMAC report is the statement that less than half the population ‘with proven cardiovascular disease are on a statin’. This suggests there is a good case for more public funding of the availability of non-publicly advertised medicines, such as statins, to deal with real health problems. This is a far more important area of debate than DTCA.

The PriceWaterhouse Coopers report to the Researched Medicines Industry provides a framework for thinking about the allocation of the health budget.⁵ It shows that in some areas the health vote will achieve better overall results if there is greater expenditure on medicines at the early stage of a problem.

In summary, the pharmacy budget in total is not being threatened by DTCA, nor is there any evidence that growth in prescriptions of some medicines as a result of DTCA has led to reduced allocations for others. It should be noted that there can be significant variations from year to year in PHARMAC’s expenditure on different classes of medicines, regardless of DTCA. Whether the overall impact on the health funding is positive or negative cannot be determined on the basis of the evidence available, but is likely to be small, and could even be positive.

Does DTCA compromise or improve patient health?

Clearly, DTCA leads to some patients visiting doctors who would not otherwise have done so and some are issued with prescriptions. There is no evidence, however, that doctors typically write prescriptions for people who do not need them. Thus, it follows that the people who now have prescriptions as a result of the advertising stimulus have in fact improved their health prospects.

Research from Massey University shows that some doctors use the opportunity created by such a visit to discuss other health areas and lifestyle issues the patient might address. In this sense, DTCA has a positive effect.

There is no evidence presented by Toop or the Massey University researchers that a significant proportion of visits to doctors are as a result of anxieties created by DTCA that are not justified by reality. It is true that some patients will have illusions about what medicines may achieve in areas such as obesity. However, their visits provide doctors with the opportunity to deliver a reality check, which is better than them not having had that opportunity.

On balance, DTCA is therefore likely to be positive for the health of patients.

Does DTCA have a negative or positive effect upon the patient–clinician relationship?

Like all other professionals, doctors will be subject to pressures from their clients/patients. This is for them to manage while maintaining their professionalism. Denying patient's possible knowledge through a ban on DTCA is an implicit admission on the part of doctors that they lack the skills to manage patient relationships. If some doctors are struggling, they should seek guidance from their professional organisation.

In reality, whether or not there is a real health problem is a question that can only be answered by both doctors and their patients. In some cases, DTCA will be positive in that it opens up a new subject for discussion. It is conceivable that in some individual doctor–patient cases the answers may not be the same. It is almost certainly true that there will be cases where a doctor has rejected a patient's request for a DTCA medicine, and some strain on the relationship results. None of the evidence available suggests this problem exists with anything more than a tiny proportion of patients.

What should medical organisations and the Government do?

DTCA is subject to specific and generic laws and regulations. It is also subject to the Advertising Standards Authority Advertising Codes of Practice, and the Researched Medicines Industry Code of Practice.^{6,7}

Instead of seeking government intervention, the medical fraternity should engage directly with the RMI and the ASA to see if any further refinements are necessary to either their codes or the way they are managed. Industry regulation can be more responsive and effective than that determined by government.

Only after exhausting these options should they consider promoting changes to existing regulations. Any proposals to the Government should be based on better evidence than has been advanced so far by Toop and others.

For its part, the Government is equally well advised to explore further with industry ways in which its voluntary codes are designed and being administered. Only if these are unproductive, and there is clear and quantifiable evidence of public harm, should it consider making changes to existing regulations or statutes.

Finally, the fact that most Western countries effectively ban DTCA does not constitute a case for us following them. There are many policies followed by other countries that New Zealand has not adopted. Freedom of speech is a precious right that must only be compromised when there is compelling evidence to do so, which at present does not exist. There are serious health issues such as cholesterol, obesity and diabetes, which dwarf DTCA, that should receive more attention because the returns to society will be so much greater.

Author information: Barrie Saunders, Public Policy Consultant, Saunders Unsworth Limited, Wellington

Correspondence: Mr Barrie Saunders, Saunders Unsworth Limited, P O Box 10-200, Wellington. Fax: (04) 914 1760; email: barrie@sul.co.nz

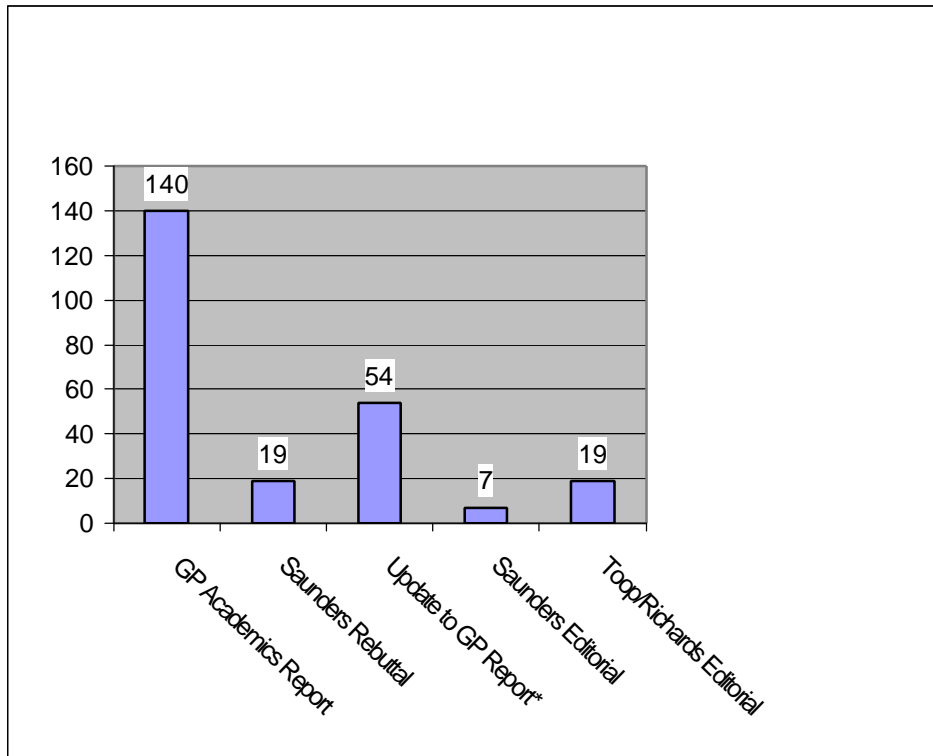
References:

1. Toop L, Richards D, Dowell T, et al. Direct to consumer advertising of prescription drugs in New Zealand: for health or for profit? Report to the Minister of Health supporting the case for a ban on DTCA. Dunedin: University of Otago, 2003. Available online. URL: <http://www.chmeds.ac.nz/report.pdf> Accessed August 2003.
2. Evans D. Preliminary inquiry into the advertising authority complaint – Professors Dowell, Tilyard and Toop. 3 February 2003.
3. Saunders B. Direct to consumer advertising of prescription drugs in New Zealand: Professors' 'protest to government' placed under the microscope. 7 April 2003. Available online. URL: http://www.asa.co.nz/Research_Papers/medicine_advertising/DTCA.rtf Accessed August 2003.
4. PHARMAC. Annual Review 2002: building relationships, Wellington: PHARMAC; 2002.
5. A model for delivering better health outcomes. Report to the Researched Medicines Industry. Wellington: PriceWaterhouseCoopers, January 2003.
6. Advertising Standards Authority. Advertising codes of practice. Available online: <http://www.asa.co.nz/codes/codes.htm> Accessed August 2003.
7. Researched Medicines Industry Association. RMI code of practice. Wellington: Researched Medicines Industry Association of NZ Inc; 1999. Available online. URL: <http://www.rmianz.co.nz/pdfs/copsep99.pdf>

Response

We are comfortable to let the reader judge the strength of the arguments and assertions put forward in this editorial. We do note, however, that Mr Saunders has used the word 'evidence' 11 times. In his critique of our report to the Minister he used the same word 35 times. In both pieces it is used mainly in the context of his thesis that there is *no evidence* to support our arguments for a ban on DTCA.

Figure 1. Number of supporting references listed in documents for and against a ban of DTCA in NZ



*June 2003 update of GP academics' report, including comments on Saunders' and other pro-DTCA reports, is available from www.chmeds.ac.nz/report4.htm

QED.

Les Toop

Dee Richards

Department of General Practice

Christchurch School of Medicine and Health Sciences, Christchurch