Direct-to-consumer advertising of prescription medication in New Zealand

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Abstract

The last decade has seen increasing measures aimed at regulating the influence of ‘Big Pharma’ following a number of scandals relating to unethical marketing. Despite these international trends, New Zealand continues to tolerate direct-to-consumer advertising (DTCA) of prescription medication, a controversial pharmaceutical marketing strategy that has been prohibited in all but two countries in the industrialised world.

While the pharmaceutical industry asserts that DTCA is informational and empowers consumers, in this viewpoint article we argue that DTCA is a heavily biased source of health information that favours representation of benefits over harms, and is associated with unnecessary prescribing, iatrogenic harm and increased costs to the taxpayer.

In this paper, we show that DTCA provides unbalanced information to consumers who may misconstrue DTCA as public health messages, and fail to recognise inherent commercial bias. We describe how DTCA has been linked with inappropriate prescribing and overtreatment, with evidence indicating that patients request and receive specific medications in response to DTCA, even when treatment is not clinically indicated. This exposes patients to unnecessary adverse effects and iatrogenic harm, and increases costs for the health-care sector through the prescription of expensive branded medication. We use local examples to illustrate these points.

New Zealand remains an outlier in allowing DTCA to continue which, in our view, is a controversial and harmful practice. The available evidence suggests that consumers and health care professionals are generally opposed to DTCA. Therefore, we believe that the New Zealand government should review its stance on DTCA.

Background

In recent years numerous pharmaceutical companies have incurred financial and reputational damage from scandals relating to unethical marketing. Since 2009 many of the major pharmaceutical players including GlaxoSmithKline (GSK), Johnson & Johnson, Eli Lilly, Abbot and Astra Zeneca have been found civilly and criminally responsible for multiple offences including unlawful promotion of medicines and failure to report safety data, resulting in record, billion dollar fines. Furthermore, the pharmaceutical industry continues to attract criticism from the scientific community over suppression of unfavourable results, ghostwritten publications, and undeclared payments to health professionals. The selective
publication and flawed design of industry-funded studies has been argued to be so extensive as to undermine the entire medical evidence base. Consequently, there have been increasing calls over the last decade to regulate the influence of ‘Big Pharma’. 

The winds of change are clearly in the air. In December 2013, GSK announced it would stop paying doctors to promote its medications and would abolish prescription targets for marketing staff. American pharmaceutical companies are now legally obliged to disclose payments to doctors, with similar legislation coming into force in Europe from 2016.

Despite these international trends, New Zealand continues to tolerate DTCA of prescription medication, a controversial pharmaceutical marketing strategy prohibited almost everywhere else in the industrialised world.

**DTCA in New Zealand**

Turn on the television and New Zealand viewers might find celebrity Jude Dobson expounding on the merits of a proprietary intravenous infusion for osteoporosis, or the well-modulated Mark Perry chatting about remedies for erectile dysfunction. Mark and Jude are hosts of the ‘Family Health Diary’, described by its parent company to be “a health information network that aims to keep you informed on health conditions and current issues” ([www.familyhealthdiary.co.nz/](http://www.familyhealthdiary.co.nz/)).

Such industry funded ‘health information’ campaigns have been banned in almost all industrialised countries since the 1940s. New Zealand and the United States are lonely exceptions.

To what does New Zealand owe this dubious honour? While most other developed countries enacted legislation prohibiting this practice approximately three quarters of a century ago, the New Zealand Medicines Act 1981 failed to address DTCA, seemingly more by accident than design.

Prescription medications were simply not being advertised in 1981, so DTCA had little visibility at a time when the ethical frameworks governing relationships between the pharmaceutical industry and health care sector were but inchoate concepts. Following the United States relaxing regulations around broadcast advertising in 1997, lawmakers failed to anticipate the dramatic increase in DTCA that occurred in New Zealand. DTCA is now the most rapidly growing form of pharmaceutical marketing in the United States. American pharmaceutical companies spend in excess of US$4 billion per year on DTCA. In comparison, this advertising budget exceeds the entire Food and Drug Administration (FDA) budget for the evaluation of new drugs by approximately 10 fold. In New Zealand, expenditure on DTCA has been estimated to be in the tens of millions of dollars annually.

DTCA is controversial. Advocates assert that the advertisements are informational and empower consumers with medical knowledge, encourage dialogue with health practitioners and enable informed choices about treatment options.

Opponents argue that the information presented in commercials provides an unbalanced view of prescription medications in favour of benefits over harms, leading to unnecessary prescription, iatrogenic harm and increased costs.

In the following paragraphs we discuss these points in more detail.
DTCA provides information to consumers—Advocates of DTCA argue that DTCA is informational and represents a net positive transfer of information to consumers. Is this correct?

While both American and New Zealand regulations and codes (e.g. the government’s Therapeutic Products Advertising Code; also the Code of Practice issued by Medicines New Zealand, an industry lobby group) emphasise the need for balance such that consumers are informed of both benefits and adverse effects of advertised products, it is common for this not to occur in practice. Misleading promotion of prescription medication has led to recent billion dollar settlements paid by large pharmaceutical companies to compensate for damages.

The pharmaceutical industry is subject to the same commercial incentives as any other manufacturer marketing their wares. Even DTCA that does not breach regulations employs overt and covert methods to enhance the attractiveness of the advertised product over any detriments. For example, while implying high success rates, most pharmaceutical advertisements in magazines fail to report the actual likelihood of treatment response or to compare this with alternative (or indeed no) treatment.

Research published in the Lancet found 87% of the direct-to-consumer advertisements studied described benefits in only vague terms, often utilising emotive language (for example: “help your child out of the jungle of allergies”). Only 13% of advertisements provided any evidence to support claims. The minority of DTCA that did provide evidence, tended to present data in ways that exaggerated the magnitude of the benefits such as citing relative rather than absolute risk reduction.

This should not come as any surprise. Johnny Mercer’s lyrics “accentuate the positive, eliminate the negative” would be widely accepted as an Advertising 101 theme tune. Unfortunately, the biases inherent within DTCA have tended to remain largely hidden from the public eye compared with other forms of advertising.

Research from the United States indicates that many consumers believe that a state agency is responsible for ensuring that all DTCA is balanced, accurate and truthful. In one survey, 29% of consumers believed that only medications that were regarded as completely safe could be advertised on television. In California, 42% of respondents thought that only the safest medications could be advertised. ‘Health information platforms’ were commonly and erroneously perceived to be more informational than other advertisements.

Naturally, these misperceptions are exploited by marketing campaigns. In the United States it is not uncommon for industry-employed celebrities to confer a veneer of independence while discussing their ‘personal’ positive experience with a particular branded pharmaceutical product. New Zealand’s best-known version of this practice is the Family Health Diary.

Brandworld, the company responsible for Family Health Diary, openly claims that the success of their advertising platform depends on the infomercials being “highly trusted and perceived as an independent source of information… Our research shows that Jude Dobson, Mark Perry and other presenters are considered to be trusted friends and that Family Health Diary is [considered] a third-party endorsement, rather than simply another ad.”

Thus, marketing information provided by the pharmaceutical industry can mislead consumers who believe in the independence and reliability of the claims being made.
Consumers are unlikely to have the means or inclination to critically appraise the scientific evidence supporting any purported health benefits. Thus while DTCA does present information, it is routinely biased and unreliable.

**Unnecessary prescribing**—DTCA has been linked with inappropriate prescribing and overtreatment. Comparing prescribing in Canada (where DTCA is banned) with the United States, Gilbody et al. found American patients were more likely to believe they needed medication, to request products advertised on television, and to receive prescriptions for these.

No similar research has been conducted in New Zealand, but it is widely accepted that advertised treatments are more commonly requested and received by consumers. Brandworld claims to have surveyed pharmacists about the impact of these DTCA strategies, with 94% of pharmacists believing Family Health Diary increased sales and 99% of pharmacists reporting fielding customer enquiries about advertised products.

The effect of DTCA on prescribing practice in vivo was demonstrated by Kravitz et al. Trained actors (‘standardised patients’) were sent to family practices in the role of a 48-year-old woman with a short and uncomplicated presentation of mild to moderate depression. The actors were randomly assigned to behave in one of three ways: to describe having seen advertisements for paroxetine (a selective serotonin reuptake inhibitor (SSRI)) antidepressant, and request it by name; to describe having seen advertisements for antidepressants and request generic medical treatment; or to make no specific request.

Patients requesting paroxetine were seven times more likely to receive this medication than those making no requests. Prescribing SSRIs at the behest of the patient may not seem unreasonable, but meta-analyses indicate the benefits of SSRIs over placebo for mild to moderate depression are minimal at best, with best practice guidelines recommending non-pharmacological therapies to be offered as first line treatment.

More dramatically, when more actors—now no longer feigning depression, but reporting stress following redundancy—specifically requested paroxetine, 55% received prescriptions for antidepressants, with almost 40% receiving paroxetine, despite the absence of any evidence supporting SSRIs for what was clearly an adjustment disorder. In contrast only 10% of those making no request were prescribed antidepressants (and none received paroxetine).

Understandably, doctors want to please their patients and the evidence suggests that when a patient requests a specific medication (as instructed to do in advertisements), they are more likely to receive this, even when that treatment is not clinically indicated.

Pharmaceutical companies are well aware of the added value of advertising; indeed promotional budgets often exceed those allocated to research and development of new medications. This also explains why pharmaceutical companies have lobbied vigorously to defend the legality of DTCA in USA and NZ, and to extend the practice to other jurisdictions, notably Europe.

**Iatrogenic harm**—Related to the issue of unnecessary (and therefore increased) prescribing, DTCA can serve to promote pharmaceuticals for milder health problems, for which safer, non-pharmacological therapies can be as effective. Thus, DTCA can result in the unnecessary exposure of consumers to potential harm.
Rofecoxib (Vioxx) and celecoxib (Celebrex), non-steroidal anti-inflammatory drugs used in treating arthritic pain, are now infamous examples where DTCA has been implicated as a major contributor to iatrogenic harm. At the time they were introduced, rofecoxib and celecoxib were amongst the most heavily advertised products in the market with $US161 million and $US78 million spent marketing them respectively. These drugs were later found to have potentially fatal side-effects leading to large-scale population mortality and morbidity; Celecoxib was restricted and rofecoxib withdrawn, but not before the occurrence of thousands of avoidable deaths.

**Increased costs**—Alongside unnecessary prescribing, DTCA also may increase costs through the preferential use of expensive branded medication over equally effective generic medication and other less costly alternatives.

Overall, the pharmaceutical industry spends approximately twice as much on marketing and promotion as it does on research and development. These costs are passed on to the consumer through high costs of new medications which persist until patents lapse. Industry is incentivised to promote the ongoing prescription of expensive branded medication, and DTCA is a means to achieve this. Almost all DTCA focuses on patented or branded medication.

DTCA of injectable risperidone (an antipsychotic medication) and venlafaxine (an antidepressant medication) provide salient New Zealand case studies. A large scale marketing campaign promoting long-acting injectable (depot) risperidone was launched in May 2013. This included prominent advertisements on free-to-air television (including Maori TV), with linked print and internet advertising. Articulate young New Zealanders were portrayed discussing the benefits of the depot preparation and remarking on the convenience of no longer needing to remember their daily tablets.

Depot on-patent risperidone is an expensive medication, over 50 times the price of its oral (no longer patented) counterpart (see [http://www.pharmac.govt.nz/patients/PharmaceuticalSchedule](http://www.pharmac.govt.nz/patients/PharmaceuticalSchedule)), although these costs are not borne by consumers who meet criteria, rather, by the taxpayer.

Depot risperidone may have value for patients with schizophrenia who have tried but failed to comply with oral antipsychotic medication. However, it does not offer efficacy advantages over the oral form, nor does it necessarily improve adherence rates. The campaign messages extolling convenience and choice naturally failed to raise these issues.

The 2011 advertising campaign for proprietary venlafaxine followed soon after the expiry of its patent. Consumers were informed that branded venlafaxine was fully funded and urged to, “Just remember, you can stay on Efexor-XR if you want, you don’t need to change, especially if it’s working for you. Efexor-XR: ask your doctor and pharmacist if it’s right for you.” Unsurprisingly, there was no mention of equivalent alternatives such as generic venlafaxine which costs one-third the price of the branded version.

The costs to the New Zealand taxpayer of the increased demand that results from such campaigns have not been quantified, but are likely to be significant. For example if, as a result of the risperidone advertising, 1000 people switched from the oral to depot preparation, this would cost the country over $5 million per annum. A study in
Britain found that potential savings of £1 billion (out of a total NHS pharmaceutical budget of £9 billion) could be achieved by doctors prescribing generic alternatives. Thus, through unnecessary prescribing and promoting branded medications over generics, DTCA can undermine the principles of distributive justice and impose a significant opportunity cost on the health-care sector.

Attitudes towards DTCA

Empowering consumers to make informed choices about their healthcare is a central tenet of modern medicine. It is on the coat tails of this philosophy that pharmaceutical companies typically justify DTCA. However, many prescribers and consumers do not accept this justification.

In 2002 nearly one half of all New Zealand GPs responded within a week to an advocacy call from several General Practice Academics who were concerned about misleading DTCA campaigns. Four out of five of those respondents were supportive of a ban on DTCA, with many citing personal examples and experiences of harms to the doctor-patient relationship and to public health.

Between 2002 and 2004, many health professional groups in New Zealand issued position statements supporting the prohibition of DTCA, advocating that it be replaced with centrally funded independent (and unbiased) health information.

In 2006, The Ministry of Health reviewed DTCA. Of those who made submissions, DTCA was opposed by, or of concern to, all consumer groups (n=8), all government agencies (n=5), all educational /research agencies (n=9) and the majority of members of the public (11/12) and academics (10/11). DTCA was unsurprisingly unanimously supported by advertising agencies and pharmaceutical companies. The opinions of health professionals making submissions were divided. However, despite the submissions, no further actions were taken by the government, let alone any legislative change to prohibit DTCA.

Two of us (RD and DM) were recently involved in researching mental health service users’ views about DTCA following the depot risperidone campaign. Service users voiced overwhelmingly negative opinions, expressing concerns about pharmaceutical company motivation, unbalanced medication information, the over-emphasis of medical treatments, neglect of other treatment modalities, and potential adverse impact of DTCA on service users, families, and the doctor-patient relationship. It was felt that this campaign in particular might be capitalising on the fears of a vulnerable population.

Other consumer groups have also recently expressed disquiet about DTCA overall, and particularly about the risperidone depot campaign. While critical of DTCA, service users emphasised the importance of unbiased information, a sound doctor-patient relationship, and shared decision-making in accordance with the principles of evidence based practice.

Consumer criticisms of DTCA have been mirrored in the USA, where successive consumer surveys conducted by the FDA reveal increasingly negative attitudes towards this practice.

In summary we found little consumer or health professional support for DTCA in New Zealand.
Health professionals’ engagement with industry

It might be argued that it is hypocritical for health professionals to condemn DTCA, yet themselves continue to engage with pharmaceutical industry marketing activities. As with DTCA, it has been shown that the quality of information provided by pharmaceutical companies to doctors is often poor, with benefits exaggerated and risks minimised.34-36 It is a commonly mistaken presumption that doctors’ knowledge and experience insulate them from the effects of pharmaceutical promotion.37 Although outside the scope of this paper, these concerns constitute one set of reasons why health professionals’ relationships with industry are also in need of review.38

Conclusion

Pharmaceutical companies have touted DTCA as a pro-consumer activity, encouraging dialogue, empowerment and choice. Whilst available evidence is incomplete, it generally refutes this view. DTCA is a biased source of health information and is associated with unnecessary prescribing, iatrogenic harm and unnecessary costs to the taxpayer. The choice of medical treatment should be made on the basis of best evidence combined with patient history and values, not on the cleverest or most compelling marketing message. Most of the developed world has taken a firm stand against DTCA. Notwithstanding the influence of lobby groups advocating for DTCA, the New Zealand government’s inertia on this matter is concerning.

While we support any initiatives that increase the provision of accurate, accessible and independent sources of health information so consumers and clinicians can make informed choices about treatment, we do not believe DTCA represents an appropriate vehicle for these objectives. In the interests of quality, cost-effective healthcare, we believe that the New Zealand government should review its stance on DTCA.

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