



Direct-to-consumer advertising – yes it can compromise patient health

Barrie Saunders has recently written in the Journal about direct-to-consumer advertising (DTCA).^{1,2} Space precludes us debating the benefits and risks of DTCA. However, we do wish to rectify omissions and misrepresentations about PHARMAC.

When PHARMAC wrote to Mr Saunders it said that there is good evidence that DTCA leads prescribers to switch to new and more expensive medicines that in many cases offer no real benefit for patients, eg, fluticasone (from beclomethasone (BDP)) and proton pump inhibitors (from H2 antagonists). Accompanying material explained the many ways that DTCA creates fiscal risk on the limited government pharmaceutical budget, including increased demand for PHARMAC to subsidise medicines that are advertised. A copy of the letter and accompanying material sent to Mr Saunders is available on the PHARMAC website, www.pharmac.govt.nz.

Mr Saunders also understates how PHARMAC manages financial risks through not funding poor investments, alongside demand-side activities, where both are based on assessment of costs and benefits.³ DTCA-promoted medicines are typically more expensive for little additional benefit. These include both products that PHARMAC has not funded (for that reason), or funded products, such as in the Flixotide switch campaign (when existing BDP is no less effective).⁴ PHARMAC does not have an 'iron grip' over availability and costs,² as the effects of the recent Flixotide DTCA campaign show.

We estimate that the 2002 Flixotide DTCA campaign caused 139 800 person-months of switching to fluticasone at the very least, costing more than \$900 000 extra compared with BDP (less costly but equally effective). This public money is no longer available to DHBs. It would, for instance, fund 43 coronary artery bypass graft operations. Or it would gain 202 quality-adjusted years of life (QALYs), along with saving \$254 000 in other DHB costs, if invested in other priority pharmaceutical areas. These are health improvements that DHBs cannot access because money had to be spent funding patients who switched from BDP to Flixotide directly because of DTCA.

We agree that there is a case for improving the uptake of statins for those with proven cardiovascular disease.⁵ PHARMAC is actively promoting improved lifestyle and access to medicines where appropriate,⁶ with its 'One heart, many lives' campaign. But most statins are cost effective.⁷ Most pharmaceutical products promoted by DTCA may not be.

Finally, Mr Saunders needs to declare his conflicts of interest here, including funding he receives from the pharmaceutical industry.

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Conflicts of interest: Wayne McNee is Chief Executive, Peter Moodie is Medical Director, and Scott Metcalfe (public health physician) is externally contracted to the New Zealand Pharmaceutical Management Agency (PHARMAC). PHARMAC is the crown entity responsible for funding community medicines, on behalf of district health boards. PHARMAC is currently involved in litigation with GlaxoSmithKline relating to the 2002 advertising campaign for Flixotide.

References:

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Editor's comment

An editorial decision was taken not to include specific conflict of interest statements with the articles relating to direct-to-consumer advertising published in the previous issue of the Journal, as the authors' interests were felt to be self evident. All authors clearly stated the extent of their personal involvement in the DTCA debate within the text of their articles.