



September 7, 2007

# Policy Brief

*The Prescription Project promotes evidence-based prescribing and works to eliminate conflicts of interest in medicine due to pharmaceutical marketing to physicians.*

*It is promoting policy change by working with*

- *State and Federal Policymakers*
- *Academic Medical Centers*
- *Professional Medical Societies*
- *Private Payers*

*Created with The Pew Charitable Trusts, the Project is led by Community Catalyst in partnership with the Institute on Medicine as a Profession.*

## Control Pharmaceutical Marketing to Improve Health Care Quality and Cost Recommendations for State Policymakers

### Introduction

State policymakers can improve health care quality and reduce its costs by restricting inappropriate drug industry marketing tactics that undermine the objectivity of doctors, hospitals and other health care providers. States can provide leadership in several ways: as large-scale purchasers of drugs, as providers of medical education in publicly funded medical schools, as industry regulators, and as influential leaders in health care policy.

### I. The Problem

The pharmaceutical industry spends almost \$30 billion annually on promoting and marketing prescription drugs, with more than \$7 billion spent on direct marketing to physicians as of 2005.<sup>1</sup> The industry employs over 90 thousand sales representatives who try to influence what medicines doctors prescribe by offering free drug samples, catered lunches, "medical education" sponsorships, and other gifts. A recent survey indicates that 94% of doctors have received such incentives from the industry.<sup>2</sup> Studies indicate that even small gifts create an unconscious demand for reciprocity.<sup>3</sup>

This intense marketing is widely believed to undermine quality of care and increase costs because new and expensive drugs are promoted more heavily than lower cost drugs that are equally or more effective. While the annual increase in prescription drug spending has slowed in recent years, the enduring increase in prices of prescription drugs is directly related to marketing by pharmaceutical companies. Of the drugs responsible for the nearly 19% rise in spending on pharmaceuticals in 2001, the four top sellers were among the top ten most heavily marketed drugs. The negative impact of pharmaceutical marketing is wide-spread and enduring. Examples include:

- **Avoidable deaths due to Vioxx®.** Vioxx, the heavily marketed Merck pain killer, may have caused tens of thousands of avoidable heart attacks and strokes before it was removed from the market. This occurred even though the drug was no better for the vast majority of patients than older, less expensive drugs.<sup>4</sup>

- **Illegal promotion of Neurontin®.** The pharmaceutical company Warner Lambert promoted the epilepsy medication Neurontin for unapproved uses. The Massachusetts Attorney General joined with the Department of Veterans Affairs and the federal Department of Justice to successfully sue the company for a total of \$430 million in damages for losses the Medicaid programs suffered as a result of Warner-Lambert's fraudulent drug promotion and marketing misconduct.<sup>5</sup>
- **Profiting from inappropriate use of Epogen® and Procrit®.** Recent studies have shown that physicians, dialysis clinics and the pharmaceutical industry profited from the over prescribing of the anemia drugs, Epogen and Procrit, compromising patient safety and driving up costs.<sup>6</sup>

State policymakers and public purchasers can have difficulty obtaining objective, unbiased information comparing the clinical and cost effectiveness of prescription drugs. Pharmaceutical companies are for-profit companies whose purpose is to promote the sales of their products, so they strictly control what information is publicly available about their products. Information about new drugs often emphasizes their benefits, while obscuring costs and long-term consequences. One particular concern for Medicaid programs is that their beneficiaries are often sicker and older than the patients enrolled in the clinical trials, presenting a greater risk for adverse events and reactions to drugs.

State administrators can encourage the use of cost-effective medicines in public programs by establishing formularies and preferred drug lists, but pharmaceutical marketing often undermines evidence-based guidelines through direct advertising to consumers, free drug samples, and gifts for physicians. Clinical guidelines may be biased because of financial relationships between the pharmaceutical industry and professional medical associations and academic medical centers.

## II. Solutions for State Policymakers and Administrators

Public purchasers can control pharmaceutical industry influence. Over the past decade, the Department of Veterans Affairs (VA) has led the way, holding per capita costs flat, while improving health care access and quality -- especially around prescription drugs.<sup>7</sup> VA has used several tools to improve the drug purchasing and prescribing process including a formulary design based on evidence-based information; communication with physicians to encourage adherence to recommended therapies; restrictions on the access of pharmaceutical sales reps to physicians at VA hospitals; and the use of electronic medical records in order to provide physicians easy access to preferred drugs and treatment options, as well as safety information.

State lawmakers and administrators can improve prescription drug policies and programs by using two strategies (1) reducing financial conflicts of interest due to pharmaceutical marketing to doctors and (2) increasing evidence-based prescribing.

### 1. Strategies to Reduce Conflicts of Interest

- **Gifts and disclosure legislation:** By statute, ban gifts and other financial incentives to physicians by the drug industry and/or require disclosure of financial relationships. Such a ban exists in Minnesota, and disclosure laws exist in six states, including Vermont, Maine, West Virginia and the District of Columbia. Contact The Prescription Project for model legislation around this issue.
- **Academic medical centers:** Create a statewide task force by executive order to bring together leaders of academic medical centers and teaching hospitals to draft and implement standards to prevent financial conflicts of interest from affecting medical decisions. Use the standards published in 2006 in the *Journal of the American Medical Association*<sup>8</sup> as a foundation.

- **Medical education:** Require educators in all medical, pharmacy and nursing programs to disclose conflicts of interest, including the specific amounts they are receiving from pharmaceutical companies. Educators should not be biased by marketing information and financial incentives from drug companies.
- **Purchasing policies:** Purchasing decisions should be made by objective medical experts, not by those who have ties with for-profit pharmaceutical companies. Improve the public purchasing process by excluding any individuals with recent or active financial relationships with the pharmaceutical and medical device industry from the decision making process. This should be done at every level – government, insurer, hospital – and applied to formulary committees, pharmacy and therapeutics (P&T) committees and clinical guideline committees. The VA and other exemplary health care institutions already have such requirements for key decision makers.
- **Disclosure requirements for providers at state-funded health care organizations:** Ensure that all doctors and other providers who practice in publicly-funded health care institutions (state hospitals, public teaching hospitals, nursing homes and dialysis centers) are subject to the same policies that require public employees to disclose external financial relationships to the state Ethics Commission and other regulatory bodies. Extend the disclosure requirement to all purchasers in the state using public dollars in their drug purchasing process. In some instances, these policies may be introduced administratively; others will require legislation.

## 2. Strategies to Increase the Use of Medical Evidence in Prescription Drug Purchases

- **Support and use systematic drug reviews** such as those developed by the Drug Effectiveness Review Project (DERP). DERP is a collaboration of public and private purchasers, including 13 states, which have joined together to provide systematic evidence-based reviews of the comparative effectiveness and safety of commonly used drugs.<sup>9</sup> DERP reports are a valuable source of unbiased information to inform public policy and guide purchasing decisions. Participating states have reported substantial cost savings. For example, after consulting a DERP report, several states decided not to put Vioxx on their Medicaid preferred drug lists, saving lives and significant costs.
- **Educate consumers about prescription drugs.** Provide patients and their families with unbiased drug information by promoting sources such as Consumer Reports Best Buy Drugs ([www.crbestbuydrugs.com](http://www.crbestbuydrugs.com)) and the Effective Health Care website ([www.effectivehealthcare.ahrq.gov](http://www.effectivehealthcare.ahrq.gov)).
- **Introduce legislation on evidence-based purchasing.** Require all state agencies (public hospitals and health clinics, health insurance programs for public employees, correctional facilities) to include the explicit use of evidence in their purchasing process for drugs. If drugs in a class are homogeneous, price competition should be required. Such a broad-based statute has been successfully implemented in Washington state.
- **Implement evidence-based preferred drug lists** that include all classes of drugs, including mental health medications. Create appropriate protections by introducing efficient prior authorization procedures that ensure timely patient access, appropriate physician discretion, and clear accountability.
- **Strengthen drug approval procedures** by (1) focusing on medicines and medical devices with significant safety issues and (2) preventing financial conflicts of interest from affecting drug purchasing and approval decisions by restricting the participation of health care providers who have financial

relationships with pharmaceutical companies and medical device makers.

- **Establish academic detailing programs to collect and distribute unbiased medical information**  
Establish academic detailing programs, which use teams of physicians, pharmacists, and nurses, rather than salespeople, to provide prescribers with objective information on prescription drugs, grounded in the best evidenced-based science – conveniently and efficiently in the physician’s office.
  - Pass statutes and provide funding to establish an academic detailing program in your state. Use the statutes passed in Maine and Vermont in 2007 as a reference.
  - Build on the experience of existing programs, such as Pennsylvania’s Pharmaceutical Assistance Contract for the Elderly (PACE) and state employee programs.
  - Focus on key prescribing issues, including (1) Important and controversial medications (such as those for mental illness, HIV, and cancer) which are not on the preferred drug list and have significant evidence issues (2) Drugs with safety concerns, especially when off label use is encouraged by companies; and (3) Highly marketed drugs for which the evidence does not show unique effectiveness that would justify the price.
  - Consider targeting providers who write prescriptions for large numbers of patients enrolled in publicly funded health programs—such as Medicare and Medicaid—in order to promote evidence-based treatments and prevent potential fraud and abuse.
  
- **Pass legislation opposing “data mining” by pharmaceutical marketing companies.**  
Pharmaceutical industry sales reps rely on their ability to buy prescribing profiles of individual doctors. The industry uses this information to target advertising pitches, often for costly new drugs.  
  
New Hampshire has banned the use for marketing purposes of personal prescribing information collected through data mining (use of aggregated data that does not identify the prescriber is still permitted). The law was struck down in federal district court, but the state attorney general has appealed the ruling, and consumer, senior, physician and health advocacy organizations have joined the appeal. A Prescription Project legal analysis provides a review of the lower court’s decision, and outlines the basis for the state’s appeal seeking to uphold the law. (See [www.prescriptionproject.org](http://www.prescriptionproject.org)).  
  
As an alternative to a flat-out ban on marketing uses of this information, states can shield the data about doctors’ prescribing patterns by requiring pharmaceutical companies to obtain prior agreement from individual physicians before their prescribing data can be sold to or shared with pharmaceutical marketing companies. Vermont has passed such a law; Maine law permits prescribers to designate their intentions through a check-off on medical licensing forms. The data mining industry has also filed legal challenges to these laws, and the states’ attorneys general have mounted a vigorous defense. Similar bills are currently active in Massachusetts, New York, and Washington state.
  
- **Prohibit advertising in electronic medical records.** Follow the VA’s example and ensure that electronic medical records only display evidence-based treatment guidelines, such as information on generic drugs and therapeutic equivalents that offer better value than expensive brand-name drugs. Prohibit publicly-funded hospitals and health care organizations from using electronic medical records with advertising in them. Look to Florida, Maine and New Hampshire, where statutes exist.

### III. Next Steps

State policy makers and administrators can protect the health and economic well-being of their citizens by promoting evidence-based prescribing and by restricting financial conflicts of interest introduced by pharmaceutical marketing to physicians. Doing so will prevent the use of unnecessary and expensive prescription drugs, and enable states to expand prescription drug coverage to more constituents.

For more information, including fact sheets, model legislation, and technical assistance, please see our website [www.prescriptionproject.com](http://www.prescriptionproject.com) or contact Marcia Hams, Assistant Director and lead of state strategy initiatives at [mhams@communitycatalyst.org](mailto:mhams@communitycatalyst.org)

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