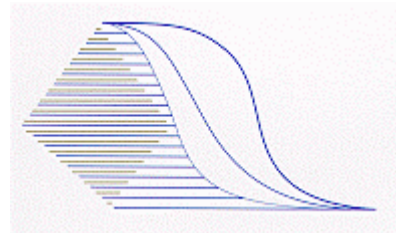


Centre for Health Services and Policy Research



AN ASSESSMENT OF THE HEALTH SYSTEM IMPACTS
OF DIRECT-TO-CONSUMER ADVERTISING OF
PRESCRIPTION MEDICINES (DTCA)

Volume IV: Pills, Persuasion and Public Health Policies

Report of an Expert Survey on
Direct-to-Consumer Advertising of Prescription Drugs in
Canada, the United States and New Zealand

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EXECUTIVE SUMMARY

BACKGROUND

Direct-to-consumer prescription drug advertising (DTCA) is controversial, with many claims made about potential benefits and harm. This is a survey of pharmaceutical policy experts in sectors directly affected by DTCA in the two countries where DTCA is legal, the United States and New Zealand, as well as in Canada, which does not currently allow prescription drug advertising aimed at the public, but is strongly affected by US cross-border advertising. Canada is currently reviewing its legislation and considering introducing DTCA.

METHODS

A faxed questionnaire was sent to 150 drug policy experts from health professional organizations, non-profit consumer and disease/patient groups, government agencies that manage public drug benefit schemes or regulate drug promotion, private insurance, managed care, the advertising industry, the media and the pharmaceutical industry. Experts from these sectors were identified through an Internet search for fugitive literature on DTCA, participation in relevant consultative and advisory committees, and through contacts in government and the pharmaceutical industry. The questionnaire asked their opinions the quality of information in DTCA, its effects on appropriateness of care and on direct health care costs, as well as the type of evidence on which these opinions were based. Questions on regulation included the types of limits respondents would support in settings where DTCA is allowed and the types of prescription drug advertising aimed at the public, if any, Canada should allow.

RESULTS

106 questionnaires were returned, a 71% response rate: 60 were from Canada, 24 from the US and 22 from New Zealand. Thirty percent of respondents were government employees, 17% from consumer/non-profit groups, 17% from health professional associations, 10% from the advertising industry or media, 10% from the pharmaceutical industry, 8% from private payers and 7% from disease-specific patient groups.

Reported exposure was highest in the US, with 79% of respondents saying they had seen more than 10 brands advertised in the last year, versus 55% of New Zealanders and 52% of Canadians. Two thirds judged the information on drug benefits and risks to be poor to very poor, and 28% thought it was good to excellent. Opinions were heavily divided by sector, with advertising and pharmaceutical industry respondents overwhelmingly positive. No difference was observed by country in spite of national regulatory differences governing information content.

Similarly, most respondents judged the effects of DTCA on knowledge of drugs and diseases and health care quality to be negative or at best neutral, with the exception of doctor/patient communication, for which opinions were nearly evenly divided (41% believed DTCA improved communication; 38% believed it worsened communication). Most respondents from all sectors believe that that DTCA leads to increased costs in the form of public and private spending on drugs and an increased frequency of doctor visits.

The types of evidence cited varied by question, with all respondents stating that assessment of information quality on drug benefits and risks was based on their own experience with DTCA, and a higher proportion (45%) saying that there was little to no evidence on effects of DTCA on

appropriateness of physician consultations than other measures. The latter is an accurate reflection of the lack of published research evidence on this issue. More respondents cited empirical studies as a basis for opinions on effects on drug costs (41%-43%) than on measures associated with quality of care. In most cases, a similar proportion cited direct empirical studies whether they believed the effects of DTCA were positive or negative.

Just over half believe that limits should be placed on the timing of advertising campaigns in settings where DTCA is allowed, including one quarter who believe that DTCA should not be allowed until five or more years post market launch. Product-specific limits on advertising were supported by 74 (70%), most commonly based on drug safety profile, followed by drug efficacy and patients' health condition. New Zealanders were more likely to support limits based on private or public payment than Americans or Canadians (27% versus 14% and 17%, respectively). New Zealand has a public national drug plan covering costs of prescription drugs for the entire population, unlike the US or Canada.

Six population groups were listed and respondents were asked whether DTCA campaigns should specifically target each group. Taken together they included the entire population except infants. Seventy-eight percent thought that children should not be targeted, 72% adolescents, 69% low income or disadvantaged groups, 61% the elderly, and 58% men or women. Sixty people (57%) thought that none of the listed groups should be targeted, and 7 (7%) thought all should be targeted. Currently, in countries allowing DTCA any population group may be targeted. Sixty-five percent thought that billboards were an inappropriate medium for prescription drug advertising and 59% thought television was inappropriate. The Internet and magazines were judged more positively, with 49% and 51% respectively considering them to be appropriate.

Respondents were asked whether Canada should allow five types of prescription drug advertising aimed at the public:

- Full DTCA, including product name and health claims
- Full DTCA, also including promotional offers such as free trials or price reductions
- Disease-oriented advertisements, which mention no product name
- Reminder ads, which include brand names and images but no health claims
- Comparative price advertising (listings of name, price and quantity only, no images or advertising text; joint listings of competing products).

The greatest support was expressed for disease-oriented advertising, with 55% stating that it should be allowed. The majority thought that the other listed types of DTCA should not be allowed: 84% were opposed to full DTCA with promotional offers; 62% were opposed to reminder advertising; 56% to full DTCA and 55% to comparative price advertising. Comparative price advertising is allowed in Canada under a 1978 amendment to the Food & Drugs Act. However, in practice it occurs rarely.

CONCLUSIONS

This survey indicates that many policy experts from Canada, the US and New Zealand believe that the quality of information in DTCA is poor, the effects on appropriateness of care will be negative, and health care costs will increase. The one exception to this finding is doctor/patient communication, for which opinions were nearly evenly divided. No attempt was made to solicit opinions on indirect effects such as hospitalization rates, morbidity and mortality, as there is no

research evidence linking DTCA to longer-term impacts. However, short-term harm is unlikely to lead to long-term benefit.

The results were highly polarized, with the exception of beliefs about effects on costs of pharmaceuticals and physician services, which almost all respondents believed would increase. There was a great deal of support for the introduction of DTCA in Canada among experts from the advertising and pharmaceutical industries in Canada, the United States and New Zealand and to a lesser extent among representatives of patient groups, but very little support among experts from the health professions, governments, private payers and consumer/ non-profit groups.

This is an opinion survey, not a direct assessment of the empirical literature on outcomes of DTCA, and the conclusions should be taken as a reflection of expert opinion only. However, the survey raises serious concerns about the current proposed direction of policy change in Canada, particularly given the opinions expressed by policy experts in key positions in provincial and federal governments, including drug plan managers, advertising regulators and pharmaceutical policy advisors. From a public policy perspective, a shift leading to increased drug and physician costs might be considered if health care quality was expected to improve. If quality is largely expected to deteriorate, it seems hard to reconcile such a shift.

INTRODUCTION

What are the opinions of experts in pharmaceutical policy on the likely effects of direct-to-consumer prescription drug advertising (DTCA) on public understanding of drugs and diseases, quality of health care, and health care costs? Do they think that prescription drug advertising aimed at the public should be allowed, and if so, to what extent?

This is the report of a survey carried out in February 2001 to solicit the opinions of pharmaceutical policy experts in sectors directly affected by direct-to-consumer advertising (DTCA) in Canada, New Zealand and the United States. The survey was funded by Health Canada as part of a larger research project to assess the impact of direct-to-consumer advertising of prescription drugs on the Canadian health care system. The US and New Zealand are the only industrialized countries to allow DTCA. Canada's Food & Drugs Act forbids DTCA, but this legislation is currently under review. Additionally, since late 1997, when the US Food and Drug Administration relaxed regulatory requirements for broadcast advertising, Canadians have been exposed to a large and increasing volume of American broadcast advertising.

Four types of organizational sectors were included in this survey, reflecting a range of relationships to prescription drug advertising:

- *Health care service providers*: health professional organizations
- *Health care users*: non-profit/consumers and disease/patient groups
- *Health care payers, managers and regulators*: governments and private payers
- *DTCA producers and disseminators*: advertising and pharmaceutical industries and media.

The questionnaire examines exposure to DTCA, opinions on information quality, and potential impacts on knowledge, quality of health care services, and direct costs. Additionally, respondents were asked their opinions on regulatory issues, including what type of advertising should or should not be allowed, and appropriateness of different target groups and advertising media. These topics were derived from a literature review and individual interviews.

Under Canada's Food and Drugs Act, the main rationale for prohibiting advertising of prescription medicines to the public is health protection. Medicines have prescription-only status

because they are associated with greater inherent risks, either under normal conditions of use or if used inappropriately, or because there is little experience with their use, leaving many questions open about longer-term or uncommon harmful effects. A second rationale is associated with the seriousness of the health condition treated, with treatments or preventatives of a specified list of diseases (“Schedule A” diseases), prohibited under the Act.

Another rationale for prohibiting DTCA, particularly within a publicly funded health care system, is related to costs. Most prescription drug advertising in the US and New Zealand has been for a relatively small number of new, expensive drugs for chronic or intermittent long-term use for large target populations. This reflects a need for adequate return on advertising investment, particularly the more expensive forms of mass media such as television.

The main rationale for allowing prescription drug advertising is that the public will become better informed about the existence of new drug treatments and will be able to discuss these treatments with their doctors. As the doctor has the ultimate responsibility for prescribing decisions, inappropriate utilization is considered unlikely. Advertising may make patients feel better about medicines they are taking and make them more likely to take them as directed. Additionally, people may recognize disease symptoms at an earlier stage and obtain needed drug treatment, thus avoiding costlier hospitalizations further down the line.

These are arguments about whether DTCA leads to a better or worse informed public, more or less appropriate drug treatment, and better or worse allocation of limited health care resources.

DTCA is controversial, with many claims made about benefits and risks and often very little empirical research to back those claims. In order to shift the discussion from opinion alone into what is and is not known about the effects of prescription drug advertising, this survey included questions about what type of evidence respondents had seen to support stated opinions. The questionnaire did not assess indirect effects of DTCA on hospitalization, morbidity or mortality because these effects have not been researched and cannot be ascertained through personal observation alone.

METHODS

DEVELOPMENT OF CONTACT LIST

A librarian with expertise in fugitive literature searches identified contact organizations and individuals in the US during an Internet search on DTCA in November/December 1999. In New Zealand, both RMI, the brand-name industry association, and PHARMAC, the national drug reimbursement plan, provided lists of contacts in the relevant sectors.

In Canada, Health Canada personnel working on drug policy and advertising regulation were invited to participate in the survey, as were representatives of the three pharmaceutical industry associations. Participants in the following committees and advisory groups were also contacted:

Non-governmental (industry, health professionals, consumers, patient groups):

- Multi-stakeholder consultation on DTCA held by Health Canada in April 1999
- Therapeutic Products Programme Advisory Panel on Drug Licensing

Government (provincial and federal):

- Federal/Provincial/Territorial Advisory Committee on Health Services' Pharmaceutical Issues Committee (PIC)

In Canada, provincial governments administer health services, including publicly financed drug benefit plans. PIC includes drug plan managers and policy experts from provincial ministries of health, as well as federal policy-makers working on pharmaceutical policy issues. Additional names of provincial personnel were suggested by contacts in Manitoba and Quebec, and Health Canada provided names of policy experts from national industry associations.

SURVEY PROCEDURES

150 people, 79 in Canada, 40 in the US, and 31 in New Zealand, were invited to participate in the survey. The aim was to obtain at least 90 completed questionnaires (60% response rate). Contacts received a faxed questionnaire and cover letter explaining the survey, asking them to reply as soon as possible. Non-respondents received up to two additional questionnaires, by fax and e-mail, over a three-week period. Ethics approval was obtained from the University of British Columbia's Research Ethics Board. Results are reported by sector only, with individual responses kept confidential.

RESULTS

QUESTIONNAIRE RESPONSES

Table 1: Affiliations of survey participants

<i>Type of affiliation</i>	<i>Canada</i>	<i>New Zealand</i>	<i>USA</i>	<i>Total</i>
Government agency	24	6	2	32 (30%)
Consumer and public interest non-profit group	9	2	7	18 (17%)
Health Professional Organization	11	4	3	18 (17%)
Pharmaceutical industry	5	4	2	11 (10%)
Advertising industry and media	4	4	3	11 (10%)
Private insurance, managed care & employers	2	-	7	9 (8%)
Disease-specific patient group	5	2	-	7 (7%)
<i>Total</i>	<i>60 (57%)</i>	<i>22 (21%)</i>	<i>24 (23%)</i>	<i>106</i>

The response rate was 71%, with 106 of 150 questionnaires returned. Table 1 presents a breakdown of respondents' affiliation by sector and country. Respondents with academic affiliations were grouped with their discipline: marketing professors with the advertising industry, medicine or pharmacy professors with health professionals. Similarly, if a non-profit organization was associated with a specific sector, it was classified accordingly. For example, pharmaceutical industry trade associations were classified with the pharmaceutical industry.

If less than four responses were received per sector, they were joined with another sector in order to adequately maintain confidentiality. There were only two media responses; these were grouped with the advertising industry. Similarly, private sector agencies mandated to review advertising were classified with the advertising industry because of the small number of respondents within this sector.

EXPOSURE TO DTCA

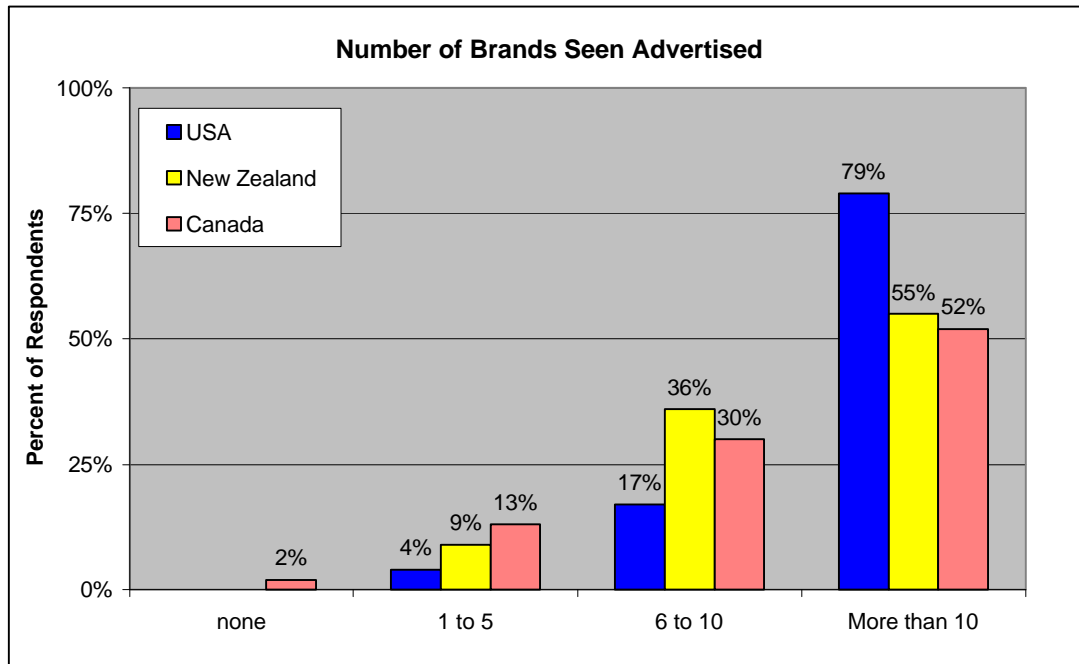


Figure 1: Number of brands seen advertised in previous year.

The questionnaire began by asking how many different prescription drugs respondents had seen advertised to the public during the last year. The aim of this question was twofold:

- To focus attention on concrete examples of DTCA;
- To compare DTCA exposure rates reported by respondents in the three countries.

There was relatively little difference in reported exposure between Canada and New Zealand, in spite of the different legal status of DTCA in the two countries. US respondents reported greater exposure to DTCA than either New Zealanders or Canadians, with nearly four out of five reporting having seen more than 10 products advertised within the last year.

EFFECTS ON ORGANIZATIONS' WORK

More US respondents reported that DTCA had a substantial effect on their work (59%) than respondents from New Zealand (30%) or Canada (33%). This varied considerably by sector, as described in Table 2.

Table 2: How much has DTCA affected your work?

<i>Sector</i>	<i>Substantial Effect</i>	<i>Moderate Effect</i>	<i>Little to No Effect</i>	<i>No comment</i>
Private payers (n=9)	67%	33%	-	-
Advertising industry/media (n=11)	64%	18%	9%	9%
Government (n=32)	50%	38%	-	13%
Health Professionals (n=18)	17%	39%	33%	11%
Non-profit/consumers (n=18)	18%	53%	24%	6%
Disease/patient groups (n=7)	14%	58%	28%	-
Pharmaceutical industry (n=11)	9%	55%	36%	-

QUALITY OF INFORMATION ON DRUG BENEFITS AND RISKS

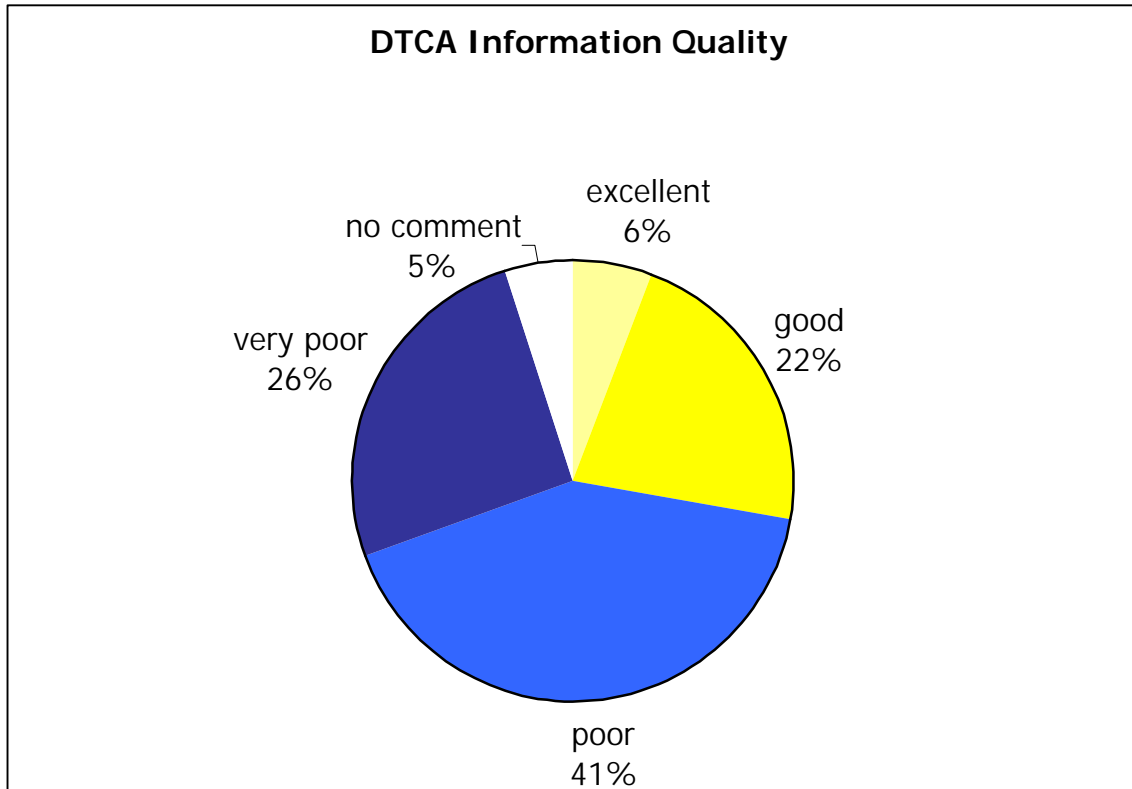


Figure 2: Assessment of drug information quality in DTCA

Two thirds of respondents judged the quality of information on drug benefits and risks in DTCA to be poor or very poor, 22% thought the quality was good, and only 6% thought it was excellent. One respondent commented that risk information was generally much lower quality than benefit information. Several others mentioned that the quality varied for different types of DTCA. There was a large degree of polarization by sector in the assessment of information quality, with advertising and pharmaceutical industry respondents generally judging the information quality to be positive, and all other sectors judging it to be negative. All respondents cited their own experience with DTCA as the basis for their judgment on quality. Only one

person, who judged quality to be poor, also cited a range of other types of evidence, including empirical studies and theoretical analyses.

Table 3: What is the quality of information on drug benefits and risks in DTCA?

	<i>Poor to very poor</i>	<i>Good to excellent</i>	<i>No comment</i>
By Sector			
<i>Mainly negative</i>			
Private payers (n=9)	100%	-	-
Disease/patient groups (n=7)	86%	14%	-
Non-profit/consumers (n=18)	82%	12%	6%
Health Professionals (n=18)	83%	11%	6%
Government (n=32)	75%	19%	6%
<i>Mainly positive</i>			
Pharmaceutical industry (n=11)	27%	73%	-
Advertising industry/media (n=11)	9%	91%	-
By Country			
Canada (n=60)	75%	20%	5%
USA (n=24)	70%	26%	4%
New Zealand (n=22)	50%	50%	

EFFECTS ON KNOWLEDGE AND APPROPRIATENESS OF HEALTH CARE

Overall, more respondents believed that the effect of DTCA on public understanding of drugs and diseases and on appropriateness of care would be negative than positive, although up to 40% either did not comment or believed that advertising was unlikely to have an effect on these outcomes. This trend was only reversed for doctor/patient communication. However, only 3% more respondents thought that DTCA would affect communication positively than negatively.

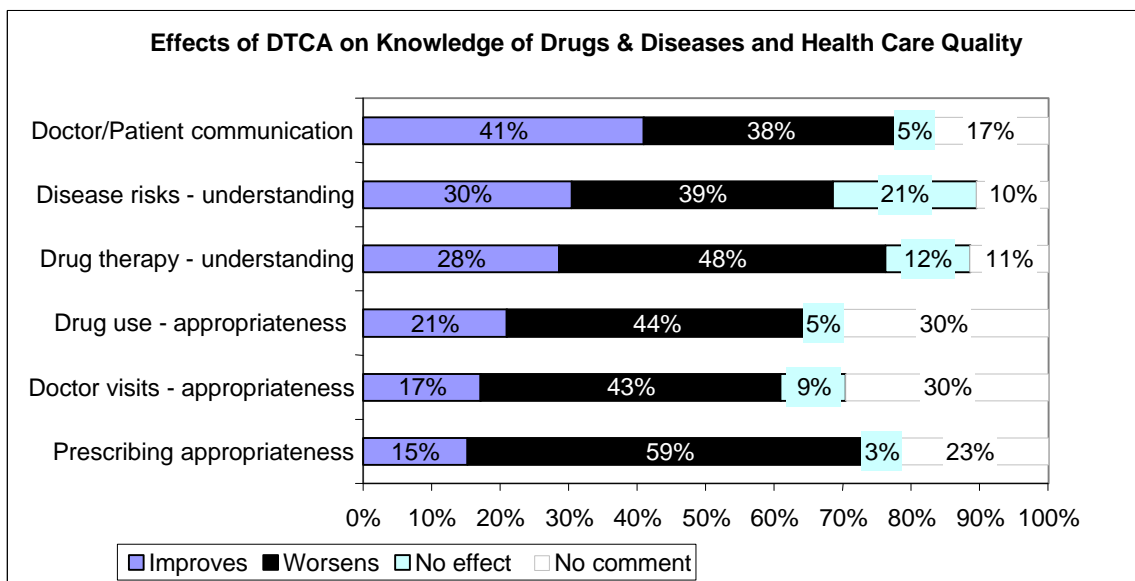


Figure 3: DTCA's effects on knowledge and appropriateness of care: positive, negative or neutral? (N=106)

EFFECTS ON PUBLIC UNDERSTANDING OF DRUG THERAPY AND DISEASE RISKS

Figure 4 and 5 present the proportion of respondents per sector who believe that DTCA leads to better or worse public understanding of drug therapy and disease risks. The percentages do not add up to 100% because some respondents chose not to comment. As both figures indicate, opinions differed considerably by sector, with only one pharmaceutical industry and no advertising industry respondents believing that DTCA worsened public understanding. In contrast, most consumers/non-profits, private payers, health professional and disease/patient group respondents believed that the effect would be negative. These are sectors representing providers and users of pharmaceuticals.

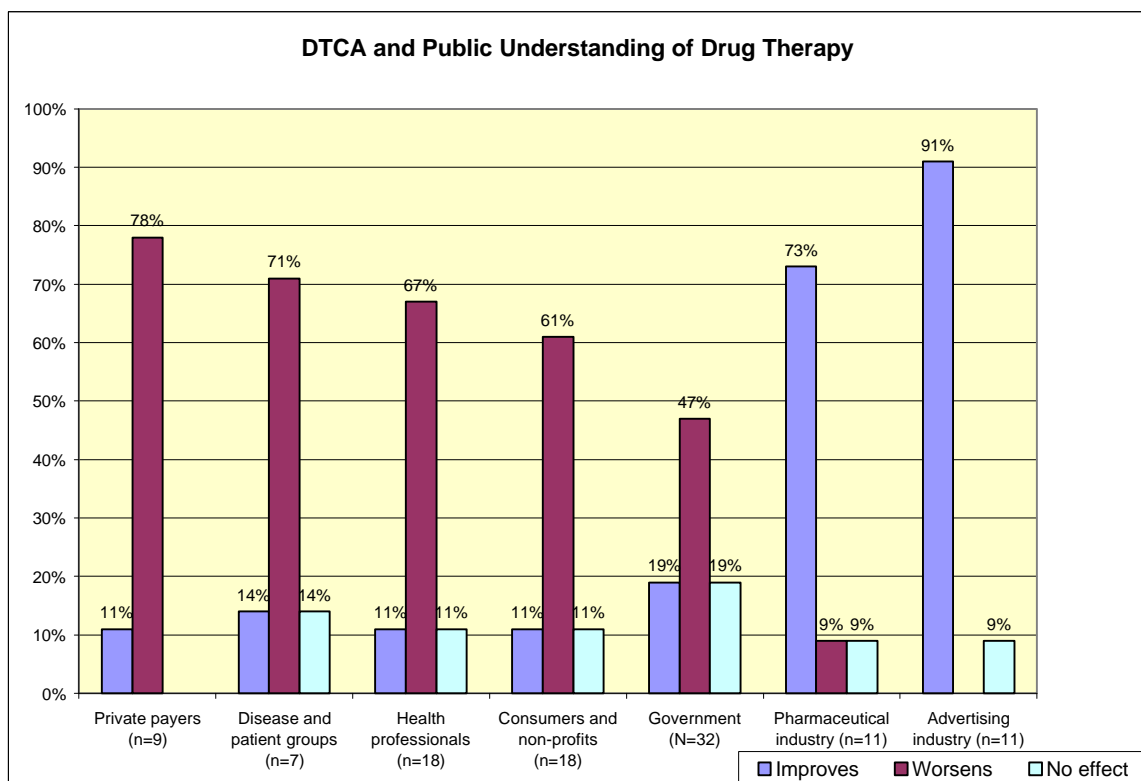


Figure 4: Beliefs about DTCA's effects on public understanding of drug therapy: percentage by sector

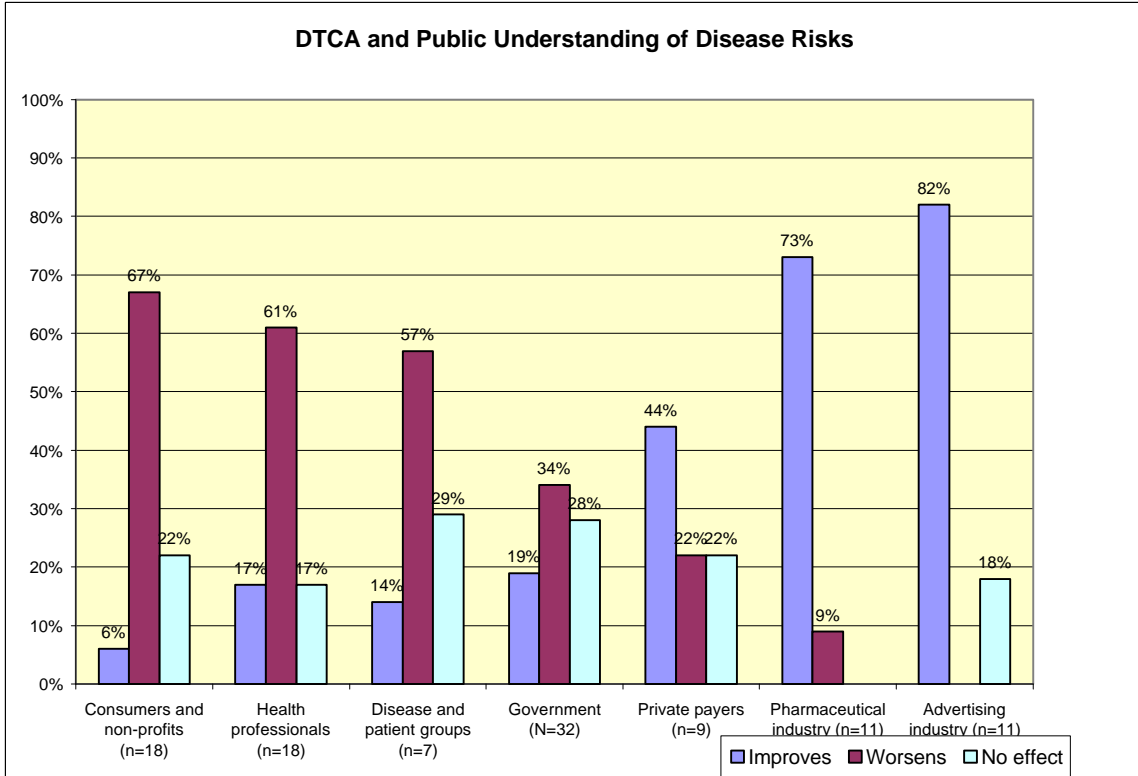


Figure 5: Beliefs about DTCA's effects on public understanding of disease risks: percentage by sector (N=106)

EFFECTS ON DOCTOR/PATIENT COMMUNICATION

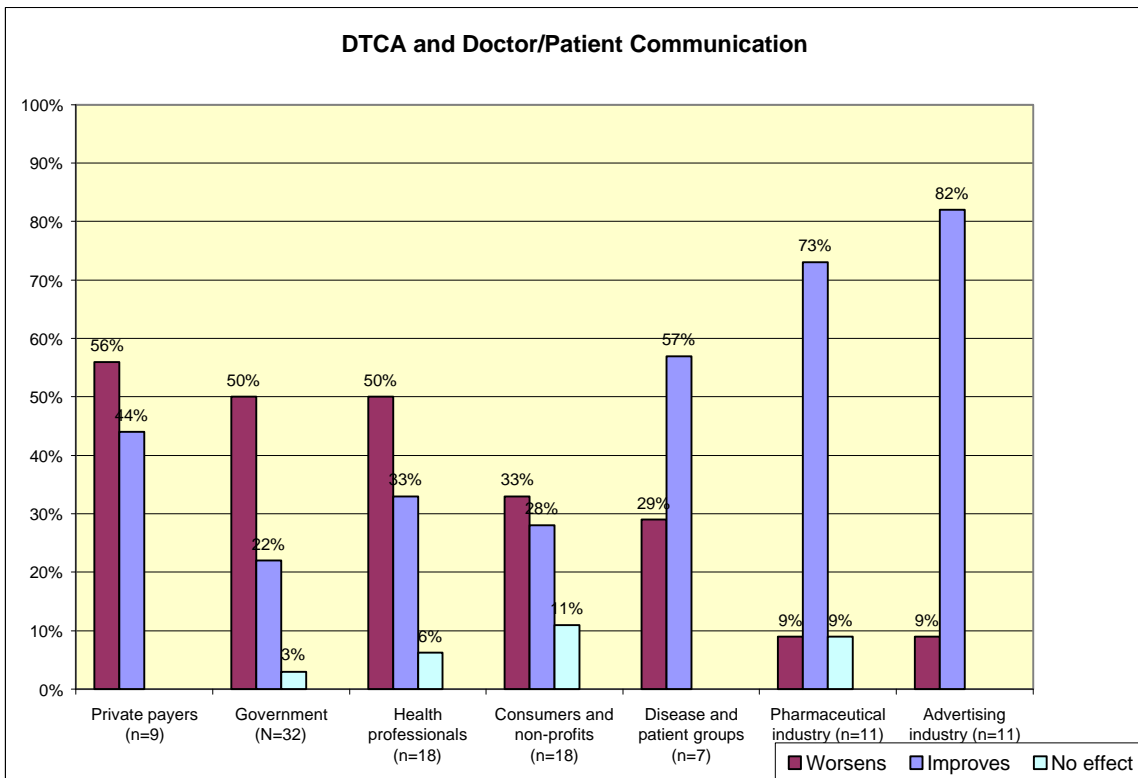


Figure 6: Beliefs about DTCA's effects on doctor/patient communication: percentage by sector (N=106)

There was more diversity of opinion within sectors in responses on doctor/patient communication. Health professional associations are the most directly implicated, since many of the people they represent spend much of their work time communicating with patients. More believed that DTCA worsens communication, 9, or 50%, than improves it, 6, or 33%. An equal number of consumer/non-profit respondents, 6 (33%) believed DTCA improved doctor/patient communication, and a higher proportion of patient group representatives 4 (57%). One doctor remarked that DTCA improved communication because you can't communicate with a patient who doesn't come in to the office. Another thought it worsened communication by shifting the focus away from the patient's health problem and onto whether a specific drug was needed.

More New Zealanders (68%) than Americans (42%) or Canadians (31%) believed that DTCA improved doctor/patient communication. If only non-drug or advertising industry responses were examined, national differences remained, with 22% of Canadians versus 32% of Americans and 64% of non-industry New Zealanders believing it improves communication. Respondents were equally likely to cite empirical studies as evidence whether they thought DTCA improved or worsened doctor/patient communication.

EFFECTS ON APPROPRIATENESS OF DRUG USE AND PRESCRIBING

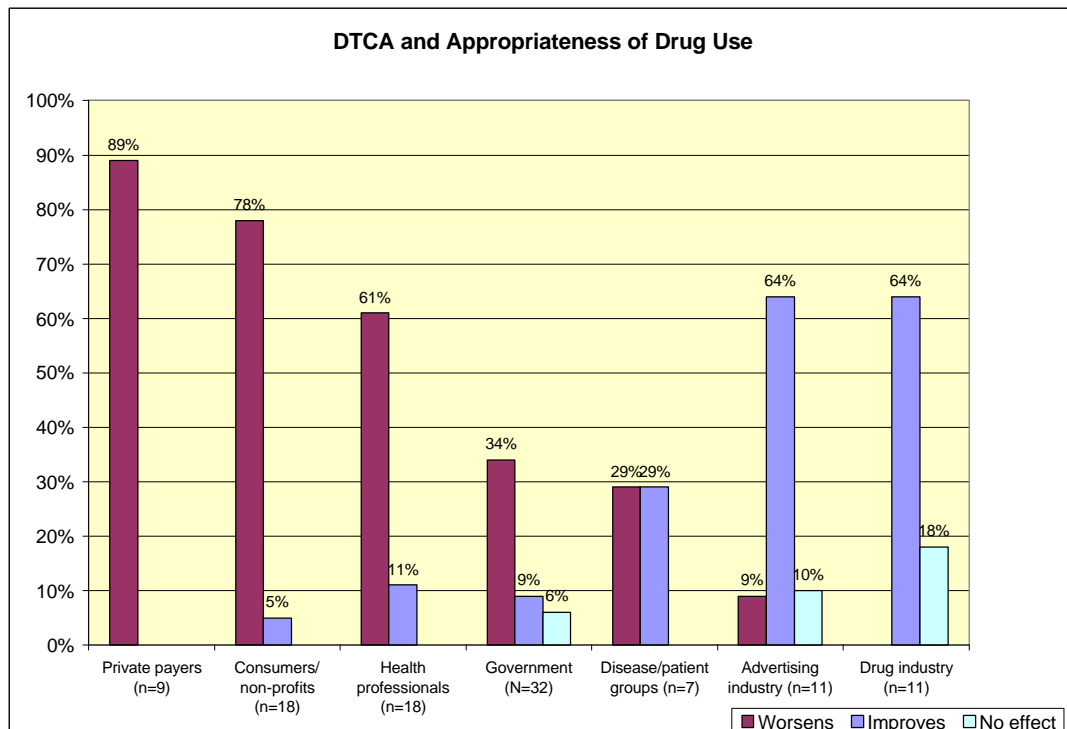


Figure 7: Beliefs about DTCA's effects on appropriateness of drug use: percentage by sector (N=106)

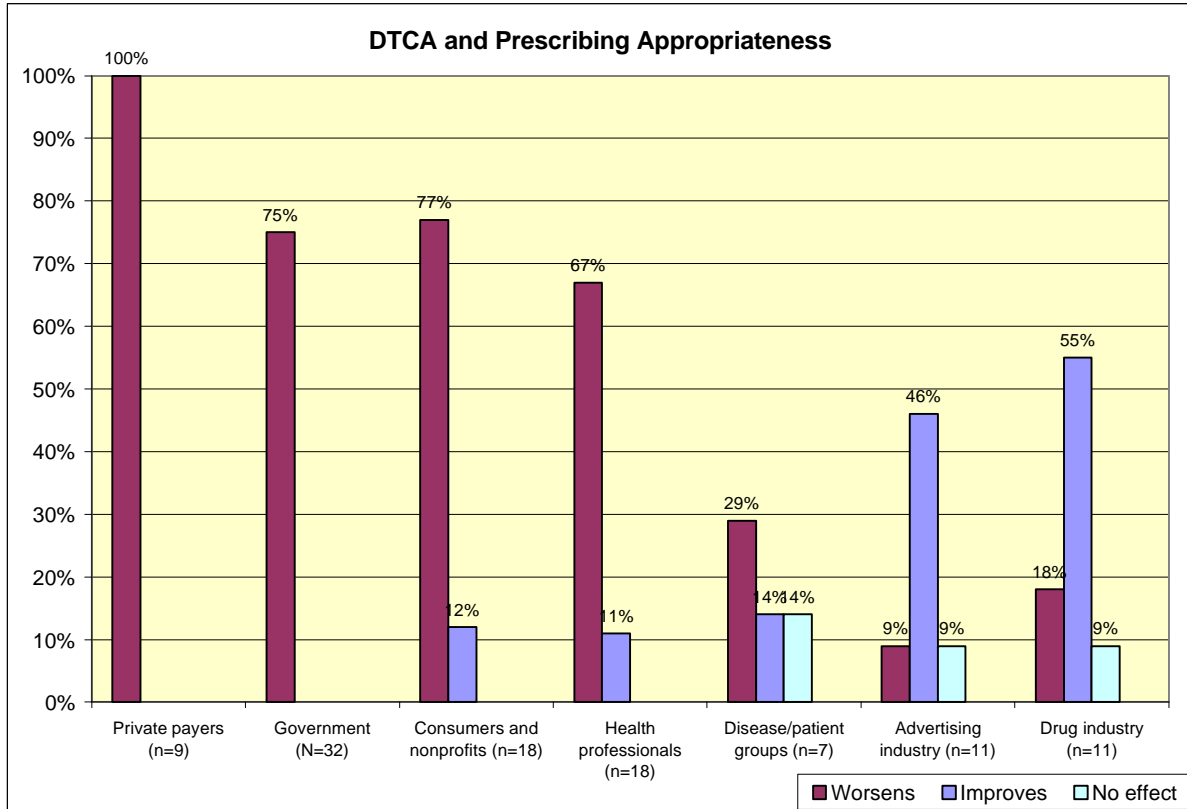


Figure 8: Beliefs about DTCA's effects on appropriateness of drug use: percentage by sector (N=106)

If successful, DTCA is expected to cause changes in drug prescribing and use, as the aim of any advertising campaign is increased product sales. Figures 7 and 8 on the previous page indicate that most non-industry respondents believed that DTCA leads to less appropriate prescribing and use. In total, nearly four times as many respondents believed DTCA leads to less rather than more appropriate prescribing (59% vs. 15% respectively). For appropriateness of drug use, the ratio was just over two to one (44% vs. 21%).

EFFECTS ON APPROPRIATENESS OF VISITS TO DOCTORS

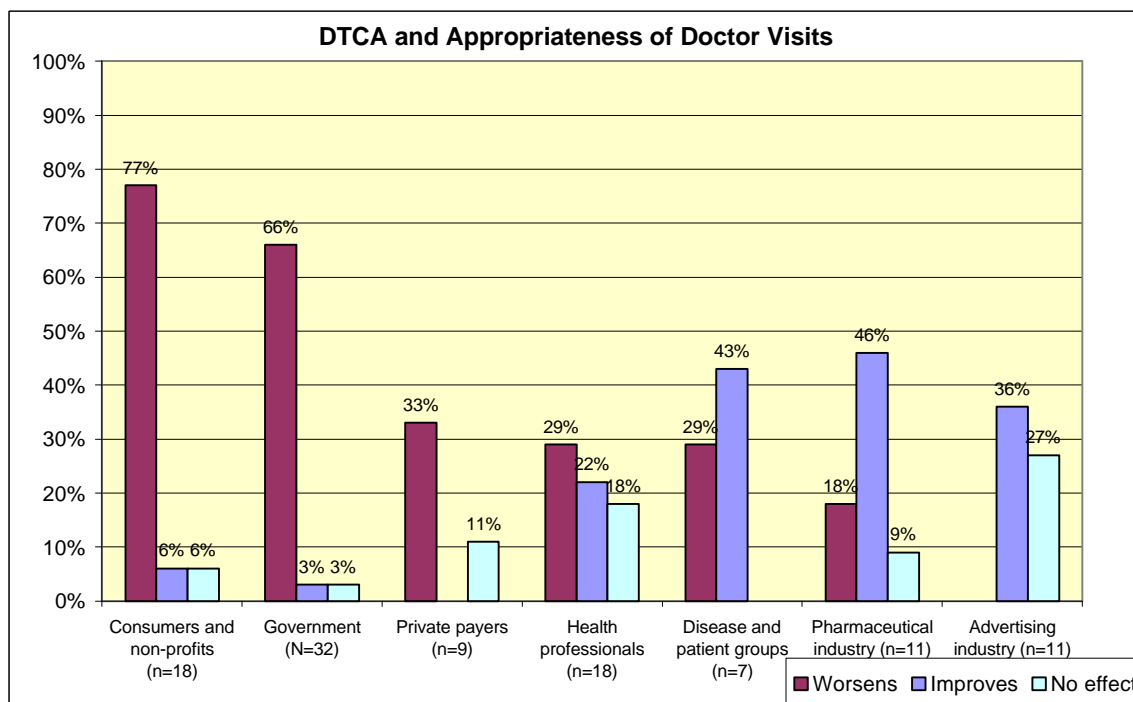


Figure 9: Beliefs about effects on appropriateness of visits to doctors: percentage by sector (N=106)

The appropriateness or inappropriateness of visits to doctors affects not only the doctors and patients who see each other on a one-to-one basis, but also those involved in management and payment for health care services, i.e. governments, private insurers, and health care management organizations. The majority of those working in government predicted a negative effect, whereas most private payers either declined to comment or predicted no effect. In general many respondents chose not comment, reflecting the lack of research in this area. Forty-five respondents (44%) stated that little or no evidence was available, 26 (25%) cited only their own experience or theoretical analyses/expert opinion, and 25 (24%) cited empirical studies as the basis for their opinion.

More New Zealanders, 9 (41%), believed that DTCA improved appropriateness than Canadians, 8 (14%), or Americans, 1 (4%). The difference persisted among non-industry respondents: 4 (36%) of non-industry New Zealanders versus 4 (8%) of Canadians and no Americans. New Zealanders pay to see the doctor, with costs subsidized only at lowest incomes. In the US, those with insurance usually pay a co-payment; those without insurance either pay full costs or attend public health services. In Canada, the costs are fully covered under provincial health plans.

EFFECTS ON HEALTH CARE COSTS

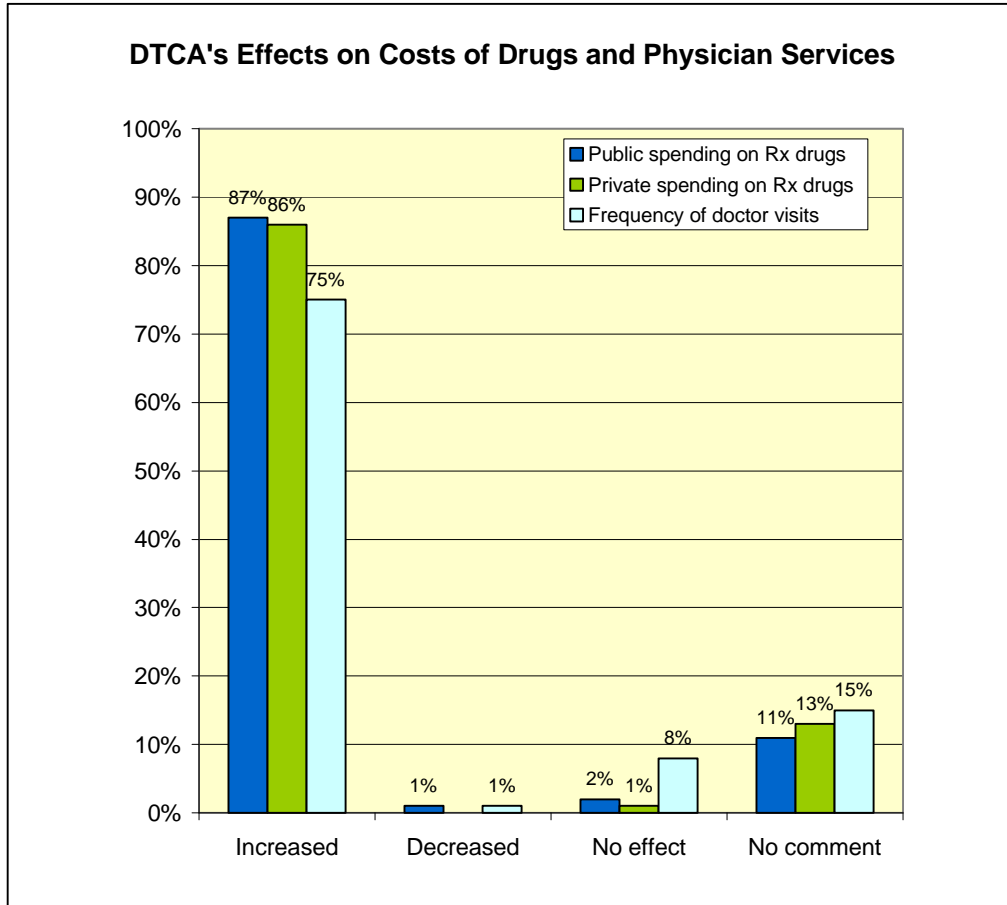


Figure 10: DTCA's expected effects on drug costs and frequency of physician consultations (N=106)

The survey included three questions related to the impact of DTCA on direct health care costs: its expected effects on frequency of physician consultations and on public and private spending on prescription drugs. Figure 9 summarizes the results for the sample as a whole. Most respondents expected DTCA to drive costs up. Only one person thought that public spending on prescription drugs and frequency of physician visits would decrease as a result of DTCA.

Respondents from government are most directly affected by changes in public spending: 31 (97%) said they believed DTCA increases public spending, and one person refrained from commenting. Those who believed that DTCA had no effect on private or public spending on drugs were all from the drug and advertising industries, and one New Zealand health professional respondent believed that DTCA decreased public spending on drugs.

Those who said that prescription drug use would have no effect on private spending or who refrained from commenting cited little to no evidence; over half of other respondents cited direct empirical evidence as the basis for their opinions.

LEVELS OF EVIDENCE CITED TO SUPPORT OPINIONS

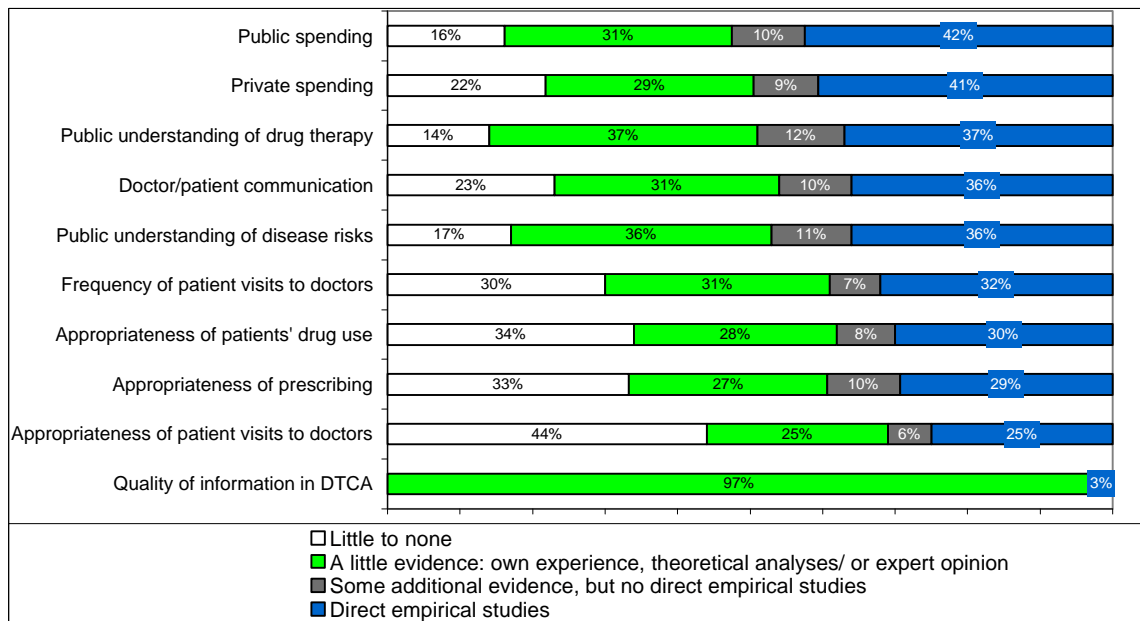


Figure 11: Proportion of respondents citing different types of evidence (N=106)

Figure 11 compares the proportion of respondents citing different types of evidence for the nine questions concerning DTCA information quality and its effects on appropriateness and cost of care. The breakdown of categories in Figure 11 is as follows:

- **Little to none:** those who marked ‘little to no evidence’ or only marked ‘no comment or don’t know’ and left the question on degree of evidence blank;
- **A little evidence:** those who either marked only ‘own experience’ or only ‘theoretical analyses or expert opinion’. Given that this is an expert survey, the two responses were considered equivalent;
- **Some additional evidence:** an intermediate category, those who marked indirect empirical evidence alone, or two to three different types of evidence, **excluding** either ‘little to no evidence’ or ‘direct empirical evidence’.

- **Direct empirical evidence:** any response that included ‘direct empirical studies of DTCA’ whether or not other types of evidence were also mentioned.

As Figure 11 illustrates, most respondents cited their own experience as the basis for opinions on information quality. Direct empirical evidence was most often cited as the basis for opinions on effects on drug costs. DTCA’s effects on appropriateness of visits to doctors, prescribing and drug use have not been directly studied, and many respondents referred to the lack of evidence available on these outcomes. In most cases, a similar proportion of respondents cited empirical evidence whether they believed that DTCA improved or worsened the quality of care. There were a few minor differences: 57% of those who thought it improved public understanding of drug therapy and 47% of those who thought it improved understanding of disease risks cited empirical evidence versus 38% and 35%, respectively, of those who thought it worsened understanding; 49% of those who thought it worsened doctor/patient communication cited empirical evidence versus 40% of those who thought it improved communication.

OPINIONS ON THE REGULATION OF DTCA

The questionnaire included two types of questions on the regulation of DTCA: possible limitations on advertising in settings where it is allowed; and whether or not Canada should allow various forms of advertising, including full DTCA.

- How soon following market launch should advertising to the public be allowed?
- Should limits be placed on which products are advertised to the public?
- Should advertising campaigns be allowed to target specific population groups?
- Are specific media appropriate for prescription drug advertising?

Limits on timing of DTCA campaigns

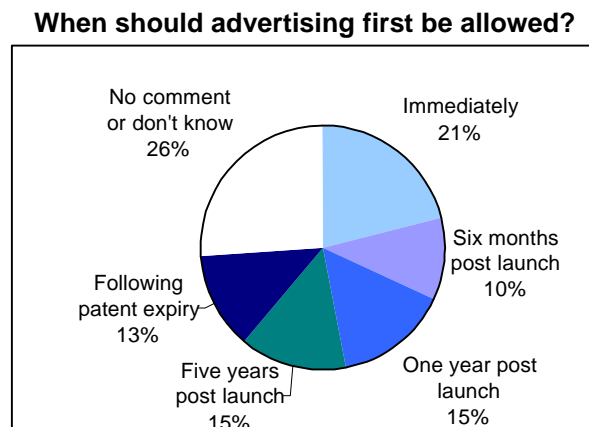


Figure 12: Opinions on limits to timing, sample as a whole (n=106)

Table 4: In settings with DTCA, how soon following market launch should it be permitted?

	<i>Immediately</i>	<i>6 months later</i>	<i>1 year later</i>	<i>5 years later</i>	<i>At patent expiry</i>	<i>No comment</i>
Sector						
Drug Industry (n=11)	64%	18%	-	-	18%	-
Advertising industry (n=11)	36%	55%	9%	-	-	-
Disease/patient (n=7)	29%	14%	14%	29%	14%	-
Health professionals (n=18)	17%	6%	11%	17%	11%	39%
Government (n=32)	13%	-	26%	19%	3%	39%
Private payers (n=9)	11%	11%	22%	11%	22%	22%
Consumer/non-profit (n=18)	6%	-	12%	24%	35%	24%
Country						
Canada (n=60)	10%	10%	22%	25%	12%	22%
United States (n=24)	17%	8%	13%	4%	25%	33%
New Zealand (n=22)	55%	14%	-	-	5%	27%

As Figure 12 indicates, around one fifth of the sample believed that DTCA should be allowed immediately post launch, as currently occurs in New Zealand and the US. Among those who thought there should be a delay, opinions were fairly evenly divided between delays of six months, one year, five years or post patent expiry. Over one fourth of respondents chose not to comment on this question. Table 4 describes the breakdown by sector and country.

Consumer/non-profit respondents were more likely to suggest allowing advertising post patent expiry than any other option. Most industry respondents suggested early introduction, either at launch or six months later; and nearly 40% of health professional and government respondents chose not to comment on this question.

Limits on which drugs may be advertised

Table 5: Should limits be set on which drugs are advertised to the public?

	Yes	No	No comment
Entire sample	74 (70%)	23 (22%)	9 (9%)
Sector			
Consumers/non-profits	16 (89%)	1 (6%)	1 (6%)
Government	26 (81%)	3 (9%)	3 (9%)
Health professionals	13 (72%)	2 (12%)	3 (17%)
Disease/patient groups	5 (71%)	1 (14%)	1 (14%)
Pharmaceutical Industry	5 (46%)	6 (55%)	-
Advertising/media	5 (46%)	6 (55%)	-
Private payers	4 (44%)	4 (44%)	1 (11%)
Country			
Canada	48 (80%)	7 (12%)	5 (8%)
United States	15 (63%)	6 (25%)	3 (13%)
New Zealand	11 (50%)	10 (46%)	1 (5%)

Most respondents thought that there should be limits on which prescription drugs could be advertised to the public in settings allowing DTCA. This was especially true of Canadians, consumer/non-profits, and people working in government. Industry respondents were fairly

evenly divided. This question has been raised in policy discussions on DTCA in Canada and New Zealand. Currently, there are no product-specific limits in the US or New Zealand.

Those who thought that limits should be set (N=74) were asked to specify whether health condition, drug profile or payment method should be the basis for those limits. Table 6 presents a breakdown of their responses. Most of those who thought that limits should be set, and 67, or 63% of the entire study sample, believed that advertising should be limited on the basis of drug safety profile, followed by efficacy (57% of entire sample).

More New Zealanders than North Americans highlighted payment as a criterion for limiting DTCA: 27% vs. 14% of Canadians and 17% of Americans. New Zealand has a national pharmacy benefit plan covering the entire population. Canada and the US both only have partial population coverage, with many people reliant on private insurance or out-of-pocket payment.

Table 6: Limits to DTCA should be based on these factors

Criterion to limit DTCA	Number (percent), n=74
Drug Safety	67 (91%)
Drug Efficacy	61 (82%)
Patients' Health Condition	50 (68%)
Private or public payment	18 (24%)

Targeting of specific population groups

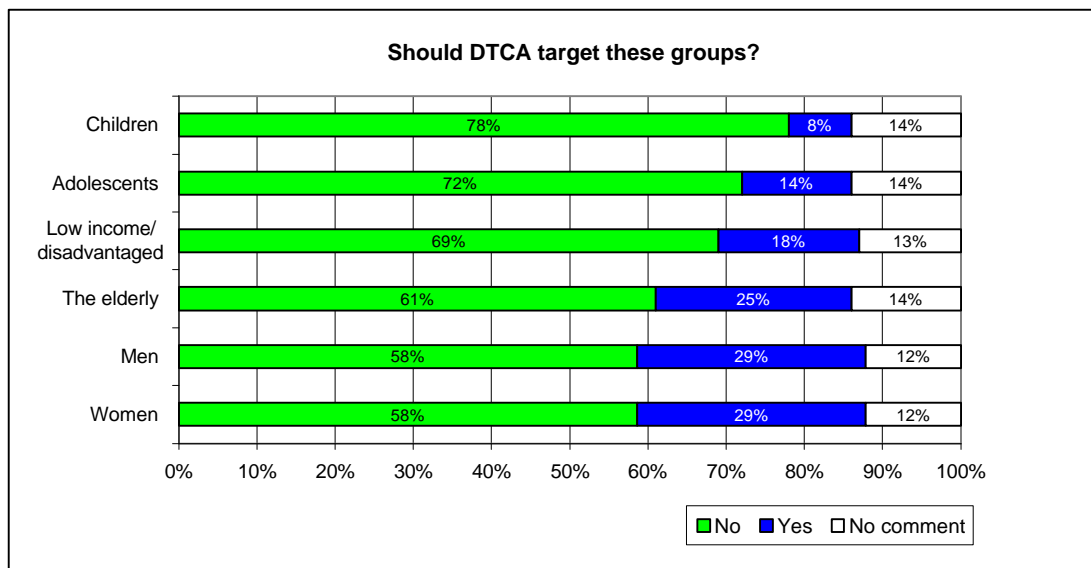


Figure 13: Percentage who thought specific population groups should or should not be targeted (n=106)

Six population groups were listed and respondents were asked whether DTCA campaigns should specifically target each group. Taken together, these categories include the entire population

except infants, who are unlikely to be the direct targets of DTCA campaigns. Many people said that children should not be targeted: 78% of the sample or 91% of those who expressed an opinion. Similarly, most people felt that adolescents were an inappropriate target group, and the targeting of low income and disadvantaged groups was generally seen negatively, with only 18% believing that DTCA should target this population group. There were no differences in responses on targeting of men and women.

Sixty people (57%) thought that none of the listed groups should be targeted in DTCA campaigns and only seven people thought that all listed population groups should be targeted. Table 7 describes these responses by sector and country. Among those who thought that none of the population groups should be targeted, over 75% (N=46) also believed that Canada should not introduce full DTCA.

Table 7: Respondents who thought that none or all of the population groups should be targeted

Sector	None should be targeted	All should be targeted
Private payers (N=9)	88%	-
Government (N=32)	74%	-
Health Professionals (N=18)	67%	-
Non-profit/consumer groups (N=18)	61%	6%
Disease/patient groups (N=7)	43%	14%
Pharmaceutical Industry (N=11)	27%	46%
Advertising industry & media (N=11)	18%	-
Country		
Canada (N=60)	70%	3%
USA (N=24)	46%	8%
New Zealand (N=22)	36%	14%

Appropriateness of Specific Media

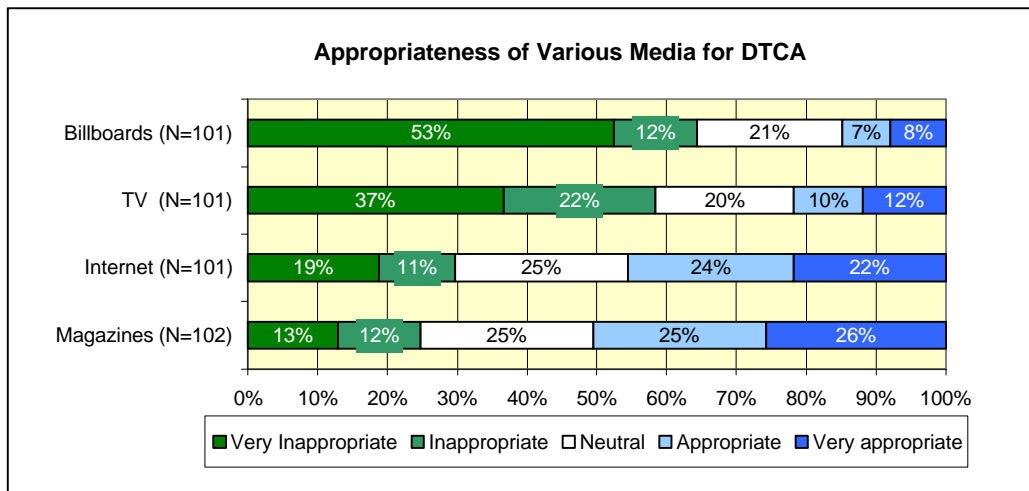


Figure 14: Assessment of the appropriateness of four commonly used advertising media.

The respondents were asked to rate the appropriateness of four types of media for prescription drug advertising aimed at the public: magazines, television, billboards, and the Internet. All are currently widely used for DTCA. More than half thought that billboards and television were inappropriate or very inappropriate media for prescription drug advertising; in contrast, more than half found magazines to be appropriate or very appropriate and nearly as many (46%) rated the Internet as appropriate. In general, respondents tended to favour media with greater information content.

Table 7 provides additional detail on the respondents who found specific media to be inappropriate for DTCA. There were large differences by sector. No consumer/non-profit respondents and only one government respondent (3%) felt that billboards were appropriate for DTCA whereas two health professionals (11%) and two disease group respondents (29%) found them to be appropriate.

Table 7: Respondents who thought that specific media were inappropriate for prescription drug advertising

Sector	<i>Inappropriate or very inappropriate for DTCA</i>			
	<i>Billboards</i>	<i>Television</i>	<i>Internet</i>	<i>Magazines</i>
Government (N=32)	78%	69%	28%	31%
Disease/patient groups (N=7)	71%	57%	29%	29%
Private payers (N=9)	67%	89%	11%	11%
Non-profit/consumer groups (N=18)	67%	61%	56%	39%
Health Professionals (N=18)	61%	61%	33%	28%
Pharmaceutical Industry (N=11)	36%	18%	9%	9%
Advertising industry & media (N=11)	18%	9%	9%	-
Country				
Canada (N=60)	67%	62%	38%	33%
New Zealand (N=22)	59%	45%	9%	14%
USA (N=24)	50%	50%	21%	13%

SHOULD CANADA ALLOW PRESCRIPTION DRUG ADVERTISING?

Respondents were asked whether or not Canada should allow five different types of prescription advertising aimed at the public:

- Full DTCA, including product name and health claims
- Full DTCA which also includes ‘free trial offers’ or price reductions
- Disease-oriented advertisements with no product name
- Reminder ads, which include brand names and images but no health claims
- Comparative price advertising (listings of name, price and quantity only; no images or advertising text; joint listings of competing products).

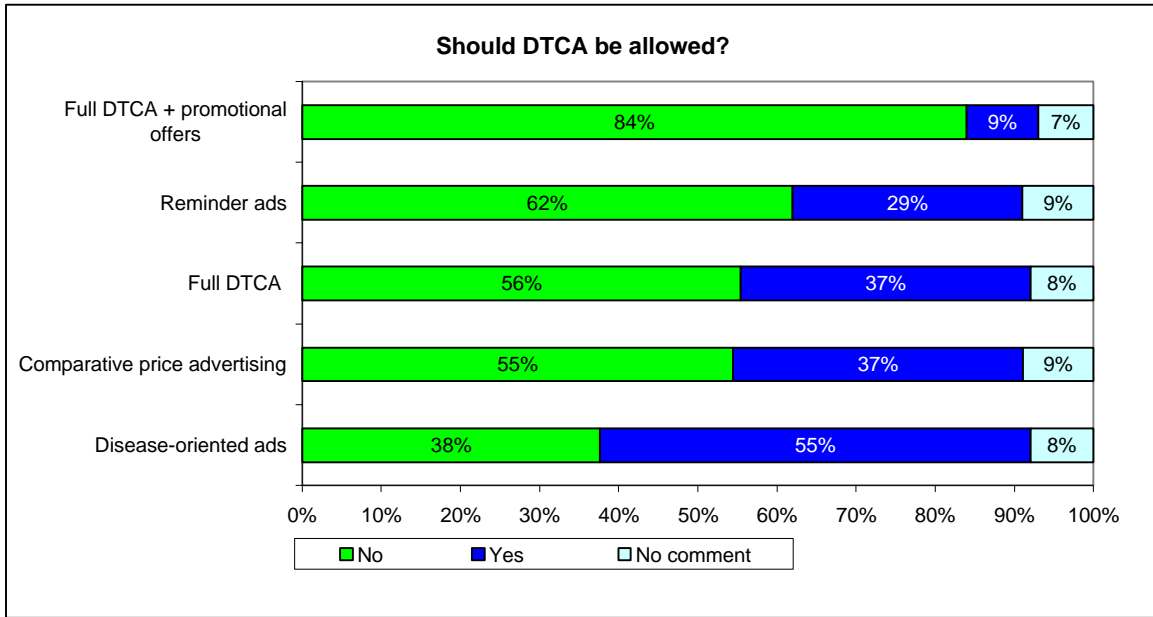


Figure 15: Respondents' opinions on whether Canada should allow various types of DTCA (n=106)

Figure 15 indicates the breakdown of opinions on legalization, by type of DTCA. More than half of the respondents thought that disease-oriented advertising should be allowed. Most respondents were opposed to legalization of all other forms of advertising, with the largest degree of opposition voiced for full DTCA with promotional offers such as free trial offers or price reductions. More than twice as many respondents opposed legalization of reminder advertising as supported it. Most were also opposed to comparative price advertising, which is currently legal in Canada under Section C.01.044 of the Food and Drugs Act.¹ In practice, however, comparative price advertising is rare to non-existent in Canada, the US and New Zealand. The questionnaire did not include any information on what types of advertising are and are not currently allowed in Canada.

Should Canada introduce full DTCA, with product name and health claims?

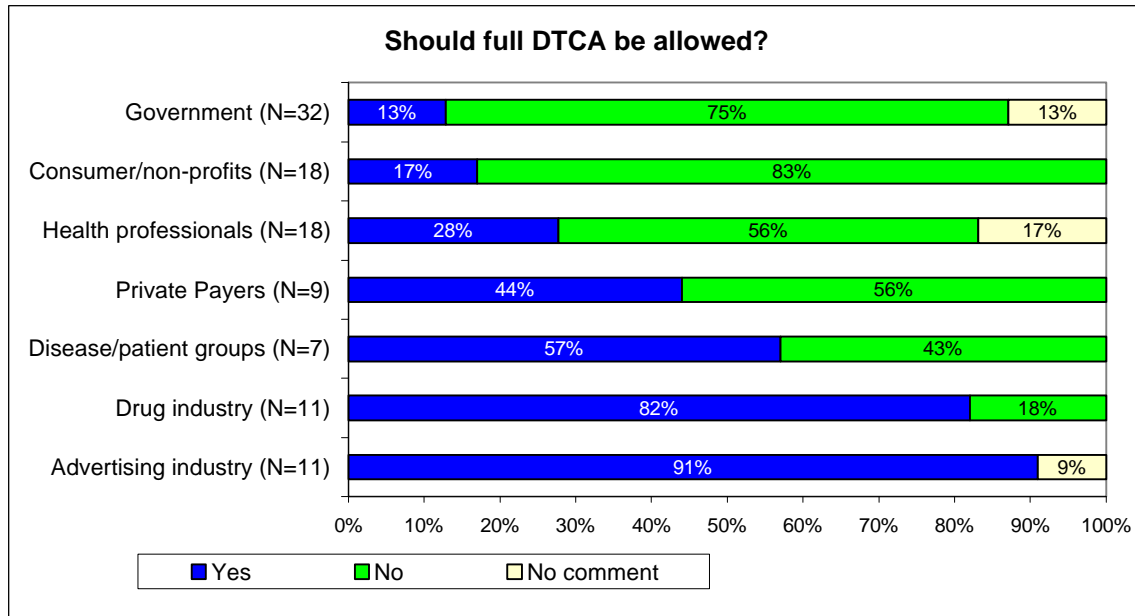


Figure 15: Opinions on introduction of full prescription drug advertising, by sector (N=106)

Canada has been undergoing a policy review since 1996 on whether full prescription drug advertising, including both product name and health claims, should be introduced. Figure 15 presents respondents' opinions about the introduction of full DTCA, broken down by sector. People in government were mostly opposed to the introduction of DTCA in Canada. This was true for the 24 Canadians in provincial and federal governments included in the sample, with 19 (79%) opposed, 4 (17%) in favour, and one (4%) refraining from commenting. All New Zealanders in government who replied to this question (5 or 83% of NZ government respondents) believed that full DTCA should not be allowed and the Americans in government refrained from commenting.

Disease/patient groups and consumer/non-profit groups both represent the intended audience for DTCA: patients and the broader public. Most consumer/non-profit respondents did not support the introduction of full DTCA; most patient group respondents did. Many patient groups receive funding from pharmaceutical companies; one New Zealand patient group respondent cited industry funding in a comment on why the group supported DTCA. There was less enthusiasm among the disease/patient group representatives for reminder ads or disease-oriented advertising. [See Table 8]

Twice as many health professionals opposed as supported the introduction of full DTCA, and most drug and advertising industry respondents supported its introduction. Table 8, on the following page, provides additional information on opinions about the introduction of each listed form of prescription drug advertising by sector and country.

Table 8: Proportion of respondents who thought each type of DTCA should be allowed, by sector and country*

Sector	<i>Full DTCA + promotions</i>	<i>Disease-oriented</i>	<i>Reminder ads</i>	<i>Comparative price ads</i>	<i>Full DTCA</i>
Advertising industry (N=11)	<u>55%</u>	91%	<u>82%</u>	27%	91%
Drug industry (N=11)	27%	73%	55%	36%	82%
Disease/patient groups (N=7)	0%	14%	0	29%	57%
Private Payers (N=9)	0%	56%	33%	33%	44%
Health professionals (N=18)	6%	53%	29%	35%	29%
Consumer/non-profits (N=18)	0%	50%	11%	56%	17%
Government (N=32)	0%	50%	19%	34%	13%
Country					
Canada (N=60)	5%	50%	23%	38%	30%
United States (N=24)	13%	63%	38%	46%	41%
New Zealand (N=22)	18%	59%	36%	23%	55%

*An underlined number represents the column maximum, a bolded number the row maximum.

Organizational policies on DTCA

Fifty respondents, or 47% of the sample, said that their organization had a policy on DTCA.

These can be roughly divided into policies supportive of DTCA, neutral or opposed. The latter included respondents supporting restrictions on the content of DTCA or the types of advertising allowed. Four Americans said that their organization supported stricter regulation of the content of DTCA. Three Canadians cited the government position as reflecting the current restrictions in the Food & Drugs Act. The 13 organizations citing a policy in support of DTCA included seven pharmaceutical industry respondents, five advertising industry/ media respondents, and one New Zealand health professional organization.

Table 9: Types of organizational policies, by country

	Generally Opposed or Supporting Restrictions			Neutral	Supportive
<i>Organizations with policies on DTCA</i>	<i>Unequivocally Opposed</i>	<i>Support current Canadian restrictions</i>	<i>Stricter regulation needed</i>		
Canada (N=24)	17 (71%)	3 (13%)	-	1 (4%)	3 (13%)
New Zealand (N=14)	5 (36%)	-	-	1 (7%)	8 (57%)
USA (N=12)	5 (42%)	-	4 (33%)	1 (8%)	2 (17%)
Entire sample (N=50)	27 (54%)	3 (6%)	4 (8%)	3 (6%)	13 (26%)

DISCUSSION

This survey represents the opinions of experts from Canada, New Zealand and the US in the sectors most strongly affected by prescription drug advertising: health professionals, patients, consumers, public and private payers and managers of health care services, and the advertising and pharmaceutical industries. Most respondents reported having seen more than 10 brands advertised during the last year, i.e. considerable exposure to prescription drug advertising.

Over two thirds of respondents judged the quality of information on drug benefits and risks in DTCA to be poor or very poor. The only sectors judging the quality to be good were the advertising and pharmaceutical industries, i.e. producers and disseminators of advertising. There was no difference by country if sector was controlled for, despite major regulatory differences governing information content. New Zealand ads are considered to meet regulatory requirements with much less detailed risk information than US ads. For example, in New Zealand no risk information is required in the audio portion of television ads. Although Canadian law on advertising aimed at the public is less permissive than US law, recent billboard advertising campaigns have featured prescription drug names, broad hints at indication, and no risk information.² Whether or not they are legal, these billboards have been allowed to run for many months. Such ads would violate US regulations because they lack risk information and do not fit into US requirements for reminder ads. In the US, reminder ads cannot list a medical specialty or include a visual representation of the indication.

Most respondents assessed the effects of DTCA on knowledge and appropriateness of care to be negative or at best neutral, with the exception of doctor/patient communication, where opinions were nearly evenly divided. In all cases, most advertising and pharmaceutical industry respondents believed that DTCA was likely to have positive effects.

The results indicate a large degree of polarization in opinion on the quality of information on drug benefits and risks in DTCA and on the effects of DTCA on public understanding and appropriateness of care, with industry respondents almost overwhelmingly positive, and most respondents from government, private payers, health professionals and consumer organizations judging quality to be poor and predicting negative effects.

There is considerable empirical evidence suggesting that quality is frequently poor if regulatory requirements are used as a minimum standard. Regulatory reviews in New Zealand and the US indicate that violations of medicines regulations are common, with inadequate representation of risk information and exaggeration of benefits the most frequently identified problems.³

No systematic analyses of direct-to-consumer advertising content in New Zealand have been published as yet. However, a study carried out in Wellington and Auckland in late 2000, commissioned by New Zealand's national drug benefit scheme, PHARMAC,⁴ provides some insight into public response to an advertisement that violates national regulatory standards because of inadequate risk information. This was a survey of 200 women aged 16 to 30, who were asked about their responses to a magazine ad for Diane-35 (cyproterone + estradiol)⁵:

- 28% had seen the ad; 12% had used the product;
- 47% believed that the ad gave them enough information to decide whether to take the drug,
- 27% believed that the ad clearly stated the product's risks and side effects.⁶

The only risk statement, in very fine print, was: "*Diane-35 has a similar side effect profile to other oral contraceptives. Some women should not use Diane-35.*" This product is no longer approved for use as a contraceptive in Europe because of concerns about liver toxicity.⁷ In Canada, a reminder advertisement for the same product provided no risk information. One version, displayed in women's washrooms in Halifax, claimed that women in Europe had benefited from the use of the product for 20 years without mentioning the European marketing restrictions.⁸

A recent US mail survey of 130 people found that consumers were more likely to say they would 'recommend or purchase' a drug if the accompanying risk information was less complete.⁹ The researchers used a brief and more extended version of risk information from eight heavily advertised drugs. The brief statement was taken from DTCA; the more extended description included all side effects with a similar incidence to those mentioned in the ad. The same researchers also asked 58 people to compare two imaginary drugs, one with more or less complete risk information, and state which they would choose. The large majority chose the drug with less risk information.

US analyses of print advertising also indicate that inadequate provision of risk information occurs frequently. Roth asked a panel of pharmacists to assess 39 ads, representing more than 90% of print DTCA in the US between 1993 and 1995; 35% did not contain a fair balance of benefit and risk information and 15% did not mention risks at all in advertising copy.¹⁰ US Consumer Reports asked clinical experts to assess 28 magazine ads that had recently appeared, and found that 33% contained factual inaccuracies; half did not convey needed risk information and only 40% were honest about efficacy, risk and benefits.¹¹

US consumer surveys have found that many people are misinformed about the regulatory safeguards surrounding advertised products. Twenty-eight percent of respondents in a US FDA national consumer survey believed that only the safest drugs could be advertised to the public,¹² and 43% of a random sample of the general public in Sacramento believed that only completely safe drugs could be advertised. Any medicine may be advertised to the US public, regardless of safety profile.

A recent study, by Robert Bell et al. sheds some light on DTCA's potential impact on public knowledge of drug therapy and disease risks based on its information content.¹³ They examined 10 years' worth of print advertising in 18 major US consumer magazines (320 ads) for their educational value, in terms of whether 11 key types of information were provided on the drug and the health condition it treats. Although most ads named the medical condition (95%) and described at least one symptom (60%), few mentioned causes or risk factors (27%), disease prevalence (12%) or clarified misconceptions (9%). Similarly, key information on drugs was usually missing, such as how a drug works (missing in 64%), other possible drug treatments (missing in 61%), behavioral changes that are helpful, such as diet or exercise (missing in 73%), time to onset of drug effect (missing in 80%), average treatment duration (missing in 89%) or success rate (missing in 91%). This study used a low standard for information provision – whether information was present or absent – not its accuracy, completeness or relevance to the target audience.

There are no published systematic analyses of information content of US broadcast ads or New Zealand print ads. However, broadcast ads tend to be less informative than print advertising because of the limits imposed by timing and the medium.

There are no published direct empirical studies on DTCA's effects on prescribing appropriateness. A number of empirical studies have looked at the effects of doctors' reliance on promotional information on prescribing appropriateness.^{14 15 16 17 18 19 20} Greater reliance on drug promotion was associated with less appropriate prescribing, in terms of the indications for use, dosage and administration, avoidance of unnecessarily hazardous therapies and use of the most cost-effective of available alternatives. A systematic review of studies on the outcomes of physicians' interactions with the pharmaceutical industry published in 2000 found an association between interactions with the industry and physicians' inability to identify inaccurate claims about medicines, prescribing of more expensive medicines without demonstrated advantage, less generic prescribing, a higher prescribing rate overall, and requests for formulary listings of drugs without clear advantages over products that were already on the formulary.²¹

This is the most relevant body of indirect empirical evidence on the likely direction of DTCA's effects on prescribing appropriateness. Eleven of the twelve respondents who based their replies on indirect empirical studies said that DTCA decreased prescribing appropriateness; the 12th marked 'no comment or don't know'.

Although DTCA's effects on patient use of medicines have not been directly studied, one frequent claim is that DTCA increases patient compliance. *Prevention* magazine's consumer surveys asked members of the public who were taking a drug that they had seen advertised whether they were reminded to take the drug or to refill a prescription.²² Around a third of those currently taking advertised drugs said that they were reminded, leading to claims of a beneficial effect on compliance. This finding raises a number of questions concerning actual behaviours, what products respondents were using and whether increased compliance was linked to health benefits. In some circumstances, better compliance is equivalent to more appropriate use, particularly when treatments are curative or prevent acute exacerbations of chronic conditions. In others, for example symptomatic drug treatment, the effect may be neutral or even harmful, as in the case of NSAID users who continue to comply with therapy in spite of symptoms of adverse effects.²³

Nearly all respondents from all sectors believe that DTCA increases direct health care costs in the form of private and public spending on prescription drugs and frequency of physician visits.

In summary, most respondents judged DTCA information quality and effects on public understanding of drugs and diseases, and health care quality to be negative, and expected costs of drugs and physician services to increase.

Regulatory Recommendations

Respondents were asked to make regulatory recommendations both for settings where DTCA is allowed, and for Canada, which is currently undergoing a policy review and considering whether to introduce DTCA.

Just over half believe that some sort of limits should be placed on the timing of DTCA campaigns, with one third believing that DTCA should not be allowed until one year post market launch, and one quarter five or more years post launch.

Marketers might be expected to support a short delay, such as three to six months, since products can be promoted to physicians before patients, helping to increase the likelihood of a prescription following a request. More than half of advertising industry respondents supported a six-month delay.

There are also health reasons for limiting advertising of new drugs, when relatively little is known about rare or longer-term health risks. A systematic review by the US General Accounting Office found that over 50% of newly marketed drugs had serious risks that were discovered only post-approval, usually in the first few years.²⁴ As a result, a US non-profit organization, Public Citizen Health Research Group, suggests avoiding using new drugs until they have been on the market five years unless they are true breakthrough products.²⁵ The second rationale for a limit on timing is cost. Allowing DTCA only post patent expiry would address concerns that DTCA leads to a substitution of costlier patented products for products of equivalent therapeutic value that are off-patent and therefore unlikely to be advertised to the public. Nearly half of consumer/non-profit respondents thought advertising should be limited to five or more years post market launch.

Most respondents thought that there should be product-specific limits to which drugs are advertised to the public, and the most commonly cited basis was drug safety profile. This is

similar to the rationale behind Canada's current legal framework limiting advertising to the public to over-the-counter products. The limitation by patient's health condition, supported by 49 (46%) of respondents, reflects a similar logic to the list of Schedule A diseases in the Food & Drugs Act, for which preventatives or treatments should not be advertised to the public.

If advertising is limited on the basis of product safety or efficacy, but advertising of some prescription-only drugs is allowed, in practice this means establishing an intermediate tier of products with prescription-only status but better-established safety and efficacy than other products. For example, ads might be allowed only for products with clear evidence of a therapeutic advantage compared to alternatives and/or a well-established safety record.

The possibility of product-specific restrictions was raised at a national multi-stakeholder consultation on DTCA held in Ottawa by Health Canada in April 1999.²⁶ Neither proponents nor critics of DTCA embraced this option. Industry representatives were concerned that it would introduce an extra layer of complexity in regulation and lead to unfair competition. Critics saw it as partial deregulation in an environment where promotion aimed at health professionals is inadequately regulated.

Nearly four out of five respondents said that children should not be targeted in DTCA campaigns and nearly three quarters believed that adolescents should not be targeted. The majority (57%) felt that none of the listed population groups should be targeted although the listed groups included the entire population in one or more category, minus infants, who are unlikely to be direct targets in DTCA.

All advertising campaigns have a target audience, whether it consists of a broad segment of the population, such as ads for allergy drugs, or a more restricted audience, such as targeting of adolescents in ads for acne drugs. There have been both negative and positive commentaries in the press about targeting of specific population groups in DTCA. In the US, targeting of young children in a campaign with a "Z is for Zithromax" Sesame Street segment has been criticized.²⁷ In Canada women's groups have objected to the targeting of adolescent girls in billboard and television/cinema campaigns for Diane-35 (estradiol/cyproterone) and Alesse (estradiol/levonorgestrel).²⁸ In New Zealand, women's groups have raised concerns about the

images of women and social ramifications of a campaign for an anti-obesity drug, Xenical (orlistat).²⁹ Authorities in San Francisco raised concerns about ads for AIDS drugs targeted at gay men and the possibility that such advertising may be linked to an increase in unsafe sexual practices and HIV infection.³⁰

Targeting of specific population groups has also been highlighted as a positive feature of advertising campaigns. RMI, the New Zealand industry association, has suggested that television campaigns are especially useful as a means to reach Maori people who might otherwise not obtain diagnosis or seek ongoing care for chronic conditions such as diabetes or asthma.³¹ They argue that broadcast DTCA meets public health objectives in reaching a lower income disadvantaged population group, those most likely to suffer from under-diagnosis and under-treatment, and also more likely to be in poorer health than higher income population groups. A UK commentator similarly suggested that television advertising could fill a gap in access to health information among low-income groups.³² However, only 18% of survey respondents believed that low income and disadvantaged people should be targeted in DTCA and nearly four times as many thought that they should not be targeted.

Billboards were considered the least appropriate medium for DTCA, with 62% of respondents considering them to be inappropriate or very inappropriate. Similarly, most respondents thought that television is an inappropriate medium. Since late 1997, when the US FDA relaxed regulatory requirements for risk information presentation in broadcast ads, television advertising in the US has expanded enormously, with \$1.1 billion spent on television ads in 1999, a 70% increase over 1998.³³

Most respondents from all three countries do not think that Canada should allow full DTCA, i.e. advertising that includes both product name and indication. Those most strongly opposed are from government and consumer/non-profit organizations, with 75% and 83% respectively opposing its introduction. In Canada, 24 of the 60 respondents have organizational policies concerning DTCA: 20 generally opposed, 1 neutral and 3 supportive.

Even greater opposition was expressed to two forms of DTCA: 89 (84%) opposed DTCA that includes promotions such as price reductions or free trial offers, and 66 (52%) opposed reminder ads.

A ten-year review of print DTCA in major consumer magazines in the US found that 17% of print ads contained such financial incentives.³⁴ The offer of monetary incentives to physicians to prescribe certain products is generally considered unethical³⁵ and is prohibited under most national regulatory guidelines or codes governing drug promotion.

Reminder ads have been the subject of recent controversy in Canada, with divergent opinions voiced about their legality under the Food & Drugs Act, mainly centering over the interpretation of Section C.01.044: “*Where a person advertises to the general public a Schedule F Drug, the person shall not make any representation other than with respect to the brand name, proper name, common name, price and quantity of the drug.*” Reminder ads generally contain elements other than name, price and quantity, including emotive advertising images and text and suggestions to ‘ask your doctor’. However, Health Minister Rock stated in August 2000 that reminder advertising is allowed.³⁶

In the US, when the FDA brought in a new guidance for broadcast advertising in 1997 relaxing the regulations for risk information provision, the agency referred to the confusion caused by televised reminder ads as one of the reasons new regulations were needed.³⁷ Reminder ads often leave viewers guessing what the advertised product is used for. From a marketing perspective, the main justification is to create brand-name recognition and loyalty, often through the use of emotive imagery. It is difficult to reconcile this aim with the type of information needed to make informed decisions about medicine use. Reminder ads have continued to be common on US television following the 1997 FDA guidance, as it did not include any restrictions on reminder advertising.

Most respondents, 58 or 55%, also opposed comparative price advertising, which is currently allowed in Canada. A recent review of Australian health protection legislation recommended against introduction of full DTCA, but in favour of introduction of comparative price

advertising, with strict criteria for the content of such advertising in order to distinguish it from reminder advertising: no images, limited font size, etc.³⁸

Consumer/non-profit representatives were mostly in support of comparative price advertising. This is logical given the mandate of consumer groups to represent the individual buyer. Fewer respondents from other sectors, around a third, supported comparative price advertising. It is likely to be of much less interest to public or private third party payers in that they are dealing with bulk rather than individual payment decisions. Pharmaceutical industry respondents were also mainly opposed to comparative price advertising.

A majority of respondents supported disease-oriented advertising, 58 or 55%. These are ads that mention a health condition but not a specific product. Pharmaceutical companies are allowed to pay for advertising to inform the public about specific diseases or health conditions in Canada as well as other industrialized countries that do not allow DTCA, as long as it is not product-specific advertising. Disease-oriented advertising is subject to few regulatory controls, and messages about diseases are sometimes strongly linked to a treatment model involving drug therapy.³⁹ The World Health Organization cautions against advertising that exaggerates risks, stating that advertising aimed at the public "...should not take undue advantage of people's concern for their health."⁴⁰

Both Canada and New Zealand are undergoing legislative review with a view to changing the status of DTCA: Canada is considering deregulatory changes to introduce some form of full DTCA; New Zealand is considering tightening up its existing legislation and either restricting or banning DTCA. These reviews are in process in both countries, with neither having publicly announced a course of action. The individuals in government included in this survey are closely involved in these policy discussions, in Canada both on a provincial and federal level. One provincial government raised concerns about DTCA in a press release on health policies,⁴¹ but in general there has been little public commentary on DTCA at either a provincial or federal government level.

One of the differences between mass media advertising and brochures in doctors' offices or promotional Internet sites is the ability of mass media to reach a public that does not already

define itself as needing the product or necessarily having the treated condition. This has been viewed both positively and negatively, with proponents of DTCA claiming an effect in reaching under-treated and under-diagnosed people and critics raising concerns about fear-mongering and feeding into people's anxieties about their health, or "creating a nation of hypochondriacs".⁴²

CONCLUSIONS

The survey indicates a great deal of concern about the quality of information in DTCA, and the effects of prescription drug advertising on appropriateness of care and direct health care costs. No attempt was made to solicit opinions on indirect effects on health care, such as hospitalization rates, morbidity and mortality as there is no research evidence linking DTCA to longer-term impacts.

However, most respondents from the health professions, consumer and patient groups and government believe that DTCA has a negative impact on public understanding of drug therapy and disease risks, appropriateness of prescribing and drug use and physician consultations. If these beliefs accurately reflect the direction of effect of DTCA on knowledge and appropriateness of care, positive effects on hospitalization rates, morbidity or mortality would be unlikely. Short-term harm is unlikely to lead to long-term benefit. The one exception to this finding is doctor/patient communication. Unlike the other measures of appropriateness of care, opinions on doctor/patient communication were fairly evenly divided: 41% thought DTCA would have a positive effect, 38% a negative effect.

This survey found a great deal of support for the introduction of direct-to-consumer advertising of prescription drugs (DTCA) in Canada among pharmaceutical policy experts from the advertising and pharmaceutical industries in Canada, the United States and New Zealand, and to a lesser extent among representatives of patient groups, but very little support among policy experts from the health professions, government, private payers or consumer/non-profit groups.

The strongest recommendation, in terms of numbers of respondents, was against allowing full DTCA with monetary inducements such as free trial offers or reduced prices. Such prescription drug advertising is common in the US. Additionally, many respondents said that reminder advertising should not be allowed and that both billboards and television are inappropriate media

for prescription drug advertising. Canada has recently seen a plethora of billboard and television reminder advertising. Controversies about reminder advertising in Canada ⁴³ highlight the need to clarify current regulatory restrictions as they apply to reminder advertising, and if necessary introduce additional regulations to the Food & Drugs Act in the absence of broader legislative change.

This is an opinion survey, not a direct assessment of the empirical literature on outcomes of DTCA. The conclusions should therefore be taken as a reflection of expert opinion only. However, the survey raises serious concerns about the current proposed direction of policy change in Canada, particularly given the opinions expressed by policy experts in provincial and federal governments, as well as Canadian health professional and public interest organizations. From a public policy perspective, a shift leading to increased drug and physician costs might be considered if health care quality was expected to improve. If quality is largely expected to deteriorate, it seems hard to reconcile such a shift. //

APPENDIX A: SURVEY QUESTIONNAIRE

SURVEY ON DIRECT-TO-CONSUMER ADVERTISING OF PRESCRIPTION DRUGS (DTCA)

After Completion Please fax back to: 1 604 - 822 5690

Note: 'DTCA' refers to all ads for prescription-only medicines aimed at the public,
i.e. print, TV, radio, billboards etc.

1. How many different brands of prescription drugs have you seen advertised to the public in the last year?

- ¹ None
- ² 1 to 5
- ³ 6 to 10
- ⁴ More than 10
- ⁵ No comment or don't know

2. Since the mid 1990's, the volume of spending on prescription drug promotion aimed at the public has grown enormously. How much has this growth affected the work of your organization and/or its members?

- ¹ Substantial effect on organization/members' work
- ² Moderate effect on organization/members' work
- ³ Little to no effect on organization/members' work
- ⁴ No comment or don't know

3. Overall, what is the quality of information on drug benefits and risks in DTCA?

- ¹ Excellent
- ² Good
- ³ Poor
- ⁴ Very poor
- ⁵ No comment or don't know

*What evidence have you seen to support this view?
[Please mark all that apply]*

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

4. How do you think DTCA affects the public's understanding of drug therapy?

- ¹ Improves public understanding
- ² Worsens public understanding
- ³ No effect on public understanding
- ⁴ No comment or don't know

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

5. How do you think DTCA affects the public's understanding of disease risks?

- ¹ Improves public understanding
- ² Worsens public understanding
- ³ No effect on public understanding
- ⁴ No comment or don't know

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

6. How do you think DTCA affects doctor/patient communication?

- ¹ Improves communication
- ² Worsens communication
- ³ No effect on communication
- ⁴ No comment or don't know

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

7. How do you think DTCA affects the frequency of patient visits to doctors?

- ¹ Increases the frequency of visits
- ² Decreases the frequency of visits
- ³ No effect on frequency
- ⁴ *No comment or don't know*

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

8. How do you think DTCA affects the appropriateness of visits to doctors?

- ¹ Increases the appropriateness of visits
- ² Decreases the appropriateness of visits
- ³ No effect on appropriateness
- ⁴ *No comment or don't know*

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

9. How do you think DTCA affects prescribing?

- ¹ Increases the appropriateness of prescribing
- ² Decreases the appropriateness of prescribing
- ³ No effect
- ⁴ *No comment or don't know*

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

10. How do you think DTCA affects patients' use of prescription drugs?

- ¹ Increases appropriateness of use
- ² Decreases appropriateness
- ³ No effect
- ⁴ *No comment or don't know*

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

11. How do you think DTCA affects public spending on prescription drugs?

- ¹ Increases spending
- ² Decreases spending
- ³ No effect
- ⁴ *No comment or don't know*

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

12. How do you think DTCA affects private spending on prescription drugs? (out-of-pocket, private insurance and health care companies)

- ¹ Increases spending
- ² Decreases spending
- ³ No effect
- ⁴ *No comment or don't know*

What evidence have you seen to support this view?

- ⁵ own experience with DTCA
- ⁶ published or unpublished empirical studies on DTCA
- ⁷ indirect empirical studies [not on DTCA]
- ⁸ theoretical analyses or expert opinion
- ⁹ little to no evidence

13. In settings where DTCA is allowed, how soon after a drug is first marketed should advertising to the public be permitted?

- ¹ Immediately
- ² Six month post market launch
- ³ One year post market launch
- ⁴ Five years post market launch
- ⁵ Following patent expiry
- ⁶ *No comment or don't know*

14. In settings with DTCA, should limits be set on which prescription drugs may be advertised to the public?

- ¹ No comment or don't know
- ² No
- ³ Yes If yes, base limits on:[mark all that apply]
 - ³ health condition
 - ⁴ drug safety profile
 - ⁵ drug efficacy profile
 - ⁶ whether payment is public or private

15. Should DTCA campaigns specifically target the following population groups?

- A. The elderly ¹ Yes ² No
- B. Women ¹ Yes ² No
- C. Men ¹ Yes ² No
- D. Adolescents ¹ Yes ² No
- E. Children ¹ Yes ² No
- F. Low income people, disadvantaged groups ¹ Yes ² No

16. How appropriate or inappropriate are the following types of media for DTCA?

	Very appropriate		Neutral		Very inappropriate	
A. Magazines	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁵
B. Television	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁵
C. Billboards	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁵
D. Internet	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁵

17. In your opinion, should the Canadian government allow the following types of prescription drug ads?

Note: Canada is currently considering legislative change.

	YES	NO
A. Full DTCA, including product name and health claims	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
B. Full DTCA as above, with 'free trial offers' or price reductions	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
C. Disease-oriented advertisements with no product name	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
D. Reminder ads [brand name, images, but no health claims]	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
E. Comparative price advertising [name, quantity and price only; no images or advertising text; joint lists of competing products]	<input type="checkbox"/> ¹	<input type="checkbox"/> ²

18. Does your organization have an official policy or position on DTCA?

- ¹ No
- ² Yes Please briefly describe: _____

19. Have you or your organization researched DTCA's effects on costs, health, or use of health care services?

- ¹ No
- ² Yes Please explain: _____

Type of organization
[please mark best fit]

- ¹ health professional organization
- ² consumer group
- ³ disease-specific patient group
- ⁴ pharmaceutical industry
- ⁵ advertising industry
- ⁶ media / publishing
- ⁷ government agency
- ⁸ private health or drug insurance
- ⁹ other, please specify _____

20. Comments?

PLEASE FAX THIS QUESTIONNAIRE TO: (1 604) 822 5690

APPENDIX B:

Additional Written Comments on Questionnaires, by sector and country

NON-PROFIT/CONSUMER GOUPS – CANADA
DTCA should never be allowed for historical reasons, the experience with thalidomide. There is also experience with the heavy marketing of thalidomide overseas, leading to increased sales and increasing negative results. The fear is that history would repeat itself.
DTCA should be banned, except for comparative price advertising.
We are against all DTCA.
We are opposed to the introduction of DTCA in Canada.
We support the current prohibition and urge more stringent monitoring and enforcement.
NON-PROFIT/CONSUMER GROUPS – NEW ZEALAND
We don't think DTCA is appropriate but recognize reality and so call for restraint and controls.
We support prohibition of DTCA. DTCA in New Zealand is of poor quality in terms of information. Ads are all 'image' not facts. Complaints are difficult and time-consuming and there is no natural counterbalance to drug companies. Individuals are unlikely to complain. Ads only talk about the product. They do not provide options or alternatives, which goes to the heart of informed decision-making.
NON-PROFIT/CONSUMER GROUPS – USA
We support improved regulation, including full disclosure of risk information.
We support full risk disclosure, with fair balance and adequate context, easy access to information. We have carried out a consumer survey on medicine use and attitudes and two roundtables on DTCA, as well as developing a consensus document with recommendations to FDA and industry. These include proposed guidelines for DTCA, approved by consumer groups, health professionals, and pharmaceutical companies.
DTCA should be regulated to assure balance, accuracy and disclosure of potential adverse effects.
NON-PROFIT CONSUMER GROUPS – USA, Continued
We want DTC regulations written.
We criticize DTCA all the time. Do everything you can to keep DTCA out of Canada.
We oppose DTCA but if it exists the risks must get EQUAL attention - font size, time, etc. We have analyzed magazine ads to determine the presentation of risk information
We prefer controls on the type of information in DTCA, not the types of medications advertised.

DISEASE/ PATIENT GROUPS – CANADA
The present Canadian situation is a maximum. We would prefer better control of what is allowed.
The quality of DTCA is currently poor. That is why I marked 'no effect' on public understanding of drug therapy. It needs to be improved so it can improve doctor/patient communication. What DTCA should be is not what it is now.
We are opposed to DTCA. More funding is needed for education. Tighter controls are required, mandatory transparent review process for advertisements, as well as a mandatory transparent reporting system for violations.
DISEASE/PATIENT GROUPS – NEW ZEALAND
We see DTCA as being of benefit to our members, people with a chronic disease. They tend to be long-term prescription drug users, use various drugs and are proficient at their use, in many cases with variation in their use depending on various needs. The ability to access new types of drugs is something they see as a benefit to themselves given the information they are able to receive through DTCA. Also, our organization gains support through sponsorship and advertising gained from various pharmaceutical companies. We think that DTCA is of more benefit than loss. Any 'losses' include patients knowing more than their doctors about new products on the market.
GOVERNMENT, PROVINCIAL AND FEDERAL – CANADA
An extra comment on the question about appropriateness/ inappropriateness of various media: all media are inappropriate for publicly funded drugs.
We have consistently supported a position of opposition to DTCA and support for regulation by Health Canada.
We have certainly seen a significant increase in client demand for products based on DTCA. Physicians and pharmacists also indicate to us concerns over patient demand as a result of DTCA.
We oppose DTCA.
We are strongly opposed – unless there is evidence to support the use of DTCA.
Advertising=marketing=selling drugs. In the US, where DTCA is permitted, what are the costs of policing regulations, in terms of money and staff? This needs to be considered. More general information on diseases is warranted ahead of prescription drug ads. More emphasis should be placed on prevention and non-drug therapies.
DTCA has no proven health benefits and real potential for harm. If you want to see the impact of DTCA on consumers, look at what direct-to-doctor marketing has done to prescribing.
In terms of research on DTCA, we review products with high utilization growth which usually also have DTC advertising. Pharmaceutical CEO's are now being chosen for their experience marketing products to the public (press clipping example enclosed). A second enclosed US press clipping draws the link between high drug prices and spending on promotion. "The subcommittee found, however, that the 22 largest pharmaceutical manufacturers were spending 24 cents of every revenue dollar on promotion. This was approximately four times their spending on research." [Mintz M. What's new about prescription... Washington Post, Feb 10, 2001 pB01]

GOVERNMENT, PROVINCIAL AND FEDERAL – CANADA, CONTINUED
I doubt DTCA helps prescribers to better prescribe and patients to better use drugs. It increases drug utilization, sometimes for the best, but also with costs and risks of inappropriate prescribing and use. My comments are based on my own analysis and my understanding of determinants of prescribing following about 15 years of observation.
I believe there should be DTCA with EQUAL TIME AND EQUAL SPACE for a balancing message from Health Canada. This would be permissible under the Charter of Rights & Freedoms, as are health warnings on cigarettes.
I disagree with DTCA
I support the current federal government position.
DTCA usually worsens understanding of drug therapy and disease risks but there have been a few exceptions, where it improves public understanding. It is likely to decrease appropriateness of visits more than increase appropriateness, but both are likely to occur.
It would have been useful to have a no comment/ don't know option on the targeting of specific population groups.
The effect of DTCA on doctor/patient communication is likely to depend on the specific therapy and disease. We need to consider the current underutilization of drug therapies for some diseases. DTCA may help in patient education in these situations.
GOVERNMENT – NEW ZEALAND AND USA
We are generally against DTCA.
A review is underway and an official policy is to be developed. In terms of the question on time frames for DTCA: it would be very difficult to enforce any post launch time frame.
We welcome New Zealand's legislative review and are opposed to product-specific DTCA (submission to New Zealand Ministry of Health provided). It includes results of research on effects on drug utilization as well as outlining the key issues and our position. In terms of research, we have also looked into the legal issues, possible legislative change (1998-9)
We are against DTCA
We are in the process of developing a position on this issue.
There is no US law against DTCA and there are both potential health benefits and risks with this form of advertising. In terms of the targeting of specific population groups, why not target any campaign appropriately?
PRIVATE PAYERS – CANADA AND USA
We are opposed to DTCA as it exists in the US.
DTCA must be oriented towards patient empowerment to take care of his or her health condition.
More stringent oversight is needed.
DTCA is a complex phenomenon, producing benefits but also unquestioningly inducing the use, possibly inappropriate, of some prescription drugs.

HEALTH PROFESSIONALS – CANADA

Too much information is presented in too short a time to be absorbed by the listener. DTCA places increased pressure on doctors to prescribe newer and more costly treatments. Doctors are under pressure to spend more time with patients and explain new therapies. The outcome would be positive if this were done; the more discussion of their therapy, the better. DTCA may not lead to the most cost-effective treatment of their condition, however. There should be ample evidence from third party programs in the US for the demand for new drugs stimulated by DTCA.

On the organization's policy: while there is discussion on this policy and concern over increasing costs of drug therapy and change in the traditional channels of distribution for drug information (less to health professionals and more to the public), no policy has been enunciated at this time.

The Canadian Medical Association opposes the legalization of DTCA.

DTCA increases awareness of new drug therapies. I'm not sure that this leads to increased understanding. It is likely to lead to more dialogue between doctors and patients. On its own, I am not sure that DTCA improves communication. Prescription rates do go up. I would hope they are appropriate. If DTCA goes ahead how will this be monitored and policed and how will the industry be held accountable?

We oppose DTCA, but support the need for better health and drug related information for consumers to make informed choices.

I found it difficult to answer some questions because I do not approve of DTCA because the present quality of prescribing is generally poor, in terms of appropriate use of medicines, and will be worsened by DTCA. The industry favours it because it will increase sales, and not appropriate use.

HEALTH PROFESSIONALS – NEW ZEALAND

The following is a personal opinion, not organizational consensus. DTCA marginally improves public understanding of drug therapy, when patients come to me and I explain something they may not otherwise have asked about. This gets communication going. As a doctor you don't communicate with patients who are not there.

Support full DTCA if it includes the product name and health claims and also information on risks, side effects, contraindications.

We support DTCA.

ADVERTISING INDUSTRY – CANADA

By allowing access to drug information/advertising provided by the source of most available drug information, the pharmaceutical industry, consumers would be in a better position to participate in their own health care. We do not need to use the US system, we can take the best parts of it and add whatever we want to make it work within a Canadian context.

With the growing spill effect of DTCA from the US into Canada, we believe strongly that 'made in Canada' guidelines could reduce confusion, aid in Canadian understanding and perhaps even improve on the US model. Regulated DTCA will assist public in gaining information on prescription drug treatments.

I believe DTCA is a good communication tool to the consumer as long as the information is presented in a balanced manner, that is, equal emphasis on both the risks and benefits of the product. Mandatory review should be enforced to avoid dissemination of inaccurate and unbalanced information. This is especially true for DTCA on TV or radio where the consumer is referred to a toll-free line or an Internet site. Content of both media must be carefully reviewed so that the consumer is not misdirected to bad information. DTCA should be allowed after a minimum of 3 months after launch, so health care professionals have the time to digest new information.

ADVERTISING INDUSTRY, NEW ZEALAND

We support DTCA, industry self-regulation and pre-vetting of advertisements

We are in favour of DTCA.

We support DTCA, provided that it is monitored by a stringent industry code of standards, enforced through mandatory pre-vetting. In my opinion, advertising for Rx drugs is very responsible, exhibits a higher standard for social responsibility than other products (although I would argue that this is both appropriate and desirable). I think the problem lies with advertising for complementary medicines, which frequently made quite unsubstantiated claims and which did not disclose any critical details, such as contraindications. The TAPS (pre-vetting) system now catches these ads so I expect that the problem will diminish over time.

In New Zealand, there has been a lot of media hype about the supposed consequences of DTC. The drug funding agency (PHARMAC) claims that DTC will lead to budget blow-outs as pressure to subsidize new advertise brands increases. However, I have seen no evidence to support these claims. Similarly doctors claim that patients are wasting their time requesting drugs that do not suit their conditions. Again, there is no empirical evidence to document the existence or extent of this problem. I am not suggesting that these problems do not or cannot exist, simply that their status is more speculative than real at present.

We support a policy of responsible industry self-regulation.

ADVERTISING INDUSTRY AND MEDIA – USA
I am in full support of DTCA. Consumers have a right to know about treatment options. Government fears about DTCA, and those of the medical community, do not supercede that basic consumer right.
DTCA improves patient understanding of disease and communication with physicians, but undeniably drives up demand (often justifiably) and increases overall health care costs. Thus Canadian government roles as guardian of public health and the public purse are in conflict.
PHARMACEUTICAL INDUSTRY – CANADA
American ads are seen in Canada. Canadian policies should be harmonized with the USA.
We are against expanding DTCA and support full enforcement of the existing legislation.
The consumer has a right to be informed. Shifts away from self-care due to prescription drug advertising should be considered during policy development. Prescription drug advertising should indicate that the product only available by prescription, following consultation with a doctor.
PHARMACEUTICAL INDUSTRY – NEW ZEALAND
We are in favour of good quality, balanced DTCA.
We support responsible DTCA within industry guidelines.
We support DTCA if it meets sound legal standards for socially responsible advertising. DTCA should be allowed when health professionals have been informed and independently assessed for awareness of the product.
This questionnaire is inappropriate. Limited and directed questions will receive limited and restricted answers. The results will be of little value.
PHARMACEUTICAL INDUSTRY – USA
We favoured the 1997 FDA changes to have fewer restrictions on broadcast advertising. DTCA enhances consumer knowledge about diseases and treatments. It also fosters competition among products, which can lead to improved quality and lower prices for consumers. Most importantly, DTCA can improve public health. It helps start a dialogue between patients and doctors.
We are generally opposed to DTCA.

APPENDIX C:

Organizational affiliations of survey respondents, by country

CANADA

Advertising Standards Canada
Alberta Health
Alliance for Access to Medical Information
BC Ministry of Health and Ministry Responsible for Seniors
Canadian Cancer Society/National Cancer Institute of Canada
Canadian Diabetes Association
Canadian Health Coalition
Canadian Nurses Association
Canadian Pharmaceutical Association
Canadian Pharmacists Association
Canadian Society of Hospital Pharmacists
Canadian Treatment Advocates Council
Canadian Veterinary Medical Association
Canadian Women's Health Network
CIHI (Canadian Institute for Health Information)
Compagnie d'Assurances SSQ
Conseil Consultatif de Pharmacologie, Quebec
Consumers Association of Canada
D.E.S. (diethylstilbestrol) Action Canada
Department of Medicine, University of Toronto; Canadian Medical Association
Drug Plan and Extended Benefits Branch, Saskatchewan Health
Extended Benefits and Pharmaceuticals Program, Yukon Territorial Government
Faculty of Medicine, Memorial University
Faculty of Pharmacy, University of Montreal
Financial and Management Services, Northwest Territory Department of Health and Social Services
Green Shield Canada
Home Care and Pharmaceuticals Division, Health Canada
National Association of Pharmacy Regulatory Authorities
National Drug Manufacturers Association of Canada
Non-Insured Health Benefits Medical Services Branch, Health Canada
Nova Scotia Department of Health
Ontario Lung Association
Ontario Teachers' Insurance Plan
Pharmaceutical Advertising Advisory Board
Pharmaceutical Consultant Group, Manitoba Health
Pharmaceutical Issues Committee (Manitoba, P.E.I., Nova Scotia representatives)

Pharmaceutical Programmes, Alberta Health
Physicians for a Smoke Free Canada
Prescription Drug Program, Department of Health and Wellness, New Brunswick
Provincial Drug Program, Manitoba Health
RhoXalPharma
Rx&D, Canada's Research Based Pharmaceutical Companies
School of Business, Concordia University
Stroud Consulting Inc.
Thalidomide Victims Association of Canada
Therapeutics Initiative
Therapeutics Products Programme, Health Canada (Advertising and Promotion Unit; Policy and Planning)
Unité Coordination des Affaires Pharmaceutique, Ministère de Santé et des Services Sociaux
Working Group on Women and Health Protection

NEW ZEALAND

Advertising Standards Authority
Association of New Zealand Advertisers Inc.
Asthma and Respiratory Foundation of NZ
Consumers Institute
Department of Marketing, Massey University
Diabetes Wellington
Glaxo Wellcome (NZ)
Janssen-Cilag Pty Ltd
Medsafe, Ministry of Health
Merck Sharp & Dohme (NZ) Ltd
Minister of Health's Office, Parliament House
Ministry of Health
New Zealand College of Pharmacists
New Zealand Medical Association (policy statement only)
PHARMAC
Pharmacy Guild of New Zealand
Royal NZ College of General Practitioners
School of Pharmacy, University of Otago
Therapeutic Advertising Pre-vetting Service
Women's Health Action Foundation

UNITED STATES

American Academy of Pediatrics
American Association of Retired Persons
American Pharmaceutical Association (policy statement only)
Blue Cross and Blue Shield
Center for Medical Consumers
Division of Marketing, Advertising and Communications, U.S. FDA
Employee Benefit Research Institute (EBRI)
Group Health Cooperative of Puget Sound
Health Insurance Association of America
I-Beacon
Institute for Health Policy Studies, School of Medicine, University of California – SF
National Association of Pharmaceutical Manufacturers
National Center for Policy Research on Women and Families
National Consumers League
National Health Law Program
National Institute of Health Care Management
No Free Lunch
PEC (Department of Defense)
Pharmaceutical Research and Manufacturers of America
Premera Blue Cross
Prevention Magazine
Public Citizen Health Research Group
Rx Health Value
Schneider Institute for Health Policy, Brandeis University
Time Magazine

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