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Introduction

The pharmaceutical industry is one of the world's most dynamic market sectors. The investment in research and development is considerable and the risks associated with any new product are extremely high. In addition it is a market highly regulated in most countries in the world.

From a marketing perspective the industry can be segmented, albeit not precisely, into those drugs freely available for sale 'over the counter' (OTC) and those that may only be obtained by prescription. OTC drugs are offered for self-medication purposes with or without the recommendation of health professionals (Hester 2005). Prescription drugs, however, can only be obtained with a prescription issued by a physician or certain other healthcare practitioners and only dispensed by registered pharmacists (Keynote 2008). According to Datamonitor (2009) the global market for prescription drugs is \$644bn with \$187bn of that from Europe. The UK market was estimated at \$25.7bn and forecast to rise to \$28bn by 2014.

Prescription drug marketing like tobacco and alcohol, are seen as controversial and even a "taboo" until quite recently (Huh et al 2006, Cox and Cox 2010). There is much controversy surrounding DTCA of prescription drugs but despite this, advertising budgets continue to grow (Mehta and Purvis 2003).

In the UK, the advertising of prescription drugs is regulated by a combination of domestic and European regulation (MHRA 2005). Prescription drugs can only be promoted to physicians or other healthcare professionals and not to the public at large (ABPI 2010). In the UK, as in the rest of the European Union, only non-prescription (or OTC) drugs can be advertised direct to the public. Although there is a general ban each jurisdiction interprets the level of restriction. In the UK, for example, disease awareness campaigns sponsored by pharmaceutical manufacturers are allowable under the regulations, but not the promotion of individual prescription brands

DTCA drug advertising – evidence from the US and NZ

In only two regulated markets in the world is direct to the consumer advertising (DTCA) of prescription drugs permitted. Legislation in the United States of America and New Zealand legislation is interpreted such that it does not inhibit (as opposed to specifically allow) the advertising of prescription drugs. In the US it emerged in the early 1980s as a result of a regulatory loophole (Hoek and Maubach 2005) when legislation introduced in 1969 was challenged as contrary to the First Amendment which stated "Congress shall make no law prohibiting freedom of speech". The first product-specific prescription advertisement was released by Boots Pharmaceuticals, the US subsidiary of Boots UK and quickly followed by other producers including Merck, Sharp and Dohme and Eli Lilly. The US Food and Drug Administration (FDA) had nominal jurisdiction in this field but rather than try to oppose it the FDA called on the industry to impose a voluntary moratorium while they studied consumer reaction. Several studies were undertaken. One suggested US consumers wanted more information about prescription drugs whilst another concluded that consumers retained more information about drug benefits than risks (Palumbo and Mullins 2002). In 1985 the FDA lifted the moratorium determining that DTCA of prescription drugs were allowable provided they met the same standards applicable to advertisements targeted at physicians. In

New Zealand the introduction of the 1990 Human Rights Bill's freedom of speech legislation was interpreted as removing barriers to the advertising of prescription drugs. Given the new regulatory framework pharmaceutical companies perceived NZ legislation as being analogous to the US Constitution and proceeded to introduce DTCA (Wolf 2002). As in the US, NZ regulators did not predict how quickly DTCA of prescription drugs would spread. Research has been more limited than in the USA. Nevertheless Hoek et al (2003) conducted a national survey which enabled a comparison to be made with the FDA surveys made around the same time (see figure 1). This comparison showed that over 40% of New Zealanders were concerned that DTCA would affect their relationships with their doctors and two-thirds doubted it would improve discussion with physicians. US consumers were significantly less pessimistic. In both countries significant numbers of consumers believed DTCA inflated the drugs benefits and even more wanted more information on the risks and side effects. Over half of New Zealanders felt it would improve health decision-making whereas in the US it was around a third. In both countries, however, the large majority of consumers believed that DTCA helped raise awareness of new drugs.

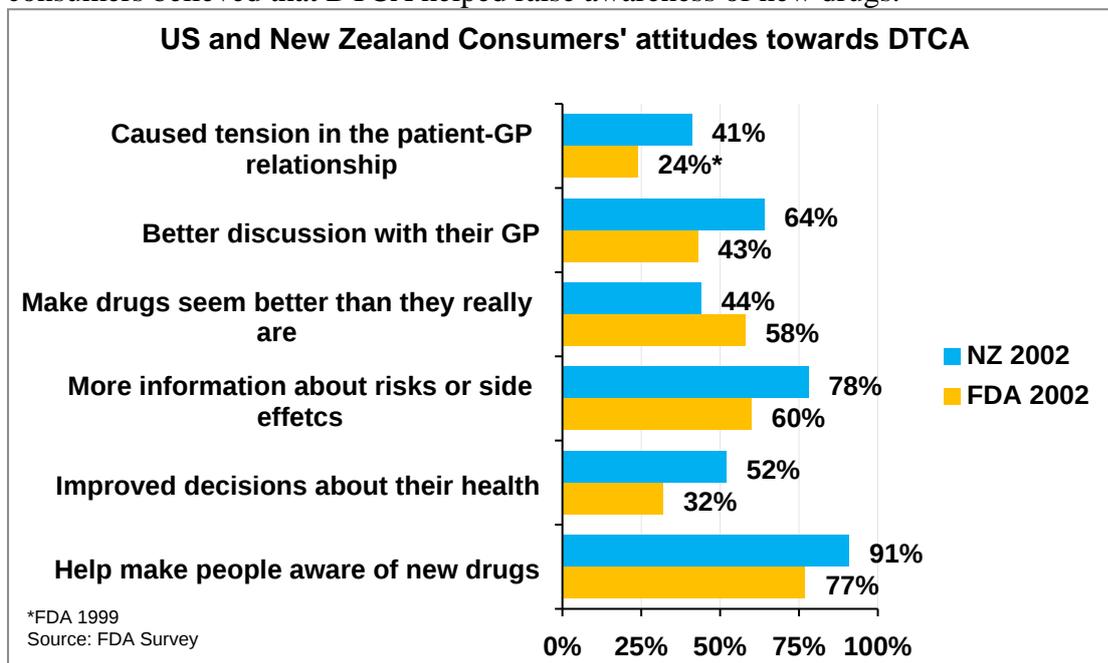


Figure 1 US and NZ Consumers' attitudes towards DTCA

Both US and NZ pharmaceutical companies took the view that explicit, DTCA would benefit sales. By 2009 \$4.3bn was being spent in the US on DTCA an average of over \$50m per drug (IMS Health 2010). Although a considerably smaller market, New Zealand DTC prescription drug advertising expenditure has also grown rapidly from \$11.6m in 1999 to \$38m by 2004 (Hoek 2008). Research in both countries suggest that this promotional effort may pay off. Metz (2007) reports that DTCA has changed how patients and physicians interact. In over 40% of cases where patients request an advertised drug a prescription for it is issued.

In Europe a proposal to allow pharmaceutical companies to advertise products associated with a limited number of health conditions was rejected by the European Parliament in 2002 (Auton 2004). According to Eagle and Kitchen (2002), however, the experience of the US and NZ provide a foundation for informed debate. The discussion that has taken place has tended to be at the health industry level.

Benefits of DTCA of prescription drugs

Proponents of DTCA of prescription drugs claim it encourages individuals to seek advice for undiagnosed symptoms (Berndt 2005), “is an excellent way to meet the demand for medical information, empowering consumers by education about health conditions and possible treatments” (Holmer 1999) or that it empowers patients to take a more proactive role in their healthcare by promoting more informed patient-physician discussion (Mehta and Purvis 2003, Spake and Joseph 2007). Opponents note that such promotion is no better than that of fast-moving consumer goods (Toop and Richards 2003) despite the product’s complexity and potential side-effects. Consumers may not fully comprehend the risks associated with a drug’s use (Mehta and Purvis 2003). The claim is also made that benefit-based advertising may potentially lead to consumer pressure based on false expectation rather than rational diagnosis (Lexchin and Mintzez 2002) and impact the patient physician relationship (Hollon 1999). Currently European governments tend to give more credence to those negative effects on society’s welfare (Fiscer and Albers 2010). Major European bodies such as the UK Consumers Association, Amsterdam-based Health Action International and Brussels-based Bureau Européen de Unions de Consommateurs actively oppose direct to consumer advertising although some, including the UK Patients Association, take a broadly supportive stance of awareness campaigns if they remain unbranded (Reast et al 2008). In the case of the UK Consumers Association their opposition was supported by a survey which suggested only 25% of respondents believed that drug manufacturers would provide unbiased and reliable information (Reast et al 2004). UK physicians, meanwhile, have, in surveys conducted over the past 10 years, consistently opposed DCTA of prescription drugs (Reast and Carson 2000, Reast et al 2004, Reast et al 2008) perhaps because it is perceived to give drug companies influence in the patient-doctor relationship (Huh and Becker 2005). Knowledge of the public’s appreciation of the issues surrounding DTCA is still, however, poor (Hoek 2008) and there has been little independent consumer-based research probably owing to its current prohibition (Reast et al 2008). This research, therefore, seeks to throw light on the UK consumers attitudes to the promotion of prescription drugs.

Methodology

This research seeks to shed light on the UK consumer’s attitude to DTCA of prescription drugs relating to the future relaxation of legislation in the UK. It does not seek to measure support or opposition at the current time *per se*. Rather it is looking to establish those issues that are paramount in consumers’ minds relative to such a change. The research objectives developed therefore are:

- To explore consumer attitudes towards direct to consumer advertising of prescription drugs
- To investigate consumer reactions to TV and press advertisements from the US and NZ
- To identify areas of resistance to DTCA among consumers.

The philosophy underpinning this research is an interpretivist one in that the social reality is subjective and shaped by perceptions (Creswell 1994). It will utilise qualitative techniques to draw results from empirical observation. As there is little research about the UK context it should be seen as an exploratory study which seeks to look for patterns of meaning rather than the testing of hypotheses (Collis and Hussey 2009). A total of 16 in-depth interviews took place and a further 12 respondents took part in two focus groups. The decision to use both individual interviews and focus groups was made to establish whether, in the latter, society-based pressures may give rise to issues that might not be forthcoming in one-to-one

interviews. Non-probability, convenience sampling was used, however, given the nature of the research a broad representation of ages and balance of genders was achieved albeit with geographical limitations. The focus groups were segregated by age with participant in the first ranging from 20 to 35 years of age and the second from 45 to 70 years. This contrasted with most US and NZ research on DTCA which focused on consumers over 35 although younger consumers are just as likely to be exposed through mass media (Baca et al 2005).

The group dynamics were ordered by a moderator using a previously prepared interview guide (Morgan 1998). As consumers would not, in the ordinary course of events have been exposed to DTCA television advertisements and press advertising from the USA and NZ were available for viewing prior to the interviews and focus groups.

The researcher complied with the ICC/ESOMAR International Code on Market and Social Research 2007 (Esomar 2007).

Findings

The findings of this study suggested that, although there were areas of general agreement, there were a number of disparities between consumers of both age groups and amongst interviewees and focus groups. Having been shown advertising emanating from the US and NZ (on products also available in the UK) there was more concern on the cultural approaches to advertising than the products themselves. As one interviewee noted about one US example 'those advertisements are too American'. As regards content the majority of younger respondents saw limitations in the claim that this type of advertising offers health education whereas older respondents were generally more positive. In general younger participants felt these advertisements attempted to give too much information leading to confusion whereas older consumers were less complaining about style and content. Many younger participants felt the advertising played upon fear. As one noted it 'tries to manipulate people's emotions'. Older respondents in general believed that this advertising was presented in a reasonably responsible way. Despite a general negativity in relation to the advertising, particularly amongst the younger age groups, most respondents believed that DTCA (presumably formatted to UK cultural norms) could provide information that would empower the consumer. The exception to this was amongst members of the older focus group who felt much of this advertising would be too technical and confuse consumers by providing too much information. Attitudes regarding providing information on side-effects in both age groups were mixed. Some felt it important that there be a balance of information between potential benefits and downsides whereas others believed this, in the words of one respondent, 'put them right off'. There was general agreement that DTCA of prescription drugs could prompt early diagnosis of a medical decision and as a reminder to adhere to existing drug therapy. However, there was discussion amongst older focus group members as to whether it would prompt many hypochondriacs to seek unnecessary help and waste their doctor's time. There was general agreement among participants that such advertising mitigated against the stigma attached to certain conditions (i.e. sexual dysfunction). As one focus group member noted 'this kind of information can act to reduce misconceptions and to improve communications'. The majority of respondents believed that, having been exposed to DTCA, they would be likely to ask for a drug by its brand name although there was general agreement that even branded drug names were confusing. However, the suggestion that a UK consumer ask a doctor to prescribe a particular drug did not sit comfortably with the majority of respondents. The vast majority of respondents would continue to rely on the physician to prescribe the appropriate drugs. Whereas they saw some benefit in being

empowered in any health discussion, particularly in an introduction, they reported high levels of trust in their doctors and saw them as the expert healthcare information providers and not the drug companies. This attitude was particularly evident amongst older focus group participants who, in general, believed such discussions were a potential cause of conflict and a waste of consultation time albeit unlikely to impact on the patient-physician relationship. Amongst older participants there were particularly high levels of trust in British physicians. Younger participants tended to feel they were held in over-high esteem and were prone to patronise but still trusted them to determine the best health care. There was general feeling that drug companies were contributing to overall wellbeing and that their spending on research was important. On the downside there was a general lack of trust in organisations making huge profits through, it was generally perceived, inflated pricing, particularly of branded goods.

Summary

This research looked at issues concerning the introduction of DTCA of prescription drugs from a UK perspective. The findings highlight concerns regarding the benefits and potential threats amongst UK consumers with particular attention to different age groups. There were also subtle differences between the attitudes of one-to-one interviewees and those emanating from focus groups. In general, considered discussion led to more negativity than in one-to-one interviews. In relation to previous research in the USA and NZ there were considerably higher levels of concern regarding the doctor-patient relationship. In relation to the USA, which has considerably less concerns, the emotional attachment in the UK to the National Health Service and the equally emotional opposition to 'socialised medicine' in the United States may, in part, be manifesting itself. In general it was felt that DTCA could promote initial discussion but should not dominate it and little support for the proposition that it improved health decisions. Again trust in the UK health professional to come to the right conclusion was paramount. There were some shared concerns that DTCA over emphasised benefits over side effects and relatively general agreement, in line with US/NZ research, on the benefits of advertising on promoting new drugs.

This research shows that there is no great demand from consumers to allow DTCA of prescription drugs and several deeply held concerns. The branded prescription drug industry will, however, continue to push for restrictions to be removed so the lobbying of national and supra-national governments will no doubt continue. The internet and, to an extent, satellite television, may *de facto* make the legislation sterile as it has in other areas of marketing (e.g. product placement regulations, television advertising regulations). Further research based upon this exploratory study may begin to reflect these changes.

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