Blurring the Boundaries: The Drug Industry as Health Care Provider

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Pharmaceutical Benefit Management Schemes (PBMs) have grown rapidly in the US during the 1990s. They first gained popularity as a means for health insurers, insurance companies, Health Management Organizations (HMOs) and large employers to cut drug costs because bulk sales allow PBMs to negotiate large discounts from manufacturers.[(151)] PBMs quickly grew to cover more than a quarter of all medicines sold in the US and originally did drive down prices, becoming a threat to industry profits.

According to a June 1997 exposé in *Money Magazine*,[(152)] the response from pharmaceutical companies has simply been to buy them: since 1993, Merck, SmithKline Beecham and Eli Lilly acquired the three largest PBMs in the US. Other companies made deals in which they paid PBMs to promote their products, such as the contracts Johnson & Johnson and Sandoz have with Value Rx, which has 27 million members, or Bristol-Myers Squibb and Pfizer with Caremark, which has 15 million members.

In two cases drug companies simply paid PBMs to list their products: "Diversified Pharmaceutical Services agreed in 1992 and 1993 to include a group of Merck drugs on its health-plan formularies in exchange for rebates," according to documents from a US court case.[(153)] In the second case, PCS, owned by Lilly, signed a contract with Pfizer agreeing to try to get its affiliated health plans to add a group of Pfizer products to their formularies and promote them for five years.

"Contrary to the conventional belief that managed care would depress the US pharmaceutical industry," reports *Scrip* in 1997, "it has actually driven up drug utilisation, causing the highest prescription growth rates the industry has every seen."[(154)] The growth has come from private managed care groups and is the result both of an increased use of prescription drugs and also from patients switching from older, less expensive drugs to newer, more expensive ones.

Unsurprisingly, given the close links between the PBMs buying drugs for managed care providers and major brand name companies, managed care has also done little to promote use of generic drugs. About 57% of all prescriptions within managed care are filled with branded products, the same proportion as within the overall US market.[(155)]

"We are allowing drug companies and their intermediaries to distort the practices of prescribing medicine as a result of discounts and rebates," says Dr Richard Wein, director

of surgery at Passaic General Hospital in New Jersey, US. “We are letting it happen without really knowing what the effects will be on patient health. And we are letting it happen in the name of cost cutting without any evidence that costs are being cut.”[156]

Dr Giacomo Buscaino, a New York cardiologist, says “I get phone calls asking me to switch my patients’ prescriptions about 10 or 12 times every day…I’ve been asked to switch specific patients to drugs that haven’t been proved to have the effects they need. I’ve been asked to switch patients to drugs that were more expensive than the ones they were on already.”[157]

Pharmacists are also under pressure to get doctors to switch their prescriptions to drugs covered by an HMO. Paul Hushin of New York says he spends two hours a day on the phone trying to get doctors to switch, and that “if I don’t make the substitutions, the managed-care plans and PBMs will take their business away from me, and I could lose 85% of my customers.”[158]

Formularies and other limited drug lists are an extremely useful way to ensure that only drugs shown to be effective, acceptably safe, and no costlier than equivalent alternatives, are used within a health service. The choice of drugs to include should be based primarily on health concerns and should not be hijacked for commercial reasons. A doctor working as a consultant to PBMs described work on drug lists: “At the sessions I’ve been in, the PBM says, ‘Here’s the list of drugs we want you to cover, because we already have national contracts in place with drug companies.’ It’s take it or leave it.”[159]

Given the pharmaceutical industry’s vociferous opposition to the introduction of restrictive formularies by governments, it is ironic that PBMs owned by drug companies are also introducing restrictive formularies.

Specialized clinics and disease management

Zeneca is the first company in the US to buy a chain of clinics which uses its products. Zeneca makes goserelin (Zoladex) a leading treatment for prostate and breast cancer. The company paid US$438 million for Salick Health Care, which runs the largest private chain of cancer clinics in the US. The departing chairman of the clinics raised concerns about the effects on doctors autonomy. A report in *The Lancet* raises concerns, “about the implications for care when a company controls drug manufacturing and use.”[160]

In France, companies are looking at disease management in the US as a model for targeted sales activities: “Pharmaceutical companies are also well-known for their ability to influence providers and patients’ behaviour, which is a cornerstone in any disease management programme,” write Peny and Dugue in *Scrip Magazine*. Therefore, companies, “should select a disease state where drugs play an important role.”[161]

RECOMMENDATIONS: Formulary development, health maintenance organizations

1. Health care providers, patients and payers need independent comparative information on

pros and cons of all available treatment options in order to ensure both that potential health and monetary costs do not outweigh potential benefits, and to be able to choose the least costly among equivalent alternatives. This could be provided through public financing of the development, regular updating and wide dissemination of treatment guidelines.

2. Financial independence should be a prerequisite for committee membership to develop formulary lists for Health Maintenance Organizations (HMOs) and other health care providers. Strict conflict of interest criteria should be developed, as well as full transparency, public accountability and consumer representation on formulary committees.

Sponsorship of public health facilities and activities

The National Health Service (NHS) in the UK is also looking into involving companies in disease management schemes. The UK National Consumer Council warns that this may not be beneficial for patients: "Disease management will involve blurring of the boundaries between the commercial sector and the NHS." They also recommend careful pilot studies assessing the impact on care and on health outcomes before implementing such schemes, and full information for patients on what a disease management scheme might offer and the extent to which a company will be privy to patient information which it could use for marketing and product development.[(162)] Recently the Calderdale and Kirklees Health Authority developed pilot disease management projects involving 23 companies. A report on the initiative notes that, "Pharmaceutical companies hope to gain audit information and data on compliance …" and that the health authority says that participating companies "regard it as a way of developing the market."[(163)]

In another move raising concerns about conflict of interest, Glaxo Wellcome will have a staff member based in the Southampton and South West Hampshire health authority's offices, "giving it an input into the health authority's purchasing of healthcare," according to Scrip.[(164)]

The UK Health Education Authority (HEA), the public agency responsible for health education, published a booklet in 1997 asking pharmaceutical companies to provide funding for health education campaigns and educational materials. The booklet, *Promoting health in partnership with the Health Education Authority*, states that the HEA is, "uniquely placed to work productively with the pharmaceutical sector on projects designed to promote health." A recent example of a joint campaign to promote use of folic acid by women is described in the booklet. This campaign was carried out "alongside partnerships with food and supplement manufacturers and retailers". The booklet uses a graph of monthly increases in sales of folic acid — not decreases in numbers of babies born with spina bifida — as a measure of the campaign's success. It goes on to state that the goal is, "to increase the supply of appropriate products and to promote them as widely as possible". The implicit promise of increased sales through funding of HEA educational campaigns is hard to miss. [(165)]

Whether this is in consumers' best interests is another question. The HEA says that it positioned the need for folic acid supplements as a women's health issue rather than a

pregnancy-related issue to promote widespread use. This may lead some women to take folic acid before an unplanned pregnancy. However, it is also likely to lead to unnecessary use of supplements by women who do not wish to have children or have already completed their families.

RECOMMENDATIONS: Sponsorship of public health services

1. Health care is and should remain a public responsibility. Governments with insufficient funds to provide health services need to look for solutions without the potential for conflict of interest.

2. If funding of public health services from private health corporations is sought, measures such as joint funding of blind trusts can be used to ensure independent control over allocation of resources.

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