

Regulation of Pharmaceutical Promotion: Why Does Regulation Matter?

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In the 1940s, the synthetic oestrogen, diethylstilbestrol (DES) was advertised around the world to “prevent miscarriages” and in healthy pregnancies “to make babies stronger”. The medicine was ineffective and women who took it ended up with a higher risk of breast cancer and their daughters, exposed *in utero*, developed reproductive tract abnormalities and, in some cases, a rare form of vaginal cancer (Giusti et al., 1995). In the 1970s, advertisements in Canadian medical journals told doctors that if children were “picky eaters” or “troublemakers”, they needed Atarax, a sedating medication (Canadian Family Physician, 1973). In 1990, the Medical Lobby for Appropriate Marketing (MaLAM, now renamed Healthy Skepticism) documented E. Merck’s promotion of Ilvico S to prevent colds and influenza in children under five. Ilvico S is an irrational combination of an antihistamine, a decongestant, vitamin C, phenazone and sodium salicylate (MaLAM, 1990). In the 1990s, Parke-Davis’ sales representatives illegally promoted gabapentin (Neurontin) for a wide range of unapproved conditions (Harris, 2004). At the time, gabapentin was only approved in the US as an additional epilepsy treatment for patients whose primary treatment failed to adequately control the disease.

All of these situations occurred because of inadequate regulation of pharmaceutical promotion. Health professionals are exposed to many types of promotion in their daily work. To varying degrees, regulations exist to govern these activities in order to ensure proper prescribing and to protect public health. This chapter uses specific examples of the intersection between pharmaceutical promotion and patient care to examine how well the current regulatory environment is meeting these goals.

Aims of this chapter

This chapter describes existing regulations and ethical codes for pharmaceutical promotion and provides an overview of the research evidence on the effectiveness of regulation. By the end of the session based on this chapter you should be able to:

- Describe how regulation of pharmaceutical promotion works in practice within two key regulatory models: direct government regulation and industry self-regulation;

- Compare national regulations with the World Health Organization's (WHO) *Ethical Criteria for Medicinal Drug Promotion*;
- Critically evaluate various codes or guidelines and identify strengths and weaknesses;
- Describe monitoring and enforcement systems in your country;
- Analyse specific promotional activity you encounter in terms of whether or not it breaches national laws, the WHO Ethical Criteria or professional codes.

Why regulate pharmaceutical promotion?

The pharmaceutical industry provides a valuable and legitimate contribution to society. At the same time, the pharmaceutical industry is a business and its profits are heavily dependent on marketing. The greater the volume of medicines sold, the greater the return on investments. Promotion is a key factor driving sales volumes. As the examples in the introduction show, when product sales are given priority over public health, promotion can lead to over-prescribing as well as poor quality prescribing and medicine use. This, in turn, leads to an increased risk of adverse effects and higher health-care costs. Prescribers often find themselves trapped between patients' needs and health-care priorities on the one hand and promotional influences on the other. Dual allegiances and conflicts of interest can cloud judgement and cause distortions in both the delivery of health care and the conduct of research in medicine.

Physicians, pharmacists, researchers, educators, managers and administrators need practical guidance on how to understand and manage their interactions with industry. At the same time, the pharmaceutical industry needs guidance about how to implement its marketing practices so that health outcomes are enhanced. The key ethical basis for any guidance is the understanding that the values of clinical care, of the welfare of society and of science should prevail over commercial imperatives and monetary concerns (World Medical Association, 2004).

A legal framework for regulation

Provisions in law governing pharmaceutical promotion usually include two key criteria concerning the information provided in advertising:

- It must be consistent with approved product information; and
- It must not be deceptive or inaccurate.

When a pharmaceutical product is approved for marketing, it is accompanied by approved product information. This specifies the use or uses for which the medicine has been approved (indication), dosage and administration, precautions and warnings and information on contra-indications, adverse effects and interactions with other medicines.

For manufacturers' advertising to be consistent with approved product information, it must stick to approved indications and conditions of use. For example, if a medicine has only been approved for epilepsy, a manufacturer may not advertise it for bipolar disorder or

depression. Physicians, on the other hand, can legally prescribe a medicine for whatever use they wish, within restrictions that may be imposed by employers and institutions. Prescribing for an unapproved use is called 'off-label prescribing'. This is often legitimate. For example, for many illnesses, there are no medicines approved for use in children. A manufacturer may apply for approval for an additional indication for its medicine. However, until that use is approved, the company cannot legally promote the medicine for that indication. A medicine may be approved for different uses in several countries, which also leads to variations in the promotional claims that can be made legally in different countries.

In practice, when regulators decide whether advertising is deceptive or accurate, they often base the decision primarily on whether it is consistent with approved product information. Sometimes key public health concerns remain unaddressed. For example, advertising of newer, broad-spectrum antibiotics for everyday problems may lead to unnecessary prescribing and contribute to the unnecessary development of antibiotic resistance. These advertisements may be technically consistent with product labelling but be highly inadequate from a public health perspective.

Beyond prohibition of 'off-label' and deceptive advertising, national laws may also prohibit specific activities such as direct-to-consumer advertising (DTCA) of prescription medicines. Promotional activities such as gifts to physicians and pharmacists in exchange for prescriptions or attaining specific pharmacy sales volumes may be covered under other laws that are not specific to pharmaceutical marketing, such as anti-kickback or anti-corruption legislation.

Regulatory standards can also go beyond the presence or absence of information. For example in the US, a 'fair balance' is required of benefit and risk information. In practice, this means that information on the harmful effects of a medicine must be present in every part of the advertisement. In countries without this provision, the advertising copy does not always contain information on a medicine's risks.

Key differences in regulation

One of the differences in regulation of pharmaceutical promotion between countries results from their different capacities to regulate medicines. In 2004, a survey of national governments by the WHO found that fewer than one-sixth of countries had a well-developed pharmaceutical regulation system and one-third reported that they had little to no regulatory capacity (World Health Organization, 2004). Slightly less than half of the countries (89) reported that they regulated pharmaceutical promotion in some way. However, the amount of staff time or effort devoted to this work can differ enormously.

Self-regulation versus government regulation

In many countries, most active regulation is carried out through voluntary codes and guidelines. Although governments in industrialised countries have the legislated authority to control promotion most have ceded nearly all day-to-day control over some or all aspects of pharmaceutical promotion to voluntary national industry associations. This approach is

called self-regulation.

Under self-regulation, regulatory activities are usually delegated to pharmaceutical or advertising industry associations or to organisations that include representation from a range of affected sectors ('multi-stakeholder groups'). These associations develop their own codes of standards and may pre-approve advertisements. They usually have formal procedures in place to respond to complaints about advertising or promotional activities. Many of these complaints come from competing companies. A key issue is whether breaching the voluntary industry code is equivalent to breaking the law. The problem here is that wording often differs and self-regulatory codes are not technically part of the law. Although governments can step in if a serious violation occurs, this rarely, if ever, happens.

An example of self-regulation and enforcement can be found in the UK. The British Medicines Act includes regulation of pharmaceutical promotion and the country's Health Minister is responsible for enforcement. However, this responsibility has been delegated to the Association of the British Pharmaceutical Industry (ABPI). The justification for this delegation is the industry's expertise and willingness and the Department of Health's ability to save money and staff time.

In a few countries, including France and the US, the government directly regulates pharmaceutical promotion. In the US, the Food and Drug Administration's Division of Drug Marketing, Advertising and Communication (FDA DDMAC) employs approximately 40 staff. By law, it cannot insist on pre-approval of advertising but companies must submit advertisements when they begin a campaign. In 2005, DDMAC staff examined some 53,000 promotional materials (Committee on the Assessment of the US Drug Safety System, Baciu, Stratton and Burke, 2006). If an advertisement is found to violate US law, DDMAC sends an 'Untitled Letter' to the company asking it to stop running the advertisement immediately and explaining why the advertisement was found to be illegal. More serious offences merit a second stage 'Warning Letter', which may require costly campaigns to correct misinformation, such as running corrective advertising or a 'Dear Health Professional' letter sent to all doctors. DDMAC's Untitled and Warning Letters are posted on the FDA's website (see: <http://www.fda.gov/cder/warn/warn2006.htm>). However, in 2002, the US General Accounting Office (the research arm of the US Congress) reported that recently introduced internal administrative procedures had resulted in a much slower regulatory response. This was especially problematic for DTCA on television. *"Without more timely action ... DTC advertisements that DDMAC (the relevant FDA division) has identified as misleading can remain on the air too long."* (United States General Accounting Office, 2002).

Five key steps in regulation

Whether regulation of pharmaceutical promotion is carried out directly by government or through industry self-regulation, there are five key components:

- National laws and regulations;
- The application of the law through codes and other standards;

- Monitoring of pharmaceutical promotion to ensure consistency with legal or other standards;
- Law enforcement with adequate sanctions to prevent violations; and
- Evaluation of regulatory effectiveness.

Even countries with adequate resources for regulatory oversight vary enormously in the extent to which they carry out any or all of these steps. There may be a law and a national code, but little enforcement and no sanctions for violations. In other cases, a functioning regulatory system is in place but no evaluation of regulatory effectiveness, for example, in ensuring that promotional claims support rational medicine use and public health goals. Ideally regular or ongoing evaluations should lead to changes in standards and the process of regulation, and these changes should, in turn, be evaluated. In practice, this rarely happens.

Regulatory oversight: far from perfect

The following section describes four hypothetical situations involving medicine promotion that you might encounter as a practicing physician or pharmacist. The first two involve forms of promotion that 'fall between the cracks' and are not covered by international industry codes or national regulation, although they involve common practices. The second two relate to the effectiveness of monitoring and enforcement. All could negatively affect patient care. In each case, existing approaches to regulation fail to provide adequate protection. Each example is presented with background information on the relevant regulatory code.

Situation 1: not covered in international industry standards

You work in a developing country without its own regulatory code. Under these circumstances, the only oversight of alleged unethical promotion is through the code developed by the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA), if the company involved is an IFPMA member. One day at the hospital, you notice that a sales representative working for a major multinational company is accompanying doctors on their rounds and is instructing them on how to treat individual patients. You file a complaint with the IFPMA but your complaint is rejected because the latest version of the IFPMA code that became effective on 1 January 2007 does not have any clauses dealing with the activity of sales representatives (IFPMA, 2006).

Background: history and evolution of the IFPMA code

Initially pharmaceutical companies voluntarily introduced ethical regulations in response to an emerging and growing public concern about the harmful effects of unethical pharmaceutical promotion on public health. In 1981, countries ratified the International Code of Marketing of Breastmilk Substitutes. In the same year, a network of consumer health organisations, Health Action International (HAI), called for a code of marketing for

pharmaceuticals, particularly raising concerns about examples of unethical marketing in developing countries. The IFPMA voluntary code was introduced shortly thereafter the same year. HAI described the IFPMA code as a bid to prevent WHO or national pharmaceutical regulatory agencies from taking stronger measures to control pharmaceutical promotion (Health Action International, 1987), and was highly critical of the code's content because of the weakness of standards and lack of active enforcement procedures. (Health Action International, 1988).

IFPMA member companies include all of the major multinationals as well as larger national companies and account for about 80% of world trade in pharmaceuticals by value. In countries without a national system of pharmaceutical regulation, companies that have endorsed the IFPMA Code recognise this as the primary standard governing pharmaceutical promotion. A substantial proportion of the IFPMA's 70 member companies and associations have their own national or regional voluntary codes. In this case, national or regional standards take precedence over the IFPMA Code, whether these standards are stronger or weaker.

Situation 2: covered in international standards that are not applied

While watching TV, you see an advertisement for a new medicine. Although the advertisement does not name the medicine, it does name the disease for which it is indicated and the advertisement uses a word play on the name of the product and shows the packaging. After watching this advertisement, you are sure that patients will be able to identify the new medicine and you are concerned that they will ask you to prescribe it. In your view, the new medicine is no better than existing medicines and you feel that your time with patients would be better spent on matters other than discussing this new medicine.

You decide to file a formal complaint with your country's authority that regulates television advertising and base your complaint on a provision in the WHO Ethical Criteria that states "*They [advertisements to the public for prescription drugs] should not generally be permitted for prescription drugs or to promote drugs for certain serious conditions that can be treated only by qualified health practitioners.*" (World Health Organization, 1988). Your country's government had recently voiced its support for these criteria at a World Health Assembly. However, your complaint is not upheld. You are told that these guidelines only apply to low-income countries and that the advertisement is legal because it did not state the name of the medicine.

Background: WHO Ethical Criteria

In 1986, five years after the first IFPMA Code was developed, a second international standard was developed for pharmaceutical promotion: the WHO Ethical Criteria for Medicinal Drug Promotion (published in final form in 1988). The Ethical Criteria were developed following the WHO Conference of Experts on the Rational Use of Drugs, held in Nairobi in November 1985 and were part of WHO's revised drug strategy, which highlighted the need not only to make sure that medicines are available to those that need them, but that guidance is available

to ensure appropriate use.

The WHO Ethical Criteria define promotion as “*all informational and persuasive activities of manufacturers and distributors, the effect of which is to induce the prescription, supply, purchase and/or use of medicinal drugs.*” They were developed as the result of a consensus involving health professionals, drug regulatory agencies, consumers and the industry, and so represent a broader viewpoint on appropriate marketing practices than either industry or professional codes.

The main objective of the Ethical Criteria is to support and encourage the improvement of health care through the rational use of medicines. The Ethical Criteria do not have legal standing, but are intended for use as general principles to be adapted by national governments developing legislation and as a standard for voluntary code development. They also provide an international ethical standard against which regulatory procedures and promotional activities may be compared.

Issues addressed by the WHO Ethical Criteria are:

- Advertising to physicians and other health professionals;
- Advertisements in all forms to the general public;
- Medical representatives;
- Free samples;
- Symposia and other scientific meetings;
- Post-marketing scientific studies, surveillance and dissemination of information;
- Packaging and labelling;
- Information for patients: package inserts, leaflets and booklets; and
- Promotion of exported drugs.

Some key provisions of the WHO Ethical Criteria include the principle that promotion should not be disguised as an educational or scientific activity, that undue advantage should not be taken of people’s concern for their health and that generally DTCA of prescription medicines should not be permitted.

Lists are also provided of information that should be included in all advertising and promotion, including, for example, the medicine’s brand and generic name, the name of the manufacturer and its approved indications. The aim is to ensure advertising provides a basic minimum of product information.

The WHO Ethical Criteria provide a broad set of principles that could be applied to many forms of promotion in both higher- and lower-income countries. Although successive World Health Assemblies, which include all UN Member States, have passed resolutions expressing support for the WHO Ethical Criteria, this international standard remains underused and in many parts of the world – especially industrialised countries – largely unknown.

Some aspects of pharmaceutical promotion have changed radically since 1988, when the

WHO Ethical Criteria were developed. For example, the Internet was not commonly used at that time, and there was less use of clinical experts as 'key opinion leaders' as part of a marketing plan for a specific brand. However, the principles of the Ethical Criteria - for example, that promotion should not be disguised or that all advertisements must include basic information, such as the generic name and adverse effects — are as applicable in all media today, including the Internet, as they were in 1988.

Situation 3: no enforcement

Your local medical association is going to mount a continuing medical education (CME) course and has sought the assistance of a pharmaceutical company in preparing the material that will be distributed at the course. The company has offered to provide slides for the speakers and you are concerned that these slides will bias the content of the course. You consult the code that your professional association has drawn up regarding interactions with pharmaceutical companies. There you find the statement that 'technical assistance' from industry in preparing educational materials is acceptable as long as the company "*has no input in the actual content of the material*" (American Medical Association, 1996). You complain to the professional association, which agrees with you but the event goes ahead as scheduled with industry involvement since the professional association has no way of enforcing its code.

Background: professional association voluntary codes

Many national health professional associations have developed ethical guidelines guiding their members' interactions with the pharmaceutical industry and participation in promotional activities. Professional organisations' codes tend to cover a wider range of promotional activities than industry codes but generally they are voluntary and lack any means of enforcement. The ability of professional associations to limit the industry's financial influence over their members' activities may also be hampered because professional associations are not free from industry influences. One example of this relationship was the heavy industry presence at the annual meetings of the American Psychiatric Association (APA) where companies paid the APA about US\$50,000 per session to control which scientists and papers were presented and to help shape the presentations (Vedantam, 2002). Unfortunately, so many academic physicians depend on the pharmaceutical industry for research funding that they tend to be reluctant to speak out about promotional abuses (Shapiro, 1997). Medical and pharmacy student associations also frequently take grants from pharmaceutical companies to support their activities.

Ambiguous standards can also create a barrier to effective implementation. For example, the American Medical Association's Code of Medical Ethics provision that CME faculty may accept 'technical assistance' from industry in preparing educational materials as long as the company "*has no input in the actual content of the material*" makes strict implementation of the 'no input' rule almost impossible. Even speakers' slides could be considered 'technical assistance'. The extent of the problem surrounding industry influence over CME should not be underestimated; Arnold S. Relman, former editor of the *New England Journal of Medicine* described existing CME as, "*a continuation of pharmaceutical marketing*

activities". (Relman, 2001).

Guidelines on gift-giving can be similarly ambiguous. In 1986, the Royal College of Physicians of London published the report *The relationship between physicians and the pharmaceutical industry* (Royal College of Physicians, 1986). The report tacitly approves the acceptance of trivial gifts, but emphasises that the costs of any gift, including teaching aids, are passed on to the public. One of the often quoted phrases is that "*doctors should avoid accepting any pecuniary or material inducement that might compromise, or be regarded by others as likely to compromise, the independent exercise of their professional judgement and practice.*" This recommendation is hard to implement in a meaningful way since individual doctors will have vastly different perceptions of what "*might compromise, or be regarded by others as likely to compromise ... their professional judgement and practice.*" (Bennett and Collins, 2002).

Professional organisations' ethical guidelines in principle represent a positive step forward in controlling pharmaceutical promotion and its harmful consequences on the public. However, without enforcement mechanisms or monitoring of their application, these voluntary codes have limited effects and may provide false reassurance. Additionally, if the professional associations are themselves financed by the pharmaceutical industry, and are unable to ensure independence of financed activities such as CME, they may be equally unable to oversee the independence of their membership. There is much scope for improvement, not only in the standards and types of activities covered by professional codes, but also in their application.

Situation 4: the price of doing business

A pharmaceutical company in your country is promoting a medicine with advertisements that make exaggerated claims about effectiveness and leave out information about serious, and possibly deadly, side effects. You are concerned that this type of advertising can cause serious harm to patients and complain to the national industry association. The association finds that the company is indeed violating the industry's voluntary code and requires the company to stop running the advertisements and issue a corrective notice in next month's national medical journal. The company runs a quarter-page announcement, which is published on one of the journal's back pages. However, the advertisement ran in several journals for a few months and it is very unlikely that the corrective notice reached all of those who were initially exposed.

Background: national industry codes

Over 30 national industry associations have self-regulatory codes governing member companies' promotional practices (Putzeist, 2009). These vary in terms of standards and approaches, and in the types of sanctions applied in cases of code violations, with some industry associations levying fines and sometimes, as in the given example, requiring corrective actions. This includes, for example, the UK, Australia and Malaysia's national industry associations (Putzeist, 2009).

The longest history of industry self-regulation comes from the UK and it provides the best example of the evolution of national industry self-regulation. How promotion is controlled in the UK is important because it is taken as a standard, especially in those countries with weaker regulatory systems.

The Association of the British Pharmaceutical Industry (ABPI) code was critically analysed in a 1990 publication that demonstrated systematic failures (Herxheimer and Collier, 1990). Only one sanction against a company had been levied in a 30-year period and there was virtually no adverse publicity for breaches. The authors judged that, "*the present system is unacceptable even for matters that fall outside the Medicines Act.*"

In response to this analysis, on 1 January 1993 the ABPI established the Prescription Medicines Code of Practice Authority (PMCPA) with the aim of setting up 'arm's length' enforcement. It includes some members from outside of industry (see: <http://www.pmcpa.org.uk>). The ABPI Code has been revised several times since then. In 2006, the ABPI introduced additional changes to enforcement procedures, including stronger sanctions and publication of advertisements in the medical and general press describing serious offences (Prescription Medicines Code of Practice Authority, 2006). Example 1 includes excerpts from a press report describing a 2006 UK Code violation in which physicians were invited by sales representatives to sports events and to a lapdancing club.

Example 1. Example of a UK code violation

Drug firm censured for lapdancing junket

Sarah Boseley, health editor, *The Guardian* (UK), Tuesday, 14 February 2006

[Excerpts]

One of the world's largest drug companies has been disciplined by the industry's UK watchdog after admitting that its staff entertained doctors to greyhound racing, lapdancing and Centre Court tickets at Wimbledon.

The Association of the British Pharmaceutical Authority (ABPI) ruled that the scale of the hospitality to doctors who might be influenced to prescribe Abbott Laboratories' drugs breached its code of practice. It suspended the company, which made \$3.4bn (£2bn) profit last year on worldwide sales of \$22.3bn, from its board of management for six months.

An anonymous whistleblower triggered the ABPI investigation when he complained that drug reps had taken 27 doctors to the greyhound track in Manchester in January 2004 and 36 others in September. He also complained that two Abbott employees had taken a senior doctor to a lapdancing club, where one of them, a senior manager, borrowed £1,000 for the evening out from the other, a rep.

...The greyhound racing outings had not been approved by head office, it [Abbott] said, because the cost had not exceeded £40 a head or £2,000 in total...

Abbott said ... it had a “zero tolerance policy” for breaches. The allegations related to “a small number of employees” who had resigned or had their employment terminated.

(Boseley, 2006)

Conclusion

Currently many countries do not adequately regulate pharmaceutical promotion because they lack the resources needed for pharmaceutical regulation in general. Other countries have advanced medicine regulatory systems but do not treat regulation of pharmaceutical promotion as a priority. Many activities are delegated to the pharmaceutical and advertising industries for self-regulation. This is problematic for two reasons: the lack of direct relationship between regulatory codes and the law itself; and the inherent conflict of interest in self-regulation. Of particular concern is the link between the effects of promotional activities – stimulation of medicine use – and public health. In many cases, laws and regulatory codes make no reference to the WHO Ethical Criteria and/or aims to promote more rational use of medicines.

Even in countries with direct government regulation of pharmaceutical promotion, legal standards that exist routinely fail to be applied. Most medical, pharmacy and other health professional associations with voluntary codes of practice do not actively implement these codes.

Two international regulatory standards exist: the IFPMA *Code of Pharmaceutical Marketing Practices* and the WHO *Ethical Criteria for Medicinal Drug Promotion*. The former is limited to pharmaceutical manufacturers who are members of IFPMA; the latter is a broader, inclusive international code with a public health orientation. Unfortunately, however, its implementation remains far from adequate. This can be understood in part to be a question of political will, as the WHO Ethical Criteria are a general set of principles that can be used to develop legislation or regulatory standards, rather than having a legal status.

What can be done?

Health professionals can take an active role in their own medical associations to ensure that high ethical standards exist both for the association’s activities and the activities of members. An individual can also set his or her own ethical guidelines for practice and can report illegal marketing activities to the relevant regulatory agency.

In Annex 1 of this chapter, you will find a comparison of the WHO Ethical Criteria and the IFPMA Code. You may want to compare the regulatory procedures and codes in your own country against these standards.

Annex 2 describes consumer and health professional organisations that are actively working to improve the quality of pharmaceutical promotion, the ethical standards governing interactions between health professionals and patients and the role of national governments in the regulation of pharmaceutical promotion. Most are international organisations that

welcome collaboration. If you are interested in working towards improved regulation of pharmaceutical promotion, you may want to get in touch with one or more of these organisations.

Annex 3 presents an argument for and against industry self-regulation of pharmaceutical promotion. You may want to take a look at these arguments and explain how you believe promotion would be best regulated.

In their involvement in promotional activities and interactions with pharmaceutical manufacturers, health professionals are bound by voluntary codes, professional standards and fiduciary responsibilities to their patients. Behind the scenes, laws governing the promotion of medicines determine the types of messages and activities that are considered acceptable. The extent to which these laws govern (or fail to govern) everyday activities may come as a surprise, especially where few resources are available for enforcement or allocated to this work. This chapter provided an overview of the link between national laws and promotional activities aimed at health professionals. As a practitioner, you may at times be faced with promotional activities that concern you. Knowing the legal and regulatory framework in which they occur can help you figure out how to respond, whether it means making a complaint to the regulatory authority, avoiding activities that appear not to be in your patients' best interests or supporting more ethical promotional practices.

Student exercises

1. Looking at regulatory codes

In Annex 1 of this chapter, you will find a comparison of the WHO Ethical Criteria and the IFPMA Code. Compare the regulatory procedures and codes in your own country against these standards. Do you feel that pharmaceutical promotion is adequately regulated to ensure that promotional messages support appropriate prescribing and that promotional activities are in keeping with high standards of professional practice? Why or why not?

- Debate the pros and cons of self-regulation.
- Are violations of codes in your country publicised? If so, is the level of publicity adequate in your opinion? If not, what could be done to improve the situation?
- Find some examples of violations of a code used in your country and look at the penalties that were imposed. Do you think these penalties were adequate?
- Describe the five components related to regulation of pharmaceutical promotion in your country: 1) the law; 2) regulatory codes; 3) monitoring of promotion; 4) enforcement; and 5) evaluation. Discuss any gaps, strengths and weaknesses.
- Draft a code of conduct that would apply to the organisation or institution where you plan to work once you have graduated.
- Develop a plan for monitoring compliance with and enforcement of these guidelines.

Annex 1

Comparison of key provisions in the WHO Ethical Criteria and the IFPMA Code

Comparison criteria	WHO Ethical Criteria, 1988	IFPMA Code, 2007
Who drafted the document?	Developed on the basis of a consensus involving health workers, drug regulatory agencies, consumers and the industry.	Drafted by an industry-selected task force.
Definition of "promotion"	<i>"All informational and persuasive activities by manufacturers and distributors, the effect of which is to induce the prescription, supply, purchase and/or use of medicinal drugs."</i>	<i>"Any activity undertaken, organized or sponsored by a member company which is directed at healthcare professionals to promote the prescription, recommendation, supply, administration or consumption of its pharmaceutical product(s) through all media, including the internet."</i>
Advertisements to the general public	<i>"should not generally be permitted for prescription drugs or to promote drugs for certain serious conditions that can be treated only by qualified health practitioners... advertisements should not be directed at children"</i>	Not regulated in the Code.
Standards of promotion and requirements for scientific evidence of the claims	<i>"...be reliable, accurate, truthful, informative, balanced, up-to-date, capable of substantiation and in good taste. They should not contain misleading or unverifiable statements or omissions likely to induce medically unjustifiable drug use or to give rise to undue risks."</i>	<i>"Promotional information should be clear, legible, accurate, balanced, fair, objective and sufficiently complete to enable the recipient to form his or her own opinion of the therapeutic value of the pharmaceutical product concerned."</i>
Communication to the public	Not present in the WHO Ethical Criteria; not considered by WHO to be appropriate.	Not regulated in the Code.

Pharmaceutical sales representatives	<p><i>“...should not offer inducements to prescribers and dispensers. Prescribers and dispensers should not solicit such inducements. In order to avoid overpromotion, the main part of remuneration of medical representatives should not be directly related to the volume of sales they generate.”</i></p>	Not regulated in the Code.
Continuing Medical Education,	<p>No requirements for continuing medical education (CME) programmes.</p>	Not regulated in the Code.
hospitality and promotional items	<p>Sales representatives: <i>“...should not offer inducements to prescribers and dispensers.”</i></p>	<p><i>“All Events should be held in an appropriate venue that is conducive to the scientific or educational objectives and the purpose of the Event or meeting. Companies should avoid using renowned or extravagant venues.” “No stand-alone entertainment or other leisure or social activities should be provided or paid for by member companies. At Events, entertainment of modest nature which is secondary to refreshments and/or meals is allowed.”</i></p>

Annex 2

Consumers and professionals promote ‘healthy skepticism’

This section provides information on a few non-profit organisations that are working to improve the regulation of pharmaceutical promotion.

BEUC - European Consumers’ Organisation

Consumer organisations have played an important role in drawing attention to problematic pharmaceutical promotion, helping to stimulate public awareness of unethical activities and to lobby governmental institutions to implement proper regulatory strategies. For example, the European Consumers’ Organisation (Bureau Européen des Unions de Consommateurs or BEUC) (see: <http://www.beuc.org>) in Brussels advocates for maintaining the current ban on the advertising of prescription medicines directly to the public in the European Union.

Health Action International (HAI)

Health Action International (HAI) is an informal network of approximately 200 consumer,

health, development action and other public interest groups and individuals involved in health and pharmaceutical issues in some 70 countries around the world (see: <http://www.haiweb.org>). HAI actively promotes more rational use of medicines through research, education, action campaigns, advocacy and dialogue. HAI has been very active in drawing public attention to the serious inadequacies of industry self-regulation of pharmaceutical promotion, criticising the IFPMA Code and its revisions. Like BEUC, HAI has actively campaigned to retain government bans on direct-to-consumer advertising (DTCA). This manual is a HAI initiative carried out in collaboration with the WHO's Department of Medicines Policy and Standards to confront the unethical promotion of medicines.

No Free Lunch

NoFreeLunch is an independent, not-for-profit organisation based in New York as the Corporation for Non-Promotion-Based Medicine. The members include physicians, pharmacists, dentists, nurse practitioners, physician assistants, medical ethicists and others. Funding comes from membership fees, donations, and sales of NoFreeLunch products. No other outside funding is received. The mission of this voluntary group of health-care providers is to encourage physicians to practice medicine on the basis of scientific evidence rather than on the basis of pharmaceutical promotion. NoFreeLunch discourages the acceptance of all gifts from industry by health-care providers, trainees and students with the goal of improved patient care (see: <http://www.nofreelunch.org>). NoFreeLunch groups now exist in France, Italy, the UK and Russia as well as in the US.

Healthy Skepticism

Another independent, nongovernmental organisation with an international membership drawn mainly from health-care professionals, Healthy Skepticism, is based in Australia (see: www.healthyskepticism.org). Its main aim is to improve health by reducing harm from misleading pharmaceutical promotion. Healthy Skepticism's core funding source is subscriptions so as to ensure that it remains controlled by individual health professionals and members of the public who have an interest in improving health.

PharmFree

The American Medical Student Association's (AMSA) national PharmFree campaign (see: <http://www.amsa.org/prof/pharmfree.cfm>) aims to educate students, physicians and the public about the professional, ethical and practical consequences of the current medicine-industry relationship. AMSA is working towards developing educational tools that highlight how pharmaceutical companies undertake their marketing campaigns. In addition, it encourages medical schools, residency programmes and academic medical centres to create 'pharm free' policies that define and limit the relationship between medical students, residents and sales representatives, believing that there is no role for the biased information distributed by representatives at centres where medical knowledge is both created and disseminated. AMSA has developed a 'score card' to grade medical faculties' conflict of interest policies, and is working in this and other ways to provide members with the tools to

bring about needed changes in medical schools, residency programmes and hospitals.

Annex 3

Debate on self-regulation of promotion

The case for self-regulation by the pharmaceutical industry

International Federation of Pharmaceutical Manufacturers & Associations (IFPMA)

The pharmaceutical industry is committed to benefiting patients by supporting the appropriate use of prescription medicines. Self-regulation, operated through international and national industry codes, makes an important contribution to ensuring good practice in the promotion of medicines.

The industry has an obligation and responsibility to provide accurate information about its medicines and has a legitimate right to promote them. The International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) website (www.ifpma.org) provides links to various codes of practice, including its own Code of Pharmaceutical Marketing Practices which outlines minimum standards throughout the world. It has recently been substantially revised and national rules must reflect its requirements. Many national codes are more restrictive than that of the IFPMA.

Key requirements are that promotion has to be accurate, balanced, fair, objective and based on up-to-date, relevant evidence. Codes also impose restrictions relating to meetings, gifts (promotional aids), hospitality and several other areas. Codes are almost invariably wider in their scope than national legislation. Many companies have their own codes of conduct containing additional restrictions.

Any health professional who is concerned about any promotional activity should contact the national trade association which will either deal with their complaint or provide advice regarding available options.

The experience from the UK and many other countries is that self-regulation is extremely effective. Companies are committed to compliance and when complaints arise they are dealt with fairly and effectively. It is very important that material in breach of a code is removed from use quickly. Code processes generally take just a few weeks. One of the most effective sanctions is publication of decisions. The UK makes public very detailed reports of the outcome of every case.

Codes of practice operate through adjudication bodies that often include independent health professionals. The principles of the codes are applied and judgements made on what is right, sensible and appropriate. In the UK, professional associations' input is important in ensuring that the regular code updates always reflect current accepted good behaviour.

The role of health professionals is important. European law makes it an offence both to offer, and for health professionals to ask for or to receive, inappropriate gifts or hospitality.

Requirements for health professionals are covered in their own professional codes and these should support the principles of the IFPMA Code.

Self-regulatory codes, compared with legislation, are wider in their scope, often quicker in their application and more responsive to current good practice. They do, however, need legislation to back them up. The IFPMA-associated codes apply to multinational companies but some local manufacturers, particularly in developing countries, are not covered by codes and thus legislation is needed.

There is major change underway with self-regulatory codes being strengthened around the world. It is worth trying the new systems to see whether concerns are satisfactorily resolved.

The case against self-regulation by industry

by Joel Lexchin

Governments in nearly all developed and developing countries have ceded control of promotion to voluntary codes operated by the pharmaceutical industry. As Lexchin and Kawachi argue (1996), the problem with voluntary regulation is that trade associations have not made systematic efforts to either monitor the advertising practices of their members or to enforce compliance. Far from being anti-competitive, many misleading advertising tactics are good for business.

A British parliamentary committee investigating the pharmaceutical industry heard evidence that led it to state: *“The examples cited to us of breaches of advertising regulations, cover-up of negative medicines information and provision of misleading information to prescribers suggest that self-regulation is not working satisfactorily”* (House of Commons Health Committee, 2005).

When industrial associations draw up their codes of practice they deliberately make them vague or do not cover certain features of promotion to allow companies wide latitude and the sanctions for violations are either non-existent or weak and ineffective. These problems can be seen in the codes from the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA), the Pharmaceutical Research and Manufacturers of America (PhRMA) and Canada’s Research-Based Pharmaceutical Companies (Rx&D).

The PhRMA Code lacks any sanctions. The latest version of the IFPMA Code retains adverse publicity as its only sanction. Although the Rx&D code does provide for fines, the maximum amount after three violations is CAN\$50,000 a trivial amount for companies that spend tens of millions or more annually promoting their products. Furthermore, the IFPMA and Rx&D decisions about whether or not the codes have been broken are made either entirely by industry personnel or with only token representation from outside the industry.

The new version of the IFPMA Code offers protection for companies wishing to present exaggerated benefits or downplay safety issues. Clause 4.1 states *“It is understood that*

national laws and regulations usually dictate the format and content of the product information communicated on labelling, packaging, leaflets, data sheets and in all promotional material. Promotion should not be inconsistent with locally approved product information." (International Federation of Pharmaceutical Manufacturers & Associations, 2006). In practice, this could mean that if weak national regulatory systems allow claims based on dubious science or do not require detailed safety information then companies are under no obligation as far as the code is concerned to provide this level of detail. There is nothing in the Rx&D Code that explicitly requires company sales representatives to supply safety information to Canadian doctors. The PhRMA code allows companies to offer doctors "modest" meals "in a venue and manner conducive to informational communication and provide scientific or educational value" (Pharmaceutical Research and Manufacturers of America, 2002). What a "modest" meal and "a conducive manner" are lack any definition.

Poor control over promotion has been linked to poor prescribing in numerous studies. While voluntary self-regulation spares governments the direct expense of setting up a regulatory system, the indirect costs from the public health perspective are substantial.

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