Contributed by Russell LaMontagne

PHARMACEUTICAL CONSUMERISM AND THE NEXT PHASE OF DRUG PROMOTION

For the last decade, many have argued that direct-to-consumer (DTC) advertising is bad for consumers. At the end of the 1990s, when drug costs exceeded hospital costs for the first time, critics of the pharmaceutical industry suggested that consumers had somehow become victims of DTC's "pill-pushing" ads. This argument never made sense. The economic benefit of keeping people out of hospitals is not difficult to calculate. Giving patients more information and incentives to use pharmaceutical products can be a direct benefit for patients in terms of improving their personal health and quality of life. Encouraging patients to ask for and take prescription drugs is not the problem; the problem is a decision-making process that lacked true consumerism and exposure to actual costs.

EVALUATING THE IMPACT

DTC allows patients to improve and, in some cases, extend their lives at almost no direct, personal, monetary cost. Initially, this was a short-term win for employees because they were allowed to ignore the direct cost of their prescriptions and pass the cost on to their employers. With DTC, employees were inspired to pursue expensive branded drugs. Doctors were happy to play along, writing prescriptions for requested brands at an alarming rate. Patients and their doctors were largely ambivalent to the cost of the drugs, which made advertising pretty easy. Because of the disconnect between the apparent cost of a drug (the employee's copay) and the actual cost of that product (a burden borne primarily by employers), employees had no incentive to be selective. The difference in costs between very expensive advertised drugs and their OTC near-equivalents was trivial for most consumers. In fact, given the complex and obtuse nature of many formularies (particularly for employees with first-dollar coverage), an expensive blockbuster drug could be less expensive to the employee than its generic near-equivalent, even though the cost difference to the employer could be a factor of 10. The industry profited mightily from this nontransparency of costs.

The era of copays and first-dollar prescription drug coverage is nearing its end. The future of pharmaceutical promotion will be closely linked with the rise of consumer-directed healthcare (CDH). The most common CDH plans comprise a high-deductible health plan combined with a health-savings account (HSA). The money in that account is funded directly by the employer or a mix of employee and employer contributions. Once the money goes into the HSA, it is up to the employee to pay directly for his or her medical costs, including prescription drugs. What employees don't spend during the year rolls over and can be saved, much like a 401(k). As more companies offer CDH plans, employees will be spending their own money on the drugs they use. They will become more knowledgeable about what things cost and why. This is going to realign the way drugs are marketed, and the cost benefit of me-too products will change dramatically.

CHANGING TIMES

This change is happening as we speak. The Economic Policy Institute estimates that 56.3% of small businesses were unable to afford health insurance in 2004. Half of the U.S. businesses surveyed in November 2005 by Deloitte have CDH plans or would soon offer them; and 77% of those companies said they expect CDH plans to change employee purchasing patterns by making them aware of the true cost of healthcare. CDH is the only immediate solution for these companies. Pharmaceutical consumerism is one of the easiest ways for employers to save money since hospital costs usually are not choice driven. Wider use of generic gastrointestinal drugs alone could save $5.4 billion nationally, but according to Express Scripts, generic gastrointestinal drugs are only dispensed 31% of the time, even though they would be appropriate in 95% of cases. This is not a trivial amount of money for any economy to swallow. Express Scripts estimates that more than $20 billion could have been saved in 2004 through increased use of generic drugs. Consumers are going to be getting this bill, and the industry will need new advertising and public-relations strategies to cope.

A NEW BEGINNING

Is this the end of pharmaceutical advertising? Actually, it is more of a new beginning. The real and personal benefits of drugs will become more critical than ever before. Marketing strategies reserved for physicians will be shifted to consumers. Publications such as the *Journal of the American Medical Association* and the *New England Journal of Medicine* will become increasingly absorbed and translated for consumer audiences. Branded me-too products will need to hunt down the small percentage of patients who actually get benefits. These drugs are not identical and brands will develop a unique following among patients based on clinical needs, not consumer ads. Hopefully, pharmaceutical companies will respond to the challenge with interactive strategies, such as directed advertising combined with incentives such as discounts for diagnostic pharmacogenomic testing.

The transition to pharmaceutical consumerism will not be easy. In defense of the industry, it was employers and insurers that set reimbursement procedures, and the current copay system for prescriptions provides minimal or no cost incentives for employees. Living in a free market, it is hard, and possibly unfair, to blame the industry for exploiting the bad reimbursement models put forward by employers and providers. Unfortunately, the public will not see it that way. The transparency associated with consumerism will shine a light on bad business practices. As America shifts from first-dollar coverage to CDH, the industry faces new marketing challenges and opportunities.

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