



Column

Appropriate use of medicines: more needed than ever

Even if “rational” or “appropriate” use of medicine sound like a well known concept for many ISDB bulletins that have tackled the issue since the eighties, there is today more than ever room for improvement. In fact, under pharmaceutical companies’ pressure, irrational use of medicines and of other health products (i.e. medical devices) is encouraged all over the world in order to increase their consumption. Many influences are to be counter-balanced such as sales representatives’ influence on prescribers (see “Prescribing advice in the UK” page 7); direct-to-consumer advertising (DTCA) allowed in the US and in New-Zealand and maybe soon in Europe, or so called “compliance programs” (see page 13); industry lobbying of politicians and health authorities. Let’s hope the WHO resolution in favor of rational use of medicines will give a strong signal to health authorities that there is a real need to tackle these influences (read page 13 in Ongoing campaign section).

Nuria Homedes (Boletín Fármacos) contributed this editorial on independent drug information in Latin America as an opportune mean to improve appropriate drug use (read below and also page 4 in News of members section). Any resemblance with reality in other regions is *not* coincidental.

“Many of our organizations pledge to promote the appropriate use of pharmaceuticals. It is common sense, who would do otherwise? And yet, when we pick a newspaper, an independent drug bulletin, a

medical journal... we find a plethora of examples of individuals, institutions, and all sorts of organizations that appear to be contributing to the misuse of medicines. What is even more discouraging is that many in this second group are endowed with large amounts of resources, including access to the media, the health professionals and the public at large. As a consequence, our common sense approach to pharmaceuticals is no longer an easy ride; one often has the feeling that it is more like David versus Goliath. The good news is that, as the story goes, David won, and that although we can not claim victory, Big Pharma’s motives are being unveiled even by Hollywood.

It is encouraging to see how the number of Independent Drug Bulletins is growing, as well as the Free Lunch movement, the International Network of Safe Medication Practice Centers, and that community pharmacists are increasingly getting involved in promoting the safe use of medicines. We owe it to many of those who started working in this field thirty years ago (...). Internet has made our work much easier, and allows us to collaborate and support each other in many different and creative ways. (...) Informed citizens and many health professionals have already heard enough, in broad terms, about the problem; it is time to present alternatives. The demand for independent sources of information will be growing and we should grasp this opportunity to expand our work.” (about the situation in Latin America read on page 4).

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WELCOME!

Boletín de información terapéutica para atención primaria de salud (Cuba)

Boletín de información terapéutica para atención primaria de salud (Cuba) joins ISDB as a new ISDB associate member. The Bulletin is funded by the Cuban Pharmacoepidemiology Development Center and Pan American Health Organization (PAHO).

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TREASURER'S VOICE

Don't forget ISDB subscription 2007!

Dear members who have not yet paid, Your membership fee for 2007 is due. There are three categories of membership to ensure that there is no financial barrier to membership of the society. We suggest contributions depending on the member's overall budget. This is not definitive but serves as a guide only. Financial constraints are not a bar to membership of ISDB.

45 Euro Developing countries

225 Euro Bulletins with budget of under 20,000 Euro

900 Euro Bulletins with budget of 20,000 Euro and more

Payments should be directed to:
Int. Society of Drug Bulletins
Bank: Sparkasse Bielefeld, Germany
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If you didn't get an invoice by mail or e-mail, please let me know so that I can send it again. If you have any questions related to your membership fee or want to apply for an exemption please contact me.

*Jörg Schaaber - ISDB treasurer
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Restricted to members

(for details read page 26)

COMMITTEE MEETING

Phone executive committee meeting
the 16th of May 2007

Present: MF, JS, FV, CK

Read minutes page 26 (restricted to members).

COMMITTEE MEETING

Phone executive Committee meeting
the 19th of June

Jörg Schaaber, Benoit Marchand, Maria Font, Florence Vandeveld and Christophe Kopp met over the phone on June 19th 2007 to discuss the preparation of the 2008 GA in Managua (Nicaragua) (see below).

Other preparatory meetings are planned in fall 2007, including a face-to-face meeting in Paris in December 2007.

Inigo Aizpurua (Spain) has been invited to participate in the coming meetings.

Benoit Marchand's report for details on organisation of the Managua GA is coming soon via ISDB webforum.

Next ISDB GA: Managua (Nicaragua)

The precise dates are: **6 to 9 october 2008**

The program will be more or less focused on the 5 action lines developed during the Verona Committee meeting in November 2006 (read "ISDB's program for promoting independent information on ISDB website"). The main objectives are to prepare joint actions and share experiences:

- Pushing for transparency of health authorities (the role of Government Agencies);
- Promoting non-profit research and independent continuous medical education;
- Monitoring Guidelines (in order to detect biased guidelines);
- Improving exchanges with "major" journals;
- Promoting independent health information to the public (closer alliances with consumers).

It will be the first GA in the region, and a good opportunity to strengthen ISDB in Latin America. Let's learn Spanish!

More information coming soon.



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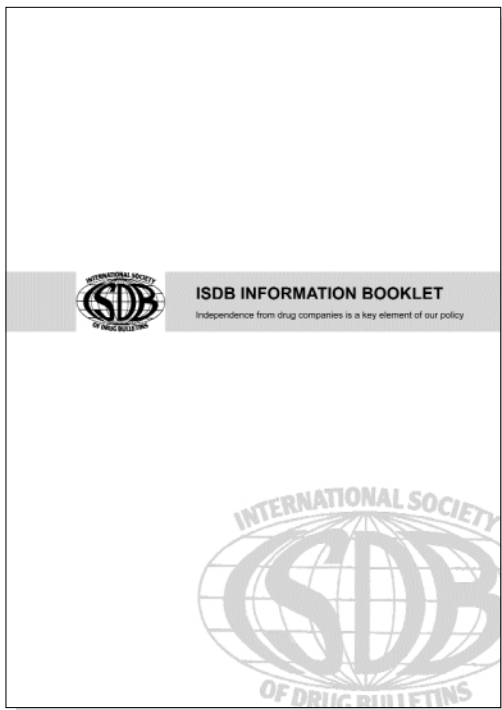
ISDB ID CARD

The ISDB Information Booklet has been launched

An 'ISDB Information Booklet' describing what is ISDB, its values and purposes has just been completed. That will be an invaluable tool for presenting ISDB to outsiders.

The Booklet is available on the IDDB website. A Spanish edition is underway.

Many thanks to Dialogo sui Farmaci and special thanks to Maria Font and Serena Frau!



WEBSITE

News of the Website

The ISDB website, regularly updated, allows ISDB to campaign actively in favor of:

- transparency: the ISDB letter to WHO Director General about conflict of interest disclosure (7 June 2007) is online (read in Ongoing campaigns page 16)
- independent health information for the public: ISDB, Medicines in Europe Forum and HAI joint open letters to EU Commissioners (May and June 2007) are online ("No way to industry-sponsored health information" section).



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WONCA

ISDB and World Organization for General Medicine in Paris on 17-20 October 2007

WONCA (World Organization for General Medicine) is heavily sponsored by drug companies, so ISDB is the right organisation for introducing independent information at this meeting.

A Prescrire editor (Mariane Samuelson) will represent ISDB and promote our values in a poster. Below is reprinted the poster abstract.

Quality in healthcare much depends on the quality of information used by physicians. Quality information on diagnostic and treatment methods means information that is evidence-based and comparative. Medical information media that are financially dependent, totally or in part, on pharmaceutical and device companies are not in a position to produce and promote independent information for practice due to obvious conflicts of interest.

The aim of the poster is to present the International Society of Drug Bulletins (ISDB), a worldwide network of bulletins and journals on drugs and therapeutics that are financially and intellectually independent of the pharmaceutical industry.

ISDB member bulletins aim to provide practical and comparative information for health care professionals especially primary care providers about treatments and to promote rational, informed decisions about their use.

More details:

<http://www.woncaeuropa2007.org/About-Wonca>



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Promoting the appropriate use of medicines in Latin America: seize the momentum

Nuria Homedes (Boletín Fármacos ; Argentina and United States) contributed this text on the situation of health (des)information in Latin America and on the importance of independent drug information (read also the column page 1).

In Latin America, there are people who have been concerned with the use of pharmaceuticals for several decades, and there are stories of success that are not always well known and publicized. Access to pharmaceuticals is now high in the agenda of several Latin American countries; and the commitment to ensuring access to antiretrovirals led the Andean countries to jointly negotiate prices with the industry. There is no doubt that the exchange of information among countries in the region is increasing, and that the number of capable researchers and practitioners is also growing. However, the task is huge, the information voids are tremendous, and affect all areas of the medication cycle from research and development to regulation, prescription, dispensation, consumption, and pharmacovigilance. The need to protect research subjects, strengthen regulation, improve prescribing and dispensing, and consumption is undisputable.

In Latin America we know that the number of clinical trials being conducted is increasing and some countries are trying to establish registers and rules for research ethics committees. To date, there is very little knowledge about the quantity, quality and outcomes of the research involving human subjects. The nature, organization, and functioning of Ethics Research Committees and Contract Research Organizations is largely unknown; and we have learned from violations of basic ethics research principles mainly through the media and after the occurrence of tragic events.

By and large, medical journals do not inform readers of potential conflicts of interest of the authors, and when in some specific cases, we have asked editors about this issue they have ignored

the request. We know that there are ghost writers but nobody has studied who they are and where and how they are operating. Regulatory agencies are not known for their transparency, and they are ill equipped to regulate the industry and the pharmaceutical information that reaches health professionals and the public. There are no studies that have analyzed the relations between the industry, political leaders, regulatory agencies, and physicians who are “role models or trend setters.” There are a handful of studies about the influence of the industry in the prescribing practices of physicians through gifts, invitations to attend international meetings and other perks that are forbidden in many countries, but more information is needed if meaningful changes are to follow.

The influence of the industry on patients’ organizations and in promoting legal action against government programs that fail to cover for very expensive treatments is known but not well documented. The role of importers and wholesalers, their monopolistic control of the market and their contribution to rendering medicines unaffordable has not been studied. We also need more information on how medicines are dispensed and how this process can better serve the needs of the citizens. We know that in many countries of the region, prescription-only medicines are sold without a prescription; and that the abuse and misuse of antibiotics is huge, but we ignore the actual dimensions of the problem.

The list of documentation needed could go on for many pages. The important point is to make the readers aware of the huge vacuum that exists, and of the need to gather more and better information so that we can be more pro-

active and able to provide information to the few political leaders who are committed to better the life of those who elected them, to advocacy groups, and to the public in general. The situation in my opinion is dismal and can be summarized as follows: there is an enormous waste of pharmaceutical resources at the same time that half of the population of the region does not have access to required medicines; to make the picture a bit more somber, an unknown number of patients are not using the medication adequately, and we certainly would like to know the iatrogenic and economic consequences that all the above behaviors have in the region.

The main constraint to this type of work is the scarce number of paid positions to carry out these tasks. So far, highly enthusiastic and committed individuals have used their posts and resources to train personnel, to conduct research, to do advocacy and, relative to the resources available, they have accomplished a lot. There is a need of more people who volunteer their time and talent, and there is also an urgent need to find philanthropists willing to invest in improving the use of pharmaceuticals in Latin America. If we fail to ensure reliable paid-positions for our altruistic trainees, our progress in this area may be hindered. We also need to increase our visibility and strengthen links with the media and with professional associations. Those tasks are not easy, but I believe that the time is ripe for them. Informed citizens and many health professionals have already heard enough, in broad terms, about the problem; it is time to present alternatives. The demand for independent sources of information will be growing and we should grasp this opportunity to expand our work.

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Drug evaluation: Spanish bulletins work together

This text by Iñigo Aizpurua presents the experience of the Spanish mixed Committee on new drugs assessment (MCNDA) and particularly the method they use. This example of cooperation among bulletins clearly demonstrates that: “united we are stronger!”.

The information available on the efficacy and safety of new medicines is limited and almost exclusively comes from the clinical trials carried out for authorization purposes. These trials may guarantee the quality, safety and efficacy of the products but do not evaluate their role in therapeutics in comparison with other available alternatives. To reach this aim there should be objective and independent information available about new medicines from evidence-based drug evaluations carried out with a systematic, rigorous and transparent methodology.

The mixed committee of new drugs assessment set up in 2003 is made up of the individual committees of five regions of Spain. Its principal aim is to evaluate the degree of therapeutic innovation in the commercialization of new drugs in comparison with what is already available on the market and thus be able to provide specific recommendations to the health professionals about them. This committee has a Normalized Working Method which guarantees that the new drugs evaluation processes are carried out in a homogeneous way and with consensus among the different constituent committees. The degree of therapeutic innovation of each new drug is determined in accordance with criteria of efficacy, safety, treatment and cost. A classification is then assigned within a range of five categories by reaching a decision algorithm.

Background. The gradual creation of different Evaluation Committees for New Drugs in Spain responds to the need for having instruments at one's disposal in order to distinguish the boundaries between therapeutic innovations from those which merely exist for commercial purposes. Earlier, there had been other initiatives of national and international kind with a methodology and similar objectives and these have served as a ref-

erence in the development of the activities of the committees (1).

In 2002, after several years of working independently on the evaluation of new drugs, five of the committees – those of Andalusia, Basque country, Catalonia Aragon and Navarre– came together to share their experiences since they shared common methods and aims. Their aim was to unite their strengths in order to improve the quality and consistency of their shared activities. January 2003 saw their first meeting take place and this would soon become known as The Mixed Committee on New Drugs Assessment (MCNDA) (1).

After organizing several work sessions about the techniques to be used, much progress has been made in creating a common policy about the different methods of evaluation used by the different committees of MCNDA. This has given rise to a Normalized Work Procedure with the common aim to improve transparency and contribute rigor to the process and to reduce inconsistency so as to ease reproduction. This Normalized Work Procedure serves as a reference for all the member committees of MCNDA and establishes the guidelines for the elaboration of evaluation reports, the procedures and datelines for reviews and for validation and revalidation. Thus, the evaluation process is made in its totality within a coordinated and agreed form among all the committees (1).

The setting up of MCNDA and the development of a common Normalized Work Procedure has allowed criteria to be unified with regard to the methodology for the evaluation of new drugs as well as to increase the number of evaluations carried out.

Aims and methods. The five committees which make up MCNDA at present share the common aim of strengthening selective and independent infor-

mation about the new drugs as a medium to improve supportive quality through the transmission of knowledge to the health professionals. Its function is to analyze and evaluate the therapeutic benefits that might come from new drugs within the pharmaceutical range on offer at present and in line with available scientific evidence. MCNDA also offer specific recommendations to the professionals directly involved within their sphere of influence for the correct usage of same.

The aim is to provide answers to the main questions raised by the introduction of a new drug. Is it more effective than others already on the market? What do we really know about its safety level? How much will it cost the patient and society in general? Is its use relevant? Are there any particular circumstances that could condition its use?

The methodology used for assessing new drugs consists in 5 steps (1-3):

1. Identification of new drugs
2. Selection of the gold standard comparative drug
3. Literature review
4. Analysis and evaluation of new drugs: reviewing the evidence (read below)
5. Validation Process (read below)

Zoom on point 4: “Analysis and evaluation of new drugs: reviewing the evidence”.

After the search and selection of literature, a critical appraisal is made of the articles by way of a value judgement, analyzing the quantity and quality of the available scientific evidence in search of the possible generalization, relevance and clinical impact of the results. In order to assess the internal validity of the clinical trials and the relevance of the results, Jadad's scale is then applied (4).

In order to establish its external validity and use in clinical practice, a questionnaire is used that allows an analysis to be made of the suitability of the comparator drugs, the endpoints, the patients' inclusion and exclusion criteria as well as other questions.

Available evidence is summarized in a Table which includes all the most ▶▶

► relevant aspects of each of the clinical trials analyzed, following a format adapted from The Scottish Intercollegiate Network (5), in which appears the type of study, the aims, the population (criteria of inclusion and exclusion), the endpoints, the outcomes effect size, p-values, confidence intervals), score in Jadad's scale, etc.

The criteria used to establish the benefits of the new medicine as opposed to the available alternatives are: efficacy, safety, applicability (the mode and form of administration) and the cost. These criteria are combined with the decision algorithm to assign a final qualification to the drug with regard to its therapeutic novelty (Fig. 2). The assigned qualification can fit into one of five established categories and it should be agreed on and evaluated by all the committees that make up the MCNDA (Table 1).

The content of the report is structured in a standard format, organized in different sections which deal with the following aspects: name of the medicinal product, trade mark, manufacturer, date of issue, therapeutic group, date of authorisation, approval procedure, indication, mechanism of action, pharmacokinetics, dosage, methods of administration, efficacy, safety, economic information, alternatives available, and comparable reference drugs and its role in therapy.

Zoom on point 5: "validation process". The evaluation reports of new drugs made by MCNDA become the object of a review and validation process on the part of the incorporated committees. In this process the docu-

Table 1. Qualification categories for new drugs according to their innovation therapy (MCNDA 2007)

Categories	Definition
0 Not possible to assess: Insufficient evidence	Available evidence is insufficient or inconclusive, or lacks good quality clinical trials including an adequate comparative drug.
1 No therapeutic innovation	The new drug has no added value over other drugs which are already available in the market for the same indication.
2 Some added value in specific situations	The new drug may have an added value in a particular condition or patient subgroup
3 Modest therapeutic innovation	The new drug provides more dosage comfort or it lowers treatment cost
4 Important therapeutic innovation	The new drug provides an added value in terms of efficacy or safety compared to the available therapeutic alternatives for the same indication or condition

mentation provided by the evaluation committee (the report text, the table of data, the literature, comments), is analyzed, determining the modifications and proposals that it deems fit. These changes are accepted in total or partially by the evaluation committee in order to produce the text of the final report, which should be agreed by all the committees, especially with regard to reference comparators and the qualification assigned to the drug. Once a consensus is reached and the definitive report is sent out, this is adapted and spread around by each one of the committees within their respective regional territories.

Final considerations. The creation and working of MCNDA constitutes an innovative organization in Spain and provides greater transparency and homogeneity for the evaluation process of new drugs.

Likewise, it is hoped that the adoption of a transparent, reproducible and homogeneous process which has been agreed on by different groups, will reinforce the

credibility of the recommendations made by MCNDA among the manufacturers and other health professional bodies.

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The full document is available in english in: <http://www.cfnavarra.es/WebGN/SOU/publicac/BJ/sumario.htm>

The full document is available in spanish in: http://www.cfnavarra.es/WebGN/SOU/publicac/BJ/textos/Bit_v15n3.pdf
<http://www.easp.es/web/documentos/BTA/00011089documento.pdf>

GERMANY

Arzneiverordnung in der Praxis joins Gute Pillen Schlechte Pillen editorial team

Gute Pillen Schlechte Pillen is a German bulletin for consumers. The editorial team initially included editorial team members from 3 ISDB drug

bulletins: Der Arzneimittelbrief (AMB), arznei-telgramm (AT), and Pharma-Brief. *Arzneiverordnung in der Praxis* joined them in January 2007.

Prescribing advice in the UK National Health Service

This text is a contribution by Rosalind Grant, pharmacist, and ex-DTB editor. Rosalind works now with the National Health Service (NHS) in England, in order to try to improve prescribing and as a consequence quality of health. She has been responsible for prescribing advice and efficient healthcare in the UK NHS for 15 years. This text presents her mission, and the way financial incentives can be used under the backdrop of the UK health system.

The “Prescribing advice in the UK national health service” project’s aim is to encourage more efficient prescribing.

In 2006 the National Health Service (NHS) in England spent £8.2 billion on prescription drugs in primary care, prescribed mainly by general medical practitioners (GP). [1] Over 10 years, the primary care drugs bill has increased from £4 billion in 1996 to more than £8 billion in 2006 – a 60% increase, taking account of differences in drug prices in those years. Similarly, the volume of prescribing increased by 55%, from 485 million in 1996 to 752 million prescription items in 2006. New drug introductions, which replace older less expensive drugs, the ageing population, government policy in encouraging more comprehensive management of medical conditions such as coronary heart disease and diabetes have contributed to the growth in prescription volume and cost.

The recent National Audit Office (NAO) report on prescribing costs in primary care in England highlighted not only the growth in the drugs bill, but also the scope for more efficient and effective prescribing, how GPs can obtain better value for money, e.g. when prescribing statins, drugs affecting the renin angiotensin system, proton pump inhibitors, and what strategies can be used to reduce drug wastage, also a significant factor in NHS costs. [1] The NAO, an organisation independent of Government, scrutinises public spending, e.g. on the NHS, on behalf of Parliament to ensure that taxpayers get good value for money. It suggests that the NHS in England could save over £200 million on prescribing in key therapeutic areas.

Improving General Practitioners prescribing

2 actions were developed in order to improve General Practitioners prescribing,

one using economical incitation (a budget to respect), the other using a data based approach with a system monitoring prescribing.

Development of prescribing budgets in General Practitioners NHS contract.

The conclusions of the recent NAO report mirrors a previous review of prescribing in general practice over a decade earlier, *A Prescription for Improvement. Towards more Rational Prescribing in General Practice* which highlighted variation in clinical practice and prescribing despite broadly similar demographics and morbidity in a defined area and examined how prescribing could be improved. [2] This earlier report followed the introduction of indicative budgets for prescribing by GP practices in the GPs’ contract for NHS services in 1990, in which ‘GPs are expected to manage their prescribing expenditure within the allocation, while ensuring that patients receive the medicines they need, through more cost-effective use of drugs and the elimination of wasteful prescribing’. GPs, like dentists, optometrists and pharmacists, are not directly employed by the NHS but operate independently as businesses providing health services to local populations via nationally negotiated contracts with the Government.

Hospital spending on medicines (i.e. the secondary care sector) was always cash-limited in the UK but accounts for only around 20% of the total NHS medicines bill with the remaining 80% attributable to primary care prescribing. Until primary care prescribing budgets were introduced, GPs had been able to prescribe any medicinal product up to 1985, but then the Government started to restrict the NHS prescription of some commonly prescribed medicines, e.g. antacids, laxatives, vitamins, hypnotics and later more categories, although sufficient drugs remained prescribable to meet clinical needs. [3-5]

Development of NHS prescribing data for General Practitioners practices.

By 1988 the then Prescription Pricing Authority had computerised prescription processing in England primarily the mechanism by which pharmacies are reimbursed for the medicines on NHS prescription forms that they have dispensed to patients. The prescription database enabled the development of other applications, e.g. checking patients’ entitlement to free prescriptions, identifying high-cost prescribers and the generation of prescribing reports (Prescribing Analyses and Cost Tables – PACT). National research validated PACT data as useful and robust tools for auditing prescribing at GP practice level and later for aggregating to NHS district, area and regional levels. [6]

PACT data (now available electronically as ePACT) are not linked to patients’ details, but comprise information on the drugs prescribed, quantity, the number of prescription items and the associated costs. PACT data highlight prescribing trends and patterns in a GP practice and prompt questions such as why, what, how and when was a product prescribed. Detailed audit of patients’ records by the GP practice can then provide the whole answer and link drug usage with clinical decision-making.

Role of the NHS prescribing advisers & medicines management teams

The NHS prescribing advisers & medicines management teams have developed simple criteria for quality prescribing, and use an evidence-based approach that helps to counter industry’s influence.

Defining quality prescribing. Primary Care Trusts (PCTs) are responsible for commissioning NHS services, including hospital, community and primary care services, in England for a defined geographical area with a local population ranging from around 90,000 – 1 million. [7] In hospital, community and primary care services the administration, prescription and supply of a medicine is the commonest therapeutic intervention and therefore the appropriate use of a medicine is clearly important in securing optimum outcomes for patients and best value for the NHS. [8]

► Many factors influence the quality of prescribing but a useful framework formulated over 35 years ago to assist with a rational approach to drug choice considers appropriateness, effective, safe and economic as the key criteria. [9,10] **Appropriateness** of prescribing should concur with the prescriber's and the patient's ideas around the use of a medicine, [11] **effective** focuses on the evidence for the efficacy of a drug treatment, that it delivers benefits that outweigh issues around **safety**, i.e. the potential unwanted effects and adverse reactions or drug interactions, and lastly that the drug is the most economic choice after the first three criteria have been considered. Good prescribing aims to maximise effectiveness, minimise risk, minimise costs and respect patient choice. [12]

Evidence-based prescribing advice.

Currently, around 600 NHS prescribing advisers (mainly pharmacists) are employed in Medicines Management Teams located in 152 PCTs to influence prescribing and drug choice, to monitor PCTs' expenditure on medicines, on average around 20% of a PCT's total funding, and to help GP practices to audit prescribing. A PCT Medicines Management Team comprises a lead pharmacist, head of medicines management, one or two prescribing advisers, an information analyst and supporting pharmacists/technicians who facilitate prescribing changes in

GP practices, e.g. to align drug choice to the local drug formulary.

Although the emphasis on the prescribing adviser's role may vary between PCTs, many are part-time advisers, the key responsibilities listed in Table 1 are likely to be common to most jobs. Armed with PACT data and an understanding of what constitutes good prescribing, the various influences and a thorough knowledge of pharmacology, therapeutics and evidence-based medicine, [13] prescribing advisers can discuss a practice's prescribing data, provide advice on drug choice and support to GPs and other healthcare professionals in the PCT area. In addition prescribing advisers need to develop and to achieve certain competencies, e.g. to understand professional issues, e.g. ethics, legislation and confidentiality, NHS structures and government initiatives and the role of pharmaceutical industry and other commercial organisations. [14]

Table 1. Responsibilities of a PCT Medicines Management Service

A medicines management strategy comprises the development, implementation and performance management (monitoring) of prescribing initiatives in a NHS primary care trust

Key areas	Activity
1. Prescribing strategy	Area-wide drug formulary & place of medicines in patient care pathways
	Managed introduction of new drugs, treatments, e.g. National Institute for Health and Clinical Excellence (NICE)
	GP practice visits to review prescribing, repeat prescribing, implementation of electronic prescribing
	Implementation of prescribing aspects of government initiatives – National Service Frameworks, e.g. coronary heart disease, older people
	Linking prescribing with clinical audit
	Safe & effective control of medicines in GP practices, e.g. Controlled Drugs, drugs for the doctors' treatment room/emergency bag
	Liaison with community pharmacy – NHS contract, public health, health promotion
	Development of non-medical prescribing strategy & local support in NHS community services
	Liaison with pharmaceutical industry – PCT policy on managing representative activity & sponsorship
2. Financial	PCT allocation of overall resource for primary care prescribing
	Identification & management of cost pressures on prescribing, e.g. new drugs, formulations, new technologies
	GP prescribing budgets from PCT allocation
	Development of prescribing incentive schemes on quality prescribing for GPs
	Agreeing medicines' audits with local GP representatives as part of national NHS GP contract
	Medicines aspects of PCT local development plans
3. Implementation	Attendance at area Prescribing & Therapeutics Committee & other strategic development groups to discuss drug choice, formulary development, management of specialist drug prescribing
	Attendance at NICE Implementation group to discuss local implementation & service changes
	ePACT Prescribing analyses to support GP practice visits, nurse/pharmacist prescribing, NHS fraud enquiries, public health initiatives
	Provision of advice/information on medicines to local healthcare professionals via query answering & newsletter items - critical appraisals of medicines use
	Influencing wider public access to medicines via nurse, pharmacist & other non-medical prescribing or patient group directions
	Financial monitoring of monthly PCT & GP prescribing spend v. budget
4. Performance management	Cost analyses of individual drug treatments, e.g. for the management of drug misusers
	Benchmarking prescribing practice in comparative analyses, e.g. bar chart comparisons of statins use
	Drug analyses around safe use of medicines, drug recalls
	Written reports on prescribing/pharmaceutical services to PCT Management Board & other committees

Countering the pharmaceutical industry's influence.

The pharmaceutical industry is the main influence on GP prescribing [15] and the stakes are high. [16] The NAO report states that it “spends more than £850 million annually on marketing and promotion and there are 8,000 pharmaceutical industry representatives (about one representative for every four GPs) visiting GPs and marketing their drugs across the country. Over half of postgraduate education and training for doctors in the UK is sponsored by the pharmaceutical industry”. [1]

NHS prescribing advisers must therefore manage local NHS expenditure on medicines and develop strategies to deliver a comprehensive medicines management service. [17] All PCTs must adopt a policy for working with the pharmaceutical industry based on government guidance. [18]

Strategies for managing prescribing in a NHS area

Prescribing in a NHS area is managed in a pragmatic way through financial incentives, collaboration, pedagogy i.e. comparison with other GPs' practices, area prescribing committees as a bridge between hospital and primary care practice, a patient centred approach.

Prescribing budgets and incentives to change prescribing.

NHS hospitals allocate prescribing budgets to pharmacy depart-

ments which manage the drugs prescribed in hospital. PCTs allocate prescribing budgets to GP practices for primary care prescribing and GPs usually continue to prescribe for their patients any medicine started in hospital. In the past, prescribing costs have sometimes been moved from secondary to primary care, particularly for expensive treatments, as tighter financial controls applied only to NHS spending in hospitals. Now that general practice and hospital are both cash-limited, PCT Medicines Management Teams together with hospital pharmacy representatives have a crucial role to play in managing prescribing in a NHS area and to support clinicians in both primary and secondary care. [19]

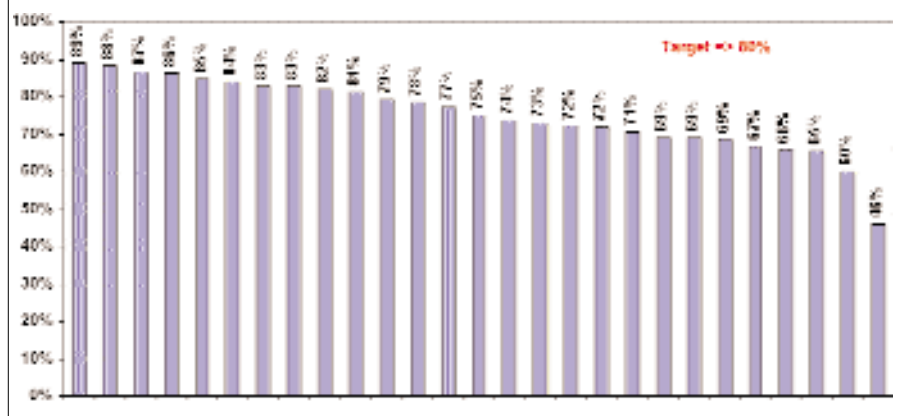
The NHS uses financial incentives to reward GP practices that change their prescribing to more cost-effective drug choices recommended by prescribing advisers, but hospitals have not generally adopted this approach. Changing patients' medication is common in hospital, but is less easy in general practice where clinicians need time, information and good communication skills to ensure that patients accept changes to medication and achieve good clinical outcomes. An incentive scheme example includes a target for practices to achieve prescribing of simvastatin and pravastatin at 80% of all statin drugs. [see Statins Chart]

General Practitioners Practice-based pharmacist support programme. Many PCT Medicines Management Teams provide pharmaceutical support with trained pharmacists and technicians to help GP practices audit their prescribing and to identify suitable patients in whom prescribing could be altered, e.g. to improve clinical and/or cost-effectiveness, e.g. through the use of a generic drug by its non-proprietary name (rINN) rather than brand name. [20;21]

Current examples of prescribing support cited in the NAO report include switching from brand name statins, e.g. atorvastatin, to generic name statins that are off-patent, e.g. simvastatin or pravastatin. [1] The NAO report suggests that £97 million could be saved in England if simvastatin and pravastatin were used in place of brand name statin prescribing at equivalent doses. Money saved can then be reinvested in other local NHS services.

Comparative data – benchmarking General Practitioners prescribing. When

ANON PCT: Simvastatin & Pravastatin as % of all Statin Prescription Items January - March 2007



prescribing data are used to compare practices' performance within a PCT, a range of drug use can usually be identified from high to low cost and/or number of items. Where GP practices are at the 'wrong' end of the range, i.e. achievement 46% v. 80% target, this should trigger an audit of statins prescribed in the practice [see Statins Chart]. Until NHS reforms a GP practice was often unaware of the levels of performance in neighbouring practices, but the formation of PCTs has meant that GP practices need to operate more collaboratively and data sharing on many areas of general practice performance have become the norm. Peer review is a powerful tool for driving health service improvement forward, and now applies not only to GP practices, but also to hospitals and PCTs.

Area Prescribing & Therapeutics Committee initiatives. As prescribing budgets operate in both hospital and general practice, collaboration across the sectors is now easier as there is a common agenda to optimise prescribing and minimise expenditure. If drug choice in hospital can align with that in general practice, through a chosen range of medicines that cover 80-90% of common conditions, i.e. a drug formulary, then this supports appropriate, quality, safe, and cost-effective prescribing. The formation and good functioning of area prescribing and therapeutics committees is now a key strategic aim for many health community areas. [19] Formulary development, managing new drug prescribing, the adoption of new technologies and the management of prescribing responsibility for drugs initiated by specialists are main agenda items. Many new drugs are expensive and need careful mon-

itoring, e.g. anti-rheumatic drugs. Many specialists would prefer to continue to monitor their patients, but this may be inconvenient for patients to have to return to hospital at regular intervals. Also GPs may not wish to take prescribing responsibility for unfamiliar treatments and hospitals cannot cope with follow up clinics nor the drug costs. There are still many unresolved issues at the interface between hospital and general practice but at least area prescribing committees provide a forum for discussion and decision-making.

Re-designing patient pathways. The Department of Health in England is committed to improving health services for patients, making services more responsive to patients' needs and bringing care closer to home. [22] To achieve these aims general practitioners, PCTs and local authorities who have direct contact with patients and service users will have more say in how best to plan and buy services for local communities. This means that some patient pathways, including prescribing will be re-designed, e.g. hospital services may run satellite clinics in the community to save patients having to return to hospital regularly.

Conclusion

The drive towards quality and cost-effective prescribing in the NHS has never been greater. NHS prescribing advisory services as Medicines Management Teams are now common in Primary Care Trusts and provide pharmaceutical support and advice to doctors, nurses and other health care professionals on quality and cost-effective prescribing and the safe and effective manage-

ment of medicines. Collaboration across health communities, between hospital and general practice combined with prescribing data, is also key in drug formulary development and in managing the uptake of new drugs and technologies. If prescribing in all 152 English Primary Care Trusts was at the level of the most efficient Primary Care Trust, then the level of savings suggested by the National Audit Office i.e. £200 million would be achieved.

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Honour to Andrew Herxheimer

Many ISDB members know Andrew Herxheimer, one co-founder of the society. He is in continuous friendly, very motivating and helpful contact with many of us. A special connection goes to Berlin, the city he was borne in. On 24 March 2007 he was honoured in Berlin with the Georg Klemperer medal for his merits.

The Georg Klemperer medal is given by the medical association of Berlin to physicians with outstanding contributions to medicine in Berlin and Germany. During a ceremony on March 24, 2007 this medal was presented to Andrew Herxheimer by the President of the Berlin Medical association, Günter Jonitz.

Georg Klemperer was a famous physician in Berlin and Germany in the beginning of the last century. He was director of the university affiliated to Moabit-hospital in Berlin, author and editor of textbooks and journals (for example *Therapie der Gegenwart*). He had been, from 1911, one of the five members, then president, of the drug commission of the German society of internal medicine, which turned out to be the Drug Commission of the German Medical Association (member of ISDB, represented by AVP, *Arzneiverordnung in der Praxis*). The aim of the drug commis-

sion in those days was to define and combat the evils of the drug market, for instance:

- Senseless overproduction
- Many names for the same substance or mixtures
- Useless or even harmful products
- Hidden ingredients
- False announcements
- Advertising to the lay public
- Abnormal drug prices

Klemperer was driven out of Berlin and Germany in 1935 and died near Boston 1946. The agenda of the drug Commission did not change to our days.

Andrew Herxheimer was borne in Berlin Nov. 4. 1925. He and his family also were driven out from Berlin when he was twelve years old. They lived in London. After the war his father was appointed back to Berlin to be the director of the University Asthma Clinic. Andrew, by that time pharmacologist in London, founded the well-known

Drug and Therapeutics Bulletin. He convinced his father that an independent bulletin was very necessary in Germany too. So his father, Prof. Dr. Herbert Herxheimer, founded in 1967 the *Arzneimittelbrief* (ISDB). Since 2005, a new independent drug bulletin for lay persons, *Gute Pillen Schlechte Pillen*, has been edited together with *arznei-telegramm* (Berlin, ISDB), and *Pharma-brief*, (Bielefeld, ISDB). So ISDB, and his co-founder Andrew Herxheimer, is well represented in Berlin. He was also markedly involved in the development of the Cochrane Collaboration. His youngest child is DIPEX, a database of patient experiences of illnesses that are collected on a website (www.dipex.org).

Andrew has never treated a patient in Berlin. But his worldwide successful commitment to independent drug information has motivated and influenced many physicians in Berlin and Germany. So he was co-author of the Berlin/ISDB Declaration on Pharmacovigilance.

Arzneimittelbrief, *arznei-telegramm*, *Pharma-brief* and *Arzneiverordnung in der Praxis* congratulate him for receiving the Georg Klemperer Medal.

The ISDB Committee links ups with our German colleagues to congratulate Andrew.

BULLETIN ROUND-UP

Warning: the following selection of news items from ISDB members are the result of random browsing in print and electronic bulletins. There is an obvious bias in favour of the few languages the Newsletter editors are familiar with. Please do not hesitate to signal us articles or news you think might interest other ISDB members (send to ckopp@prescrire.org or fvandevelde@prescrire.org). Thank you in advance!

In this Newsletter, we present a medley of references from many bulletins, accompanied by the name of the ISDB contact and the website address. Apart from new drug assessments (i.e. the papillomavirus vaccine Gardasil[®]) and disease management, commonly addressed issues include “information to patient” (read in Ongoing Campaigns page 13), mental health papers (depression, bipolar disorder, dementia in elderly, olanzapine affair) opposing pharmaceutical companies’ propaganda.

FORT News Letter (India)

This Bulletin is not an ISDB member but it was published thanks to support from BUKO Pharma-Kampagne.

FORT stands for Foundation of Rational Therapeutics, it is a non-governmental organisation (West Bengal) committed to promote rational affordable healthcare and essential medicines for all.

The January 2007 issue is the first to be published.

Editors: Amitabh Nandy and Shibdas Ghosh

We wish long live to this bulletin!

Drug and Therapeutics Bulletin (UK)

Of note in DTB vol 45 n°5 May 2007: “Which statin, what dose?” And an “Update on drugs for hyperactivity in childhood”.

Contact: Helen Barnett
(hbarnett@bmjgroup.com)
Website: dtb.bmj.com

Folia Pharmacotherapeutica (Belgium)

The April issue carried a paper initial treatment of type 2 diabetes and glitazones.

Language: French
Contact: Marc Bogaert
(marc.bogaert@rug.ac.be)
Website: www.cbip.be or www.bcfi.be

Australian Prescriber (Australia)

Of note in February: the rating of pharmaceutical companies willingness to disclose information to the Australian Prescriber. This rating was established thanks to results of T(ransparency)-scores during one year (from August 2005 to September 2006).

Of note in the June issue: papers with comment for consumers: one on “Maintenance treatments for bipolar disorders”, on “Metformin in pregnancy and lactation”, and on “Managing chronic obstructive pulmonary disease”, available free.

The June 2007 editorial tackles prescribing by healthcare professionals other than doctors: “Competency for new prescribers” More at <http://www.australianprescriber.com>

Language: English
Contact: John Dowden
(info@australianprescriber.com)

The Medical Letter

The April 9 2007 issue carried an article on aliskiren in hypertension.

Treatment Guidelines (vol 5, issue 57 May 2007) from the Medical Letter is dedicated to the “Choice of Antibacterial Drugs” This bulletin is not an ISDB member.

Website: www.medicalletter.org

The Informed Prescriber (Japan)

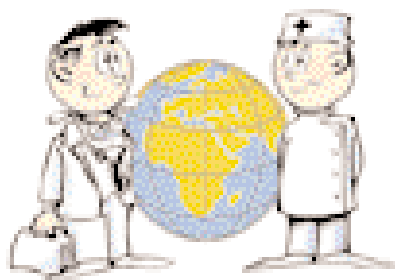
The January 2007 issue carried a paper on febrile convulsion.

Language: Japanese
Contact: Hirokuni Beppu
(PBC00234@nifty.com)

Notas Farmacoterapeuticas (Spain)

Of note a paper on iodine based products (Vol 14, 3, 2007), another one on omalizumab in asthma (Vol 14, 4, 2007), one on rotavirus vaccin (vol 14, 5, 2007), an update on diabetes treatment (Vol 14, 2, 2007), and one on pregabalin in neuropathic pain (Vol 14, 1, 2007).

Language: Spanish
Contact: Luis Carlos Saiz Fernández
(farmac.gapm07@salud.madrid.org)
Website: www.infodoctor.org/notas



Pharmainformation (Austria)

The May 2007 issue carried an update on the prophylaxis and treatment of malaria.

Language: German
Contact: Hans Winkler
(pharmakologie@uibk.ac.at)
Website: <http://info.uibk.ac.at/c/c5/c515/pharmainfo.html>

Informacion Farmacoterapeutica Vasca (INFAC)

Of note an assessment of insulin detemir (Nuevo medicamento a examen 122, 2007) and of ziprasidone in mania and bipolar disorder (Nuevo medicamento a examen 123, 2007). Other papers covered human recombinant paratide rPTH (1-84), valsartan in post myocardial infarction.

Language: Spanish
Contact: Iñigo Aizpurua
(cevime-san@ej-gv.es)
Web site: <http://www.osanet.euskadi.net/>

Pharma (Israel)

Of note a paper on long-term management of bipolar disorder.

Language: English
Contact: Philip Sax
(saxp@netvision.net.il)

Pharma-Kritik (Switzerland)

Of note: the 10 May 2007 issue covered iron based therapy. Also in Pharma-Kritik 12 May 2007 an update on dementia treatments.

Language: German
Contact: Etzel Gysling
(etzel@infomed.org)
Website: www.pharma-kritik.ch

Geneesmiddelenbrief Formulier info (Belgium)

This April 2007 issue reported on new treatments for the elderly in 2006 in a series of short articles covering major organs.

Language: French and Deutch
Contact: Stijn Dumon
Email: stijn.dumon@farmaka.be
Website: <http://www.formularium.be/> ▶▶

BULLETIN ROUND-UP

Informazioni sui farmaci (Italy) Dialogo sui farmaci (Italy)

The 2007; 31 (1) Informazioni sui farmaci and Dialogo sui farmaci March April issues reported on a collaborative follow up study of depression in the community. The objective is to describe how Italian GPs manage depression, and to evaluate outcomes.

Language: Italian

Contacts: Gianni Tognoni (gianni@marionegri.it), Maria Font

Website:

www.informazionisuifarmaci.it and
www.dialogosuifarmaci.it

Dialogo sui farmaci (Italy)

Of note in the 2nd issue of 2007 : the review of Dialogo's drug assessment in 2006.

Contact: Maria Font

(maria.font@ulss20.verona.it)

Website: www.dialogosuifarmaci.it

Der Arzneimittelbrief (Germany)

A new CD covering Arzneimittelbrief (AMB) 1997 to 2006 has been launched. AMB literature references are linked to original publications on the Internet.

Language: German

Contact: Walter Thimme

(wthimme@zedat.fu-berlin.de)

Web site: www.der-arzneimittelbrief.de

Pharma Selecta Bulletin (the Netherlands)

In the May 2007 issue there is an interesting paper dealing with pharmacogenetics (Farmacogenetica en metabolisme – praktisch bruikbaar of hype?).

The February 2007 issue covered varenicline and in vitro fertilisation.

Language: Deutch

Contact: redactie@pharmaselecta.nl

Website: www.pharmaselecta.nl

Bulletin d'information du médicament et de pharmacovigilance (France)

Of note an article in the May-June 2007 issue on how to simplify procedures for a better use of injectable ampoules, based on the gentamicin example.

Language: France

Contact: Michel le Duff

(crim@chu-rennes.fr)

Website: www.chu-rennes.fr/sections/professionnels_de_sa/crim

Bulletin d'Informations de Pharmacologie or BIP (France)

A recent BIP issue 2007, 14 (2) reports on a fancy name for a St John's worts product claimed to help control mild and transient depression ("Prosoft°: Pas si soft que cela! Non!"). The name Prosoft° sounds like a contraction of Prozac° and Soloft°, two antidepressants widely used in France.

Another article in the same issue deals with difference of perceived drug risks among health professionals.

Language: French

Contact: Jean Louis Montastruc

(montastruc@cict.fr)

Website: www.bip31.fr/index.php

La Lettre du CEDIM (Burkina Faso)

Of note: An editorial calling on African Governments and regional organisations to support research based on local needs; also a reflection paper on orphan diseases, rare diseases, neglected diseases.

Language: French

Contact: Clotaire Nanga

(cnanga@prescrire.org)

Website:

The issue of La lettre du CEDIM are accessible on WHO Africa <http://www.afro.who.int/press/french/periodicals/>

Therapeutics Initiative (Canada)

Of note: Therapeutics Letter #63: "Mild Hypertension: Using Framingham calculators"

New Therapeutics Initiative has a new website, with a user-friendlier menu. They have added expandable menus so that one can keep better track of where one is while visiting the site. In addition to English, some content is also available in French and/or Spanish.

Therapeutics Initiative' team encourage you to register and log in as a registered (you will then automatically receive notification by email whenever new content is published on their web site, etc.). Membership is free and it only takes a moment to register.

Contact: Ciprian Jauca

(jauca@ti.ubc.ca)

Website: www.ti.ubc.ca

Geneesmiddelenbulletin (The Netherlands)

Of note in July 2007 issue vol 41 n°7: articles on rimonabant, reversible anorgasmia on topiramate; and timely papers on ISDB involvement in the fight against industry-

supported health information in the EU.

Language: Deutch

Contact: Dick Bijl

(DBijl@cvz.nl or gebu@cvz.nl)

Website:

www.geneesmiddelenbulletin.nl

Centro Andaluz de Informacion de Medicamentos CADIME (Spain)

Of note: a paper on ibandronate in osteoporosis; another one on the combination felodipine/ramipril.

Language: Spanish

Contact:

José Maria Récalde-Manrique

(jose.recalde.easp@juntadeandalucia.es)

Website: www.easp.es/cadime

Arnei-telegramm (Germany)

Of note: a paper in arznei-telegramm 2007; 38: 59 on "Memantine in alzheimer's disease: negative data suppressed", translated in English and available free.

The conclusion of the article speaks volume:

"- The data on the efficacy of memantine in moderate to severe Alzheimer's disease on the basis of the published studies are sparse. The measured effects are classified as "small".

- None of the studies in which no benefit can be demonstrated has been published. The three negative studies involve more than half of all patients from studies in the licensed therapeutic indication.

- Suppression of negative data is widespread with psychiatric drugs: not even half, but rather only a third on average of clinical studies are published. A serious assessment on the basis of the published data is not possible."

Website:

http://www.arzneitelegamm.de/journal/jour_a.php3

Other papers of note: "HPV-vaccine Gardasil°: benefit overestimated?" and "Will the ban on direct-to-consumer-advertising ("DTCA") for prescription drugs be lifted?"

Also through its electronic alert system arznei-telegramm reported on EMEA warning about piroxicam: "Endlich: anwendungsbeschränkungen für antirheumatikum piroxicam".

Language: German

Contact:

Wolfgang Becker-Brüser

(redaktion@arznei-telegramm.de)

Kusuri-no-check (Japan)

Rokuro Hama contributed on June 21, 2007 a rapid response to a BMJ article on adverse reaction to Tamiflu°: "Fifty sudden deaths are more serious reactions



probably related to CNS suppressive action of Tamiflu[®] (oseltamivir phosphate). Rokuro's response was posted on ISDB forum.

Language: English

Contact: Rokuro Hama
(gec00724@nifty.com)

Worst Pills, Best Pills Newsletter (United States)

Of note in June 2007 issue: "DO NOT USE - Antibiotic Telithromycin (KETEK) Can Cause Liver Damage, Respiratory Failure and Death". The advice to patient is clear: "If you experience one or more of the signs of liver toxicity listed in the article, you should stop taking telithromycin and call your physician immediately. Do not take another dose of the drug unless instructed to do so by your physician."

More at <http://www.worstpills.org/>

Arzneiverordnung in der Praxis (AVP) (Germany)

The Newsletter 2007-108 from 19 of June 2007 carries an article on the levonorgestrel-based intrauterine device Mirena[®].

Other papers covers natalizumab in multiple sclerosis, transdermal ritigotin for Parkinson's disease

Language: German

Contact: Heiner Berthold
(heiner.berthold@akdae.de)

Pharma-Brief

Of note in January February issue: "Ein Blick zurück", the review of campaigning achievements by BUKO Pharma-Kampagne in 2006.

Of note in March April 2007: A paper addressed Lilly attempt at concealing olanzapin adverse effects: "Nichts als Lügen: Lilly versucht Risiken von Olanzapin zu unterdrücken". The Zyprexa[®] (Olanzapine) affair could become a Vioxx[®] affair...

More at <http://www.bukopharma.de/haupt.html>

Language: German

Contact: Jörg Schaaber
(jschaaber@bukopharma.de)

Butlletín d'información terapeùtica (Spain)

This bulletin issue reviews the management of obesity "Farmacs per al tractament de l'obesitat" in the first of its 2007 issue.

Language: Spanish

Contact: Neus Rams (nrams@ics.scs.es)
Website: <http://www.gencat.net/salut/depsan/units/sanitat/html/ca/publicacions/spbit.htm>

Ongoing campaigns

DTCA COMING BACK ? (FOLLOWING UP)

Industry-supported health information for patients back on the agenda in the EU

On May 17 2007 a message was sent to European members of ISDB in order to raise awareness on the need to oppose the EU Commission's push in favour of disguised direct-to-consumer advertising.

Direct-to-consumer advertising is likely to pop up again in the EU, this time masquerading as patient information on health and diseases. [see ISDB press release called "Patient-'information' by Big Pharma: a threat to public health" and campaign material on www.ISDBweb.org]

In reaction to the Pharmaceutical Forum consultation on patient information and to the EU Commission report on health information in Europe, ISDB, together with HAI, Medicines in Europe Forum and other organizations, have called on the EU Commission to interrupt any project to disseminate health information supported by drug companies [see on ISDB website > What's new > No way to industry-sponsored health information > 2 open letters and the joint statement "A clear division of roles is needed to protect public health"]. But that is not enough!

The likely timetable is the following:

1. end of May 2007: EU Commission trumpeted the results of its public consultation
2. end of June 2007: EU Commission described the situation of health information to patients in Europe as terribly poor!
3. before summer 2007: warming up of the media and society by industry spokespersons such as euroMEP Chatzimarkakis
4. fall 2007: new draft law on the table and beginning of law making process in EU institutions.

It's time to take action locally and we believe it's extremely important that ISDB members in EU countries mobilize and lobby their national policy makers and representatives, as well as media contacts. These key people should be asked to express opposition to this EU plan for health and disease information, and to support existing sources of independent information such as ISDB bulletins targeting the public.

How to proceed?

- The first step, corresponding to timetable 1, 2 and 3, that is, from end of May till early September, is to inform your readers, contact your Health Ministries, your national media, send them a warning letter or reusing the ISDB press release, translated in your language if you like.
- The second step (timetable 4), that is, once the draft law on patient information is made public (September-October 2007?), is to lobby your Members of EU Parliament (MEP) or national representative in Bruxelles (COREPERs), using the same or other material you consider appropriate.

Your MEPs can be found here <http://www.europarl.europa.eu/members/public.do?language=en>

Your COREPERs can be found here <http://europa.eu/whoiswho/public/index.cfm?fuseaction=idea.hierarchy&nodeid=3760>

Of course, repeatedly reporting on this story in your bulletin is crucial, with links to ISDB website; it will help you convince policy and opinion makers.

Feedback on your actions are welcome; should you need help, tell us.

We'll send you reminders as soon as we have more details. Many thanks!

Christophe Kopp
For la revue Prescrire and Medicines in Europe Forum
ISDB secretary

Ongoing campaigns

Press review on health information in Europe:

- A rapid screening of the bulletins received last weeks at ISDB library gives the following **ISDB press review** on this issue:
 - “Bald auch in der EU? Laienwerbung für rezeptpflichtige Arzneimittel” *arznei-telegramm* 2007; **38** (6) : 55-56.
 - “Industrie-invloed op de patient” *Pharma Selecta* 2007 : 58-59.
 - “Dopo i medici, ora anche i cittadini” *Informazioni sui Farmaci* 2007 ; **31** (1):1
 - “Relevant health information for empowered citizens” *Pharmaca* 2006 ; **4** (44) : 185-188.
 - “Information-patient: la clé du marché” *Rev Prescrire* 2007 ; **27** (285) : ??
 - “HAI Europe, ISDB, BEUC, AIM and MIEF respond to the EU patient health information initiative” *R&P* 2006 ; **22** : 271-272.
 - “Uni_n Europea: En Foro Farmacéutica debaten mejorar la informacion al consumidor sober medicamentos. Algunos temen que sea publicidad” *Boletín Fármacos* 2006 ; **9** (5): 106-108.
 - “La promotion des médicaments” *La Lettre du GRAS* 2007 ; (53) : 9.
 - On DTCA’s topic, a survey was published in *Worst Pills Best Pills*: “Don’t get sold by drug ads on TV, says study” *Worst Pills Best Pills* 2007 ; May : 36-38.

Thanks to ISDB members who already reported on this issue in their bulletins!

- There is also a follow up on this campaign in **the BMJ** and in **the Guardian**:
 - “Direct to consumer advertising should not come to Europe” by Ray Moynihan *BMJ* 2007; 19 May.
- Extract**: “An international alliance of consumer and other groups has attacked the European Commission, accusing it of supporting the drug industry’s push for direct to consumer advertising in Europe. US-style advertising of prescription drugs aimed directly at consumers is currently prohibited in Europe, and attempts to overturn the ban were firmly rejected by the European parliament in 2002. However, the drug industry and elements within the European Commission are pushing to change the rules so that drug companies can provide more information to patients across Europe, a move that critics argue is an underhand way of introducing advertising. Taking a position in support of loosening the rules, a European Commission draft report that is currently out for public discussion states, “The focus should be on the availability and quality of information, and not its source,” and it says that “the pharmaceutical industry has the potential...”
- “Consumers fight to halt move towards direct to consumer advertising in Europe” by Ray Moynihan *BMJ* 2007; 334 : 1025.

- “Sweetening the pill – Can big pharma be trusted to provide independent health information to patients?” by Hannah Brown *BMJ* 2007; 334: 664-666.
- “Pfizer conducts survey of French patients on information provided by industry” by Barbara Mintzes *BMJ* 2007; 334: 1027.
- “Coming soon: the shopping channel run by drug firms” by Sarah Boseley *The Guardian* May 21, 2007
- “Drug firms and patients groups join in fight to overturn advertising ban” by Sarah Boseley *The Guardian* May 21, 2007
- Other organisations report regularly on this issue:
 - “Information des patients : l’Ordre est inquiet” *Bulletin national de l’ordre de l’Ordre des Pharmaciens (LNP)* (Pharmacists Representative Organisation - France) 2007, May 31.
 - “Informations des patients : la législation en danger” *Bulletin national de l’ordre de l’Ordre des Pharmaciens (LNP)* 2007 ; (343) : 1.
 - “Non aux “programmes d’accompagnement” des firmes pharmaceutiques ! Oui à une information indépendante et objective sur les médicaments” *Test Achat* (Consumer organisation - Belgium) - Press release – 30/05/2007 (www.test-achats.be)
 - *APTEKARZ Pharmacoeconomic Society Journal* (Poland) “Look at EU drug policy” *APTEKARZ* 2007; 15 (3) : 73.



The pharmaceutical industry tries to wrest control over health information in the EU

The full dossier is on Prescrire’s website:
<http://www.prescrire.org/cahiers/dossierEuropeMedInfoPatientAccueilEn.php>

Background information:

A clear division of roles is needed to protect public health - Joint Position on health-information HAI, ISDB, MIEF (4 pages)

What is at stake?

Patient information driven by pharmaceutical companies: the aim is to boost sales - MIEF Factsheet on health-information (3 pages)

Pharmaceutical Forum’s biased consultation - May 2007

1st Open letter to Commissioners Verheugen and Kyrianiou and to interested parties - HAI, ISDB, MIEF (4 pages)

European Commission’s biased consultation - June 2007

2nd Open letter to Commissioners Verheugen and Kyrianiou and to interested parties - AIM, HAI, ISDB, MIEF (5 pages)

The way forward

Relevant health information for empowered citizens - Joint Declaration AIM, BEUC, HAI, ISDB, MIEF (8 pages)

Ongoing campaigns

TRANSPARENCY

Prescrire succeeded in requesting EMEA for more transparency on experts



Prescrire requested EMEA to disclose declarations of conflicts of interest of 'additional experts' working on erlotinib (Tarceva®) in pancreas cancer. Prescrire staff members were interested in these declarations as a negative CHMP (licensing committee) opinion on erlotinib suddenly became a positive one thanks to those additional experts.

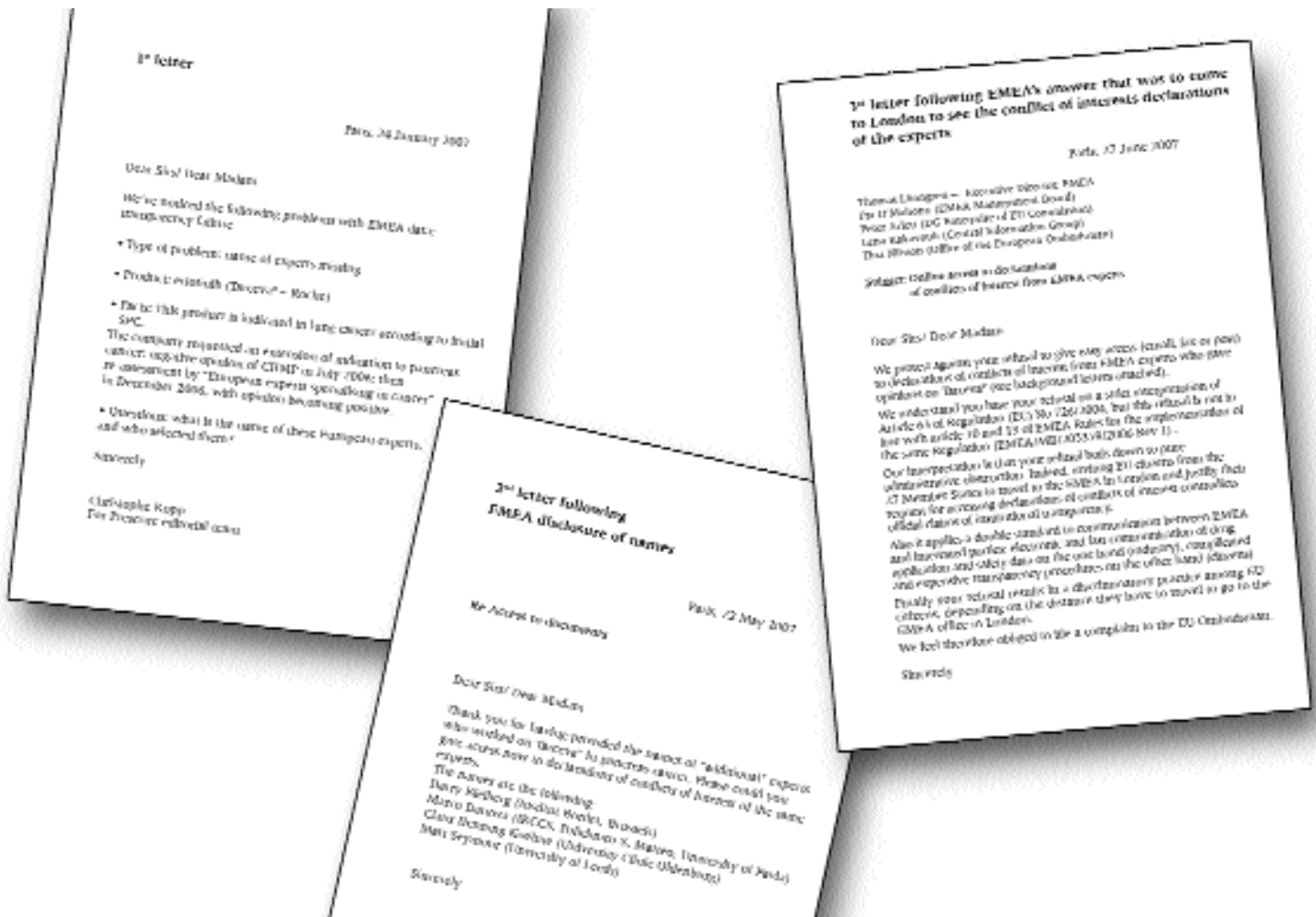
Following several requests and a complaint to the EU Ombudsman (see below), Prescrire finally got these declarations by fax. It was the first time Prescrire requested declarations of conflicts of interest of EMEA 'additional experts'. Our protest letter to Ombudsman (a Swedish word by the way) was probably the key leverage (read below). Should you want them please ask Christophe Kopp (ckopp@prescrire.org) and give him your fax number (12 pages). The declarations are 'public

documents' as defined by EU legislation. Interestingly, EMEA informed us that such declarations of conflicts of interest of EMEA experts will soon be posted online. Prescrire believes access to declarations could help the editors refine the level of evidence of drug evaluations, notably in cancer therapy where non-conflicted experts are a rare commodity. Below are reprinted the three letters Prescrire sent to EMEA for those who are interested to know more on how we proceed. Feel free to

copy, translate our letters. The more we push for EMEA transparency the better. And share your experience on ISDB forum if you like.

A few tips for successful requests to EMEA:

- Requests to EMEA should be sent to info@emea.europa.eu with copy to some other key contacts:
 - EMEA Head Thomas Lönngren (thomas.lonngren@emea.europa.eu)
 - European Commission DG enterprise/pharmaceuticals Peter Arlett (peter.arlett@ec.europa.eu)
 - EMEA management board Chair Pat O'Mahony (pat.omahony@imb.ie)
- Once the 15 working day deadline is over a reminder should be sent to the same people.
- 15 working days after, if there is no response to reminder, a complaint should be sent to Ombudsman. Ombudsman website with all EU languages is <http://ombudsman.europa.eu/> Email: eo@ombudsman.europa.eu



Ongoing campaigns

TRANSPARENCY

WHO and rational use of medicines resolution

Thanks to successful lobbying by Health Action International, conflicts of interest is mentioned in the 60th World Health Assembly resolution on Progress in the rational use of medicines.

In a remarkable Resolution (WHA60.16) on Progress in the rational use of medicines some of the real causes of irrational use of medicines were cited (1).

Indeed, the Resolution “recognized that there may be incentives for the irrational use of medicines throughout the health system, for example in some circumstances which give rise to conflict of interest” [Editors’ note: sales reps or paid opinion leaders for instance]. The Resolution is also “concerned that direct-to-consumer or Internet sales may give rise to irrational use of medicines”.

The Resolution urged the Member States “to enact new, or enforce existing, legislation to ban inaccurate, misleading or unethical promotion of medicines, to monitor promotion of medicines, and to develop and implement programmes that will provide independent, nonpromotional information about medicines”.

The Resolution requested the WHO Director-General “to report to the Sixty-second World Health Assembly, and subsequently biennially, on progress achieved, problems encountered and further actions proposed in the implementation of WHO’s programmes to promote rational use of medicines”.

1- Sixtieth World Health Assembly “Progress in the rational use of medicines” Eleventh plenary meeting, 23 May 2007 A60/VR/11.

Further reading:

- HAI at the 60th World Health Assembly

Website: <http://www.haiweb.org/>

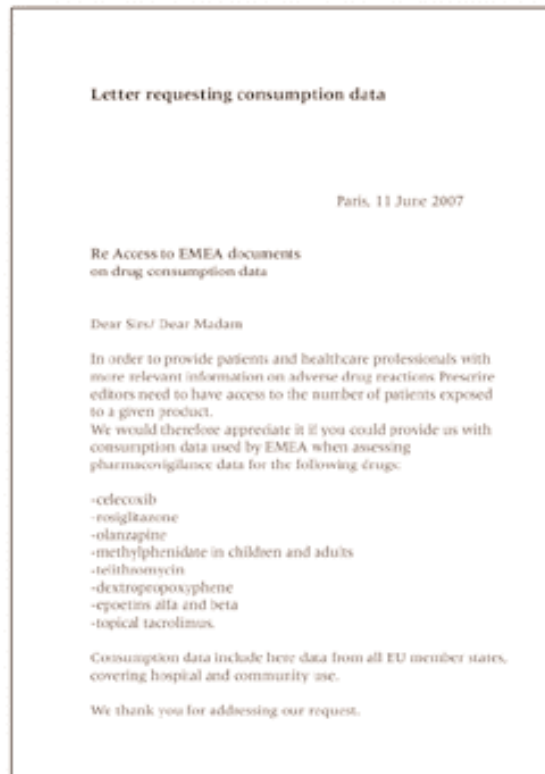
- INRUD news May 2007

Website: <http://www.inrud.org/index.cfm>

Contact for more information:

Teresa Alves (teresa@haiweb.org)

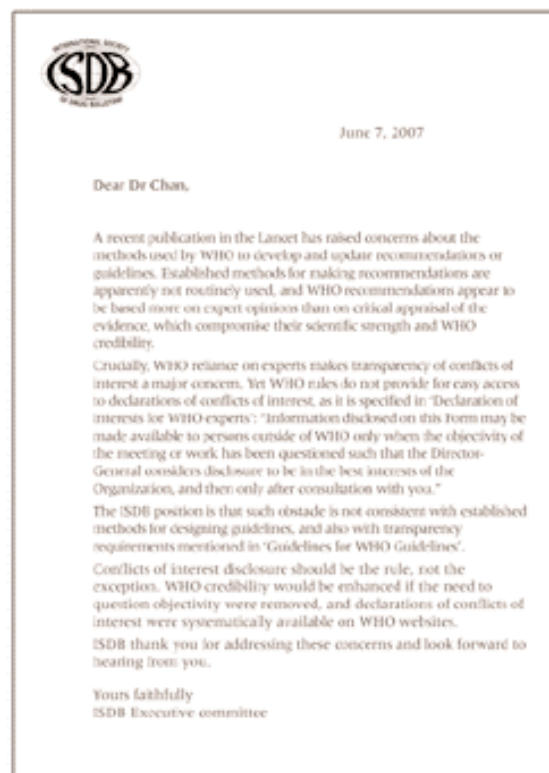
Prescrire usually sends requests to EMEA for information missing in EPARs. We have also in the pipeline a request for consumption data for a number of problem drugs (see below). So far EMEA has not replied to the latter request.



TRANSPARENCY AND ACCOUNTABILITY

ISDB letter to WHO Director

The ISDB Committee wrote to Dr Margaret Chan, Director-General of the World Health Organization, in order to have full access to declarations of conflicts of interest of WHO experts and partners. Feel free to use that ISDB letter when dealing with any WHO departments.



Regulatory watchdog

On the agenda in Europe: very hot issues!

Below are briefly presented the hot regulatory issues: modifications of legislation or EMEA guidelines in preparation.

Lifting of the ban on DTCA disguised as "Patient-information"? (end of 2007)

More information:

- Read in this Newsletter (Ongoing campaigns section) page 18
- EU Commission website: http://ec.europa.eu/enterprise/pharmaceuticals/index_en.htm
- Pharmaceutical Forum website: http://ec.europa.eu/enterprise/phabiocom/comp_pf_en.htm

- The 2 other issues tackled by the Pharmaceutical Forum:

- **relative effectiveness (2008)**
- **pricing (2008)**

More information:

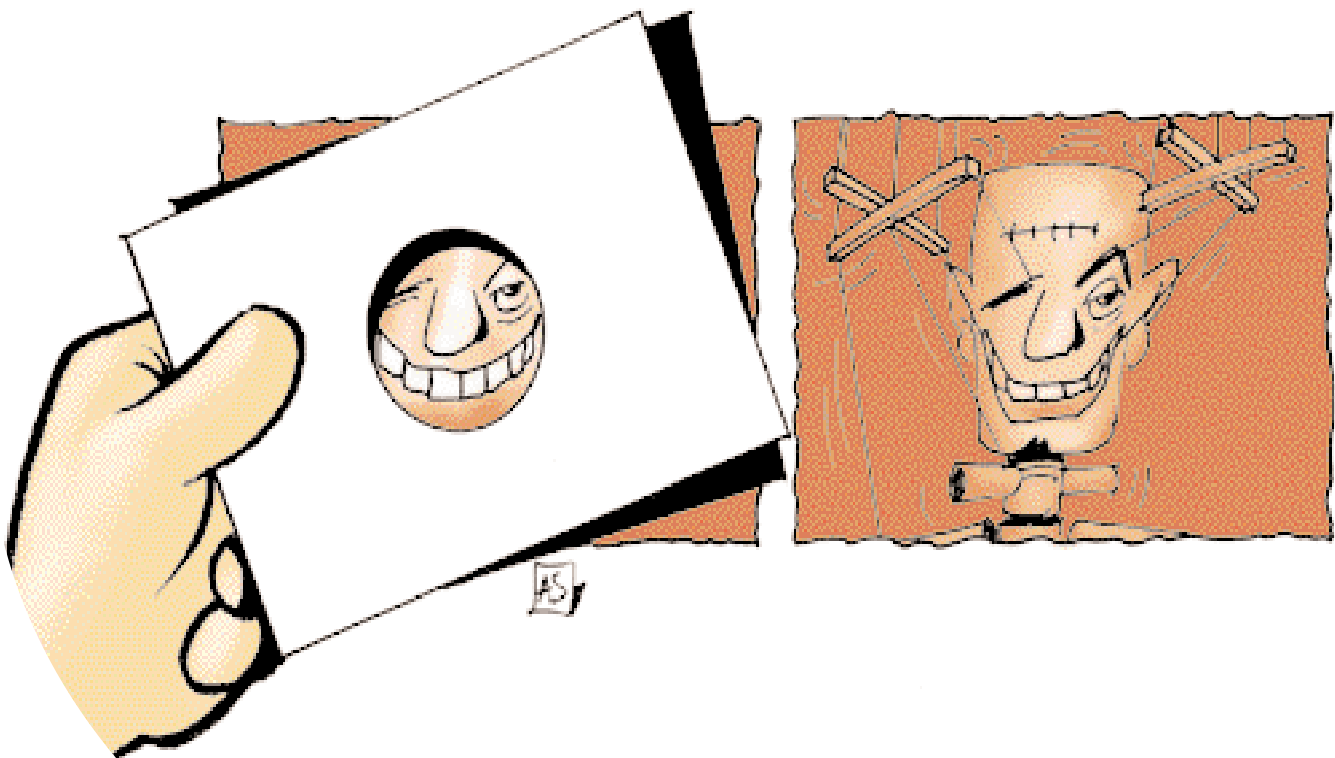
- Read ISDB, MiEF and HAI joint press release (reprinted next page and available on ISDB website)
- On these issues, refer to ISDB Declaration on therapeutic advance in the use of medicines (Paris 2001) (<http://www.isdbweb.org/pag/publications.php>)
- Pharmaceutical Forum website: http://ec.europa.eu/enterprise/phabiocom/comp_pf_fr.htm

Pharmacovigilance:

Beware of "risk management plans" that are flourishing at EU but also national level. Those "risk management plans" seem to be developed mainly by pharmaceutical companies and approved as such by drug agencies, giving companies great power in their implementation. "Risk management plans" could also be a mechanism leading to direct-to-consumer communication through patient training programs. A consultation was launched in 2006 in order to assess the European system of pharmacovigilance, and to propose legislative modifications in 2008.

More information:

- On these issue, refer to ISDB Declaration on Pharmacovigilance (Berlin 2005) (<http://www.isdbweb.org/pag/publications.php>)
- EU Commission website (read the many ISDB members' contributions to the assessment the Community System of Pharmacovigilance): http://ec.europa.eu/enterprise/pharmaceuticals/index_en.htm
- "Bfarm ADE: Arzneimittelsicherheit an die pharmaindustrie verkauft" *arznei-telegramm* 2007; 38 (2) : 17-18.
- "Vigilance" *Rev Prescrire* 2007; 27 (282) : 244.



Regulatory watchdog

EU Pharmaceutical Forum: public health is not its overriding priority

Press release (July 2007, 17)

The current priority for the European Commission is to support the competitiveness of the pharmaceutical industry. Nowhere is this clearer than in the recommendations of the EU Pharmaceutical Forum, an advisory group set up by the Commission (1). European citizens do not see their needs reflected in the recently published Pharmaceutical Forum's report and recommendations.

This report aims to increase competitiveness in three main ways: expansion of direct-to-consumer product promotion under the guise of 'patient information'; weakening comparative evaluation of therapeutic value for new drugs; and continued support for unjustified and arbitrary pricing policies. The position taken by the Commission and the Forum poses grave risks to health and sustainability of health care services. Alternative approaches are needed, as outlined below.

Practically two years' work in total opacity resulted in highly questionable outcomes. The Pharmaceutical Forum's flawed methodology and lack of transparency have already been widely criticised (2,3). By June 2007 there were still no significant improvement, and some members of the Forum even felt morally bound not to endorse a few of the report's findings (4). The Forum's conclusions were based on incomplete lists of information providers, methodologically unsound surveys and hasty observations which open up the way to biased proposals heavily favouring pharmaceutical companies.

Patient information: soon to be entrusted to the pharmaceutical industry? The report on current sources of "patient information" in the European Union drawn up by the Commission, and based on work carried out by the Pharmaceutical Forum, omits many independent providers of relevant information and undermines the role of numerous players who inform patients on a daily basis. The "quality criteria" developed by the Pharmaceutical Forum do not guarantee the requisite impartiality and relevance which enables patients to make informed choices. The "information model" on diabetes is extremely unsatisfactory and its inadequacy has been widely pointed out (4). And yet the Pharmaceutical Forum persists, blithely ignoring the numerous criticisms which have transpired during the external consultation.

In short, the Commission's patient information initiative's sole aim seems to be to support a proposal to deregulate the legislation, which has been in the pipeline for a long time, and allow the pharmaceutical industry to communicate directly with the public.

The evaluation of drugs' therapeutic benefits: postponed. The conclusions of the Pharmaceutical Forum on "relative effectiveness" of treatments fall short of the efforts made in recent years by many Member States to improve methods in the evaluation of the benefits of new medicines. These conclusions amount to a minimalist platform and lead the public to believe that a reliable comparison between new drugs and already available treatments is hardly ever possible. Conversely, all the demands of the pharmaceutical companies are taken into account, namely the rapid consideration of the slightest evidence likely to enhance a drug. The report proposes a Europe-wide "harmonisation" of practices in the comparative evaluation of a medicine's therapeutic benefit, which is likely to lead to a levelling down to the lowest common denominator, curbing the most advanced practices.

In short, the Commission's initiative has resulted in a list of wishful thoughts which will be of no help to Member States attempting to improve their methods when identifying real therapeutic innovations.

The causes for the surge in medicines' prices: ignored. The Pharmaceutical Forum's report on pricing is an opportune reminder of what is needed: a guarantee of equitable access to medication, controlled drug expenditure in Member States, and rewards for innovation. Yet the report does not specify how these objectives are to be met. It does not mention the pharmaceutical industry's artificial and unjustifiable pricing strategies, when an appropriate evaluation of research and development costs would enable setting fairer prices. Concerning the comparative evaluation of therapeutic benefits (relative effectiveness), another essential criterion for a coherent pricing policy, the report's conclusions refer to the working group in charge of this issue, whereas this group has not produced a single consistent report (see above).

In short, it would seem that the Commission's

initiative on pricing and reimbursement is not underpinned by the will to achieve a successful outcome.

The citizens' proposals: deliberately ignored. Various actors in the healthcare sector have already published robust, well-substantiated documents on the three issues which the Commission has delegated to the Pharmaceutical Forum. They define patients and consumers' needs, provide lists of the existing measures which fulfil these needs, and put forward concrete proposals for improvement. The joint Declaration by HAI Europe, the ISDB, BEUC, AIM, and the Medicines in Europe Forum on Health Information of October 2006 (5) and the ISDB Declaration on therapeutic advances of November 2001 (6) are examples of such fundamental documents. Holding these documents into account would have painted a truer picture of patients' needs. Yet, these documents have been virtually ignored by the Commission, primarily concerned with short-term interests of the pharmaceutical industry.

The signatories of this press release call upon the Pharmaceutical Forum to re-focus its work and take up public health as their overriding priority before any changes are to be considered in the legislation governing medicines information.



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- 3- "Patient-information in Europe: many concerns" press review and extracts from contributions to the consultation organised by the "patient information" group (May 2007). Website www.prescrire.org/cahiers/dossierEurope/MedInfoPatientAccueilEn.php (full information material).
- 4- ESIP and AIM "Joint Position Statement on Information to Patients on Diseases and Treatment Options". Website ec.europa.eu/enterprise: 1 page.
- 5- Joint declaration by HAI Europe, the ISDB, BEUC, the AIM and the Medicines in Europe Forum "Relevant Information for Empowered Citizens" 3 October 2006. Website www.prescrire.org or www.isdbweb.org: 8 pages.
- 6- ISDB "Declaration on Therapeutic Advance in the Use of Medicines" Paris 15-16 November 2001. Website www.isdbweb.org: 12 pages.

WHO guidelines: not evidence based

In the April 2007 Newsletter we reported on problems in WHO work (p. 17-20). The Associated Press commented on a Lancet paper published online May 9, 2007 (Oxman A et al "Use of evidence in WHO recommendations"). This Lancet article tackled the methodology of WHO guidelines development.

One more reason to analyze guidelines carefully, even from reputed sources, and check if they are biased and misleading, or simply not based on the evidence.

Extracts from the Associated Press comment

When developing "evidence-based" guidelines, the World Health Organization routinely forgets one key ingredient: evidence. That is the verdict from a study published in The Lancet online Tuesday.

The medical journal's criticism of WHO could shock many in the global health community, as one of WHO's main jobs is to produce guidelines on everything from fighting the spread of bird flu and malaria control to enacting anti-tobacco legislation.

"This is a pretty seismic event," Lancet editor Dr. Richard Horton, who was not involved in the research for the article.

"It undermines the very purpose of WHO." The study was conducted by Dr. Andrew Oxman and Dr. Atle Fretheim, of the Norwegian Knowledge Centre for Health Services, and Dr. John Lavis at McMaster University in Canada. They interviewed senior WHO officials and analyzed various guidelines to determine how they were produced. What they found was a distinctly non-transparent process.

"It's difficult to judge how much confidence you can have in WHO guidelines if you're not told how they were developed," Oxman said. "In that case, you're left with blind trust."

WHO issues about 200 sets of recommendations every year, acting as a public health arbiter to the global community by sifting through competing scientific theories and studies to put forth the best policies.

WHO's Director of Research Policy Dr. Tikki Pang said that some of his WHO colleagues were shocked by The Lancet's study, but he acknowledged the criticism had merit, and explained that time pressures and a lack of both information and money sometimes compromised WHO work. "We know our credibility is at stake," Pang said, "and we are now going to get our act together." WHO officials also noted that, in many cases, evidence simply did not exist. Data from developing countries are patchy at best, and in an outbreak, information changes as the crisis unfolds.

To address the problem, they said, WHO is trying to develop new ways to collect information in poor regions, and has proposed establishing a committee to oversee the issuance of all health guidelines. (...) The officials themselves were concerned about the agency's methods. One unnamed WHO director was quoted in the study as saying: "I would have liked to have had more evidence to base recommendations on." Another said: "We never had the evidence base well-documented." Pang said that, while some guidelines might be suspect and based on just a few expert

opinions, others were developed under rigorous study and so were more reliable. (...) When its 1999 guidelines for treating high blood pressure were criticized for, among other things, recommending expensive drugs over cheaper options without proven benefit, the agency issued its "guidelines for writing guidelines," which led to a revision of its advice on hypertension.

"People are well-intended at WHO," Oxman said. "The problem is that good intentions and plausible theories aren't sufficient."

"If countries do not have confidence in the technical competence of WHO, then its very existence is called into question," said Horton, the journal's editor. "This study shows that there is a systemic problem within the organization, that it refuses to put science first."

WHO Director-General Dr. Margaret Chan, who took over the position this year, will be under pressure to respond to the study's criticism. "We need a strong WHO," which in recent years "has seen its independence eroded and its trust diminished," Horton said. "Now is a fabulous opportunity for WHO to reinvent itself as the technical agency it was always meant to be."

The Associated Press

Sales Representatives' influence

Big pharmas investment in sales representatives forces are decreasing to the benefit of direct-to-consumer advertising (often disguised as "information"), but sales reps' influence is still important on prescribers.

Background. The negative Influence of pharmaceutical sales reps on prescribers is much discussed by health activists in blogs, mostly in the USA, and other media. Two papers dealing with this issue were published in peer-reviewed journals. Thanks to 15 years' surveillance of sales reps by Prescribe Reps Monitoring Network in France, there is strong evidence that sales reps do more harm than good (read also below "A farewell to sales reps"). In the last month there have been many stories of sales reps involved in off label promotion of antidepressants, newly marketed neuroleptics, anti-anaemia drugs (epoetins), and opiates.

A case in point: oxycodone pushers. Sales reps were caught promoting off label use of oxycodone in the USA. According to the FDA Press Release:

"An investigation by OCI uncovered an extensive, long-term conspiracy by The Purdue Frederick Company, Inc. to generate the maximum amount of revenues possible from the sale of OxyContin through various illegal schemes. To further this goal, Purdue trained its sales representatives to make false representations to health care providers about the difficulty of extracting oxycodone, the active ingredient, from the OxyContin tablet; trained its sales force to represent to health care providers that OxyContin did not cause euphoria and was less addictive than immediate-release opiates; and allowed health care providers to entertain the erroneous belief that OxyContin was less addictive than morphine. In addition, Purdue falsely labeled OxyContin as providing "fewer peaks and valleys than with immediate-release oxycodone," and by representing that "...delayed absorption as provided by OxyContin Tablets is believed to reduce the abuse liability of the drug."

The Company released the following statement: "Nearly six years and longer ago, some employees made, or told other employees to make, certain statements about Oxycontin to some health-care professionals that were inconsistent with the FDA-approved prescribing information for Oxycontin and the express warnings it contained about risks associated with the medicine. The statements also written company policies requiring adherence to the prescribing information. The misstatements were made prior to July 2001 and related to the risks of addiction, abuse, withdrawal and

tolerance compared to other pain medications. We accept responsibility for those past misstatements and regret that they were made."

However, penalties for misbranding Oxycontin were too little, even if they sent an important message to the drug industry. According to a Statement by Sidney M. Wolfe, Director, Health Research Group of Public Citizen (from the ISDB bulletin Worst Pills Best Pills): "From 2000 through 2006 alone (...) there have been \$9.6 billion in retail U.S. sales of Oxycontin. It was one of 25 top-selling drugs from 2000 to 2005 (...). Thus the government should have forced the company to disgorge far more of its ill-gotten profits in this case. [The company had to pay \$634 million in criminal and civil penalties - including guilty pleas by three current and former Purdue Frederick executives - for misbranding the potent narcotic Oxycontin] (...) Hundreds of thousands of people are languishing in jail for relatively minor drug possession or distribution crimes involving illegal drugs or, in a smaller number of cases, prescription drugs such as Oxycontin. Why have the three wealthy Purdue executives, who have pleaded guilty to orchestrating this dangerous promotional campaign, escaped jail time, and why are they pay-

ing merely \$34.5 million in penalties? The damage to the public from these white-collared drug pushers surely exceeds the collective damage done by traditional street drug pushers. Why do we have such a double standard of justice?"

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WHAT ABOUT ISDB?



An ISDB survey on sales reps

An ISDB survey on sales reps will be launched soon. The aim is to know whether ISDB members report and campaign on the influence of visits from pharmaceuticals sales reps.

What are ISDB members doing to oppose misleading promotion by sales reps? This questionnaire will be sent to ISDB members through the ISDB forum. Results will be reported in next newsletter.

Questions

- have you ever published articles about sales reps' influence on prescribers? Sometimes? Regularly? Never
- do you think ISDB bulletins should report on sales reps' influence?
- have you ever encouraged prescribers to stop receiving sales reps, and to use this extra time for independent continuing education?
- your comments?

JUST FOR FUN...

A farewell to sales reps

In 1990, Prescrire published an article entitled “A year without sales reps” (Une année sans VM), in which French health professionals were invited to do without sales reps and see what happened. It was very ‘provocative’ at this time and many subscribers were angry because they wanted to continue to receive sales reps. Prescrire’s proposal for those who wanted to continue was to join the Prescrire’s surveillance network of sales reps. Many of the subscribers who participated in the surveillance network decided after a few months to adopt the trial period without sales reps... indefinitely; a wise move on their part according to the latest report from Prescrire’s Reps Monitoring Network. We reprint below this editorial entitled “A farewell to sales reps”.

Readers who see reps continue to inform us of unacceptable practices, such as misleading presentations, blatant disinformation, ‘free’ gifts, failure to provide legally required documents. Their anecdotal reports are confirmed by the Network’s damning conclusions: virtually nothing has changed in the past ten years [Editor’s note: see also ref 9 page 20].

Prescribers and pharmacists should not expect to receive reliable information from medical sales reps. Indeed, the reps’ raison d’être is to sell; and, to sell effectively, they usually have to hide or distort certain information on their products or their competitors.

Health professionals are not obliged to see sales reps. The time spent looking at pretty visuals and listening at pseudoscientific or biased arguments could be far better spent on following a continuous education programme, for example.

But what about the free samples, the books, the gadgets and the trinkets, not to mention the free meals in classy restaurants? Don’t worry: the withdrawal symptoms are manageable. Instead of relying on free samples one

can simply buy drugs one needs. Gadget addicts can find substitutes in most high-street stores, and paying one’s own way at professional meetings comes naturally after a while.

Ten years without sales reps, and no regrets. On the contrary, appreciable extra time and professional independence are recovered.

Could you too live without sales reps? We believe you could and should.

©Prescrire

Translated for *Prescrire Int* 1999; 8 (41): 66.





The Pharmaceutical Industry and Psychiatrists in Developing Countries: Murky Waters

The paper reprinted below was first published in The Network's Watch on Medicine Aug/Sept 2006, and reprinted in BODHI Sept/Oct 2006. According to BUKO in "Taking advantage of a poor infrastructure" the marketing of irrational drugs can have tragic consequences in poor countries where health budgets are small and medical infrastructure is fragile. The pressure in favor of "mental health" treatment is a nowadays a worldwide problem.

A multinational pharmaceutical company recently launched a drug for dementia in Pakistan and flew about 70 Pakistani doctors to Bangkok, Thailand for a 3-night all-expenses-paid trip (Khan, 2004). Pakistani doctors were part of a larger group that also included doctors from other countries. A conservative estimate of costs for the Pakistani doctors alone is about 7 million Pakistani rupees (US\$ 120,000).

Although, the company could justify it, questions linger about the rationale for spending this huge amount in a developing country without a healthcare system and where all healthcare is out-of-pocket expenditure. The drug in question costs Rs320 (US\$5.40) per recommended daily maintenance dose - prohibitively expensive for the vast majority of Pakistani patients. This article addresses the murky relationship between pharmaceutical companies and psychiatrists in developing countries, using Pakistan as an example.

Mental Healthcare in Pakistan.

Pakistan's population of 150 million makes it the world's sixth most populous country. Community-based prevalence studies for common mental disorders give high figures: 25-66% women and 10-40% men (Mumford et al, 2000). There are an estimated 3 million drug addicts in Pakistan. Suicide rates have increased dramatically in the last few years, from a few hundred to more than 3000 annually (Khan & Prince, 2003). Serious mental illnesses account for another 1-3% of the population. Health spending is a pitiable 1% of the government's annual budget and mental health does not

have a separate budget. There is no health insurance and a poorly funded public health service is accessed by only the poorest. All healthcare costs are borne by patients themselves. Mental health services are almost nonexistent and limited to either psychiatry departments of teaching hospitals or privately run clinics.

There are only 150-200 qualified psychiatrists in Pakistan, an alarming ratio of one psychiatrist to a million people. The majority of psychiatrists are urban-based, whereas 70% of the population is rural-based. Except in a few instances, psychiatry is neither taught nor examined at undergraduate level, leaving most practicing physicians with poor diagnostic and management skills for psychiatric disorders.

Sales of Psychotropic Drugs in Pakistan.

Psychotropic drug sales for only 1 year (July 2003 to June 2004) were worth Rs2.76 billion (US\$46.77 million) (IMS, 2004). Of these, antidepressants sales were worth Rs821.17 million (US\$13.4 million) (an increase of 23% from the previous year), tranquilizers and hypnotics Rs1.36 billion (US\$23.18 million) (an increase of 18% and 137% respectively from the previous year) and antipsychotics Rs377.02 million (US\$6.39 million). Interestingly, sales of drugs categorized as 'nootropics' (so-called brain stimulants) were worth Rs187.6 million (US\$3.18 million). To put the above figures in context, the Gross Domestic Product of Pakistan is approximately US\$61.6 billion whereas the per capita income is US\$440.

You Scratch My Back, I'll Scratch Yours.

Pharmaceutical companies and physicians have a well-established symbiotic relationship in Pakistan, not unlike that in many other countries. However, with little or no regulation of medical practice or drug prescribing and dispensing, companies and physicians are free to act as they deem fit. Malpractice litigation against doctors is unheard of. Pharmaceutical companies have therefore targeted psychiatrists aggressively. The traffic is bidirectional - psychiatrists are as demanding of favors as companies are of providing them.

Forms of Inducements. Some of the many inducements on offer include: sponsoring attendance at conferences, underwriting symposia, all-expenses-paid trips for self and spouse for a drug launch abroad, free drug samples and expensive gifts (watches, air conditioners, briefcases, laptops, etc). Other methods include funding a physician's family wedding, holidays and other events of this nature. One of the latest incentives is for the pharmaceutical company to provide the physician with a down payment for a new car. All the physician has to do in return is write 200 prescriptions for the company's expensive drug.

A Pill for Every Ill? The medicalisation of human distress is proceeding at a rate faster than the development of new drugs. Pakistan has one of the highest numbers of common mental disorders in South Asia, with a third of the population living below the poverty line. Given the clear link between poverty, social deprivation and mental ill health (Patel & Kleinman, 2003), it is likely that in this population there are many who are psychologically distressed. The medicalisation of distress and treatment with psychotropics has boosted sales enormously. Inappropriate medicalisation carries the dangers of unnecessary labeling, poor treatment decisions, iatrogenic illness and economic waste, as well as

► costs that result when resources are diverted from treating or preventing more serious disease (Moynihan et al, 2002).

Who Listens to Patients' Stories!

As the emphasis on drug treatment becomes greater, psychiatrists are under increasing pressure to prescribe psychotropics - especially as newer psychotropics, such as selective serotonin reuptake inhibitors and atypical antipsychotics, are being marketed as panaceas for all mental disorders. It is not uncommon for a general practitioner practicing in a low-income area in Pakistan to prescribe a third-generation antidepressant, such as venlafaxine (Rs. 23.25/tab), one of the most expensive antidepressants currently available in Pakistan. Since most doctors in Pakistan have neither exposure to psychiatry nor are obliged to participate in continuous professional development (CPD), prescribing practices reflect the influence of pharmaceutical companies. This aggressive drug prescribing is not without its victims. What is lost, sadly, is the patient's story and the listening skills of the physician. The danger is that the process may have gone so far that it may be virtually impossible to turn back. The skills of medicine and psychiatry are therefore undergoing a slow and painful death in developing countries such as Pakistan.

Psychiatry: A Unique Specialty.

This uniqueness lies in psychiatry's humanistic, holistic and bio-psychosocial approach to human problems and the central importance of the patient's narrative. If psychiatry is to retain this uniqueness then it will not be by medicalising human distress or prescribing psychotropics indiscriminately, but by building on and strengthening the very qualities that make it different from other medical specialties. These qualities include the use of communication skills, counseling, problem-solving therapies and support groups. There is now good evidence that many of these approaches are effective in developing countries (Ali et al, 2003; Bolton et al, 2003).

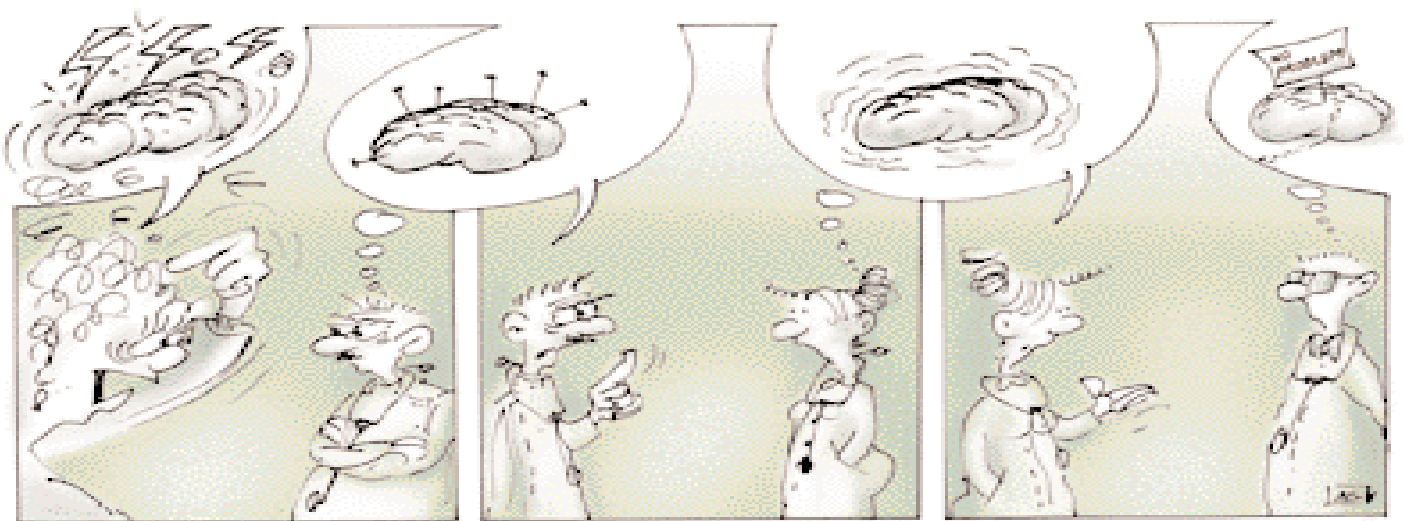
Cleansing Murky Waters: Regaining Integrity.

Can the murky waters be cleansed, boundaries redrawn and integrity regained by psychiatrists in developing countries such as Pakistan? I believe they can, providing that there is a serious will to do so. It is vital that no matter what the circumstances the interest of the patient remains paramount. Anything that compromises this must be identified and eliminated. This includes accepting any kind of inducement - large or small, in any form, shape or size - from pharmaceutical companies. Alternative ways of funding

attendance at conferences must be found. This must be strengthened by strong institutional policies limiting direct contact with pharmaceutical sales representatives.

At undergraduate level, both psychiatric training (emphasizing non-pharmacological methods of treatment) and a bioethics course (addressing issues of conflict of interest, probity and value ethics) would help in decreasing reliance on drug therapies as well as contribute to the ethical behavior of physicians. Currently, only a few medical colleges in Pakistan teach and examine psychiatry, or include bioethics teaching at undergraduate level.

Conclusion. Today, many developing countries such as Pakistan are facing a serious crisis in mental health, and resources - both manpower and fiscal - are severely lacking. Unfortunately, at the level of government planning and policy-making, there is neither an understanding nor a political will to change this status quo. Under these circumstances, institutions and individual physicians assume a far more important role than in countries with well-developed healthcare systems. Both need to be cognizant of the enormous responsibility they carry in dealing with the poor, the ill and the distressed in these circumstances.



Is your reporting more FDA or EMEA like?

Here is reprinted a funny comparison on the way FDA and EMEA communicate taking the example of Avandia.

Reprinted from:

http://www.eyonfda.com/eye_on_fda/2007/05/compare_and_con.html.

The FDA issued a press release on the issuance of a safety alert on Avandia on May 21. On May 23, the European Medicines Agency (EMA) also released a statement on Avandia safety. The author of the text compared the tone and tenor of the two statements:

EMA - An article published in the New England Journal of Medicine (NEJM) has raised concern about a small increased risk of myocardial infarction and cardiovascular death in patients with type 2 diabetes treated with rosiglitazone. (Emphasis my own)

FDA - The U.S. Food and Drug Administration (FDA) is aware of a potential safety issue related to Avandia (rosiglitazone), a drug approved to treat type 2 diabetes. Safety data from controlled clinical trials have shown that there is a potentially significant increase

in the risk of heart attack and heart-related deaths in patients taking Avandia.

EMA - Patients are advised not to stop treatment with rosiglitazone and to discuss medication with their doctor at their next regular visit.

FDA - Patients who are taking Avandia, especially those who are known to have underlying heart disease or who are at high risk of heart attack should talk to their doctor about this new information as they evaluate the available treatment options for their type 2 diabetes.

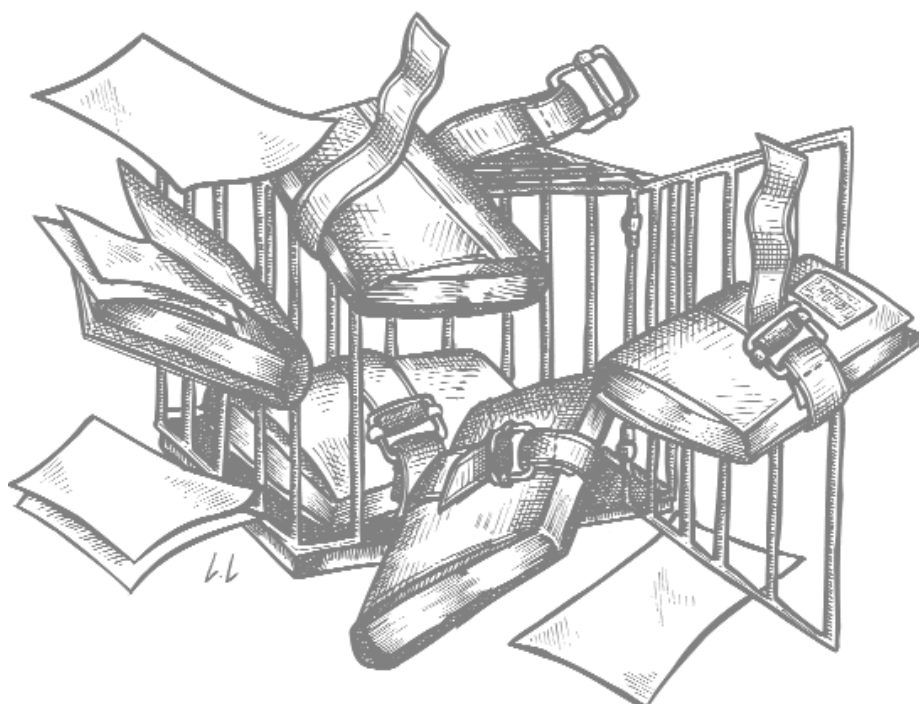
EMA - The majority of the studies included in the NEJM paper have already been assessed by the CHMP... The EU product information was updated in September 2006 with information about the risk of cardiac ischaemic events ... Some of the studies in the NEJM paper included patients who were not treated in line with the indication approved in the EU. Prescribers are reminded to adhere to the restrictions for use in patients with cardiac disease as set out in the product information. (Note the statement also includes the fact when approved in the EU, rosiglitazone was

contraindicated in patients with a history of cardiac failure.)

FDA - The most recent labeling change for Avandia also included a new warning about a potential increase in heart attacks and heart-related chest pain in some individual using Avandia. The new warning was based on the result of a controlled clinical trial in patients with existing congestive heart failure.

It is interesting to see the somewhat divergent approach in tone. The releases are not radically different, but there is a nuance of language that is interesting. The EMA statement (half page) seems a bit more relaxed about the safety concern. The FDA, on the other hand (page and a half), seems to go to lengths to assert what the FDA is doing and will do - perhaps with some members of Congress in mind. It is also interesting to note that the FDA used the trade name while the EMA used the generic name.

Given the differences in their respective approaches, consequently, it would be an interesting exercise to compare the approved EMA label with the approved FDA label.



INDEPENDENT DRUG FORMULARY

A Belgium Guide for prescribing to elderly people

The Guide called 'Formulaire MRS' is the result of a collaboration between non-profit organisations, including some ISDB members such as Farmaka and Folia Pharmacotherapeutica, and Centre Universitaire de Médecine générale UCL and the Gent Werkgroep Huisartsenformularium OCMW.

The Guide aims to help doctors, pharmacists and nurses to select treatments in elderly patients. It is based on a broad range of reliable sources, and regularly updated.

It is available in French and Deutch.

More at <http://www.formularium.be/fr/menu.html>

UNITED NATION REPORT

Abuse of prescription drugs to surpass illicit drug abuse, says International Narcotics Control Board (INCB)

The International Narcotics Control Board (INCB) is the independent and quasi-judicial control organ monitoring the implementation of the United Nations drug control conventions.

Quote: "The abuse and trafficking of prescription drugs is set to exceed illicit drug abuse, warned the International Narcotics Control Board (INCB) in its Annual Report released today (1 March 2007). The Board added that medication containing narcotic drugs and/or psychotropic substances is even a

drug of first choice in many cases, and not abused as a substitute. Such prescription drugs have effects similar to illicit drugs when taken in inappropriate quantities and without medical supervision. The "high" they provide is comparable to practically every illicitly manufactured drug."

More at <http://www.incb.org/incb/index.html>

WHO WORLD HEALTH STATISTICS 2007

A guide to statistical information at WHO

World health statistics 2007 presents the most recent health statistics for WHO's 193 Member States. This third edition includes a section with 10 highlights of global health statistics

for the past year as well as an expanded set of 50 health statistics.

More at <http://www.who.int/whosis/en/>