

Ethical questions arising from the evolution of prescriber targeting in pharmaceutical sales

PRESENTER:

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Data: industry marketing information in public domain, academic literature, auto-ethnographic data

Methods: Policy analysis, Case study: RX opioid marketing

Compliance & ethics training in pharma? No data. No national standards. *Voluntary* industry code: PhRMA Code on Interaction with Healthcare Professionals 2002/ 2009

Corporate integrity agreements –post-litigation- reactive vs. proactive response to illegal marketing

How has prescriber targeting evolved?

License/ purchase data: prescriber RXs, managed care, sales

IQVIA + database/CRM companies (Veeva, MMS...)

- AMA Physician Masterfile data
- DEA license information
- Proprietary market research, ex: DRG/ Fingertip Formulary

Territory Design in Sales Operations: Big Data Approach

“tactical territory alignments” - sales force optimization manager toolkits w/ real-time modelling → integrated w/CRM software: call reports, objectives, customer profiling

Policy levers increasingly used to counter managed care barriers:

Opioid industry ex: Abuse-Deterrent Formulations (ADF) ~100 bills in 35 state legislatures, 2015-16

Addiction Medicine:

Ethics? Industry targets *non-prescribing* stakeholders: public officials, drug court judges, law enforcement, counselors

- Enacted state laws w/ formulary mandates (i.e. buprenorphine formulations)
- Jail re-entry & drug courts- example: injectable naltrexone >700+ state & local programs 2018

Public policy account managers *instead* of sales reps (naloxone nasal spray marketing by Emergent BioSolutions)

Third-Party Advocacy- Role of PAO's Patient Advocacy Org's- limited data

Public policy interventions have been slow to respond to sophisticated pharma marketing

Changing industry tactics:

Public policy levers

Top-down system sales calls

Multi-channel marketing

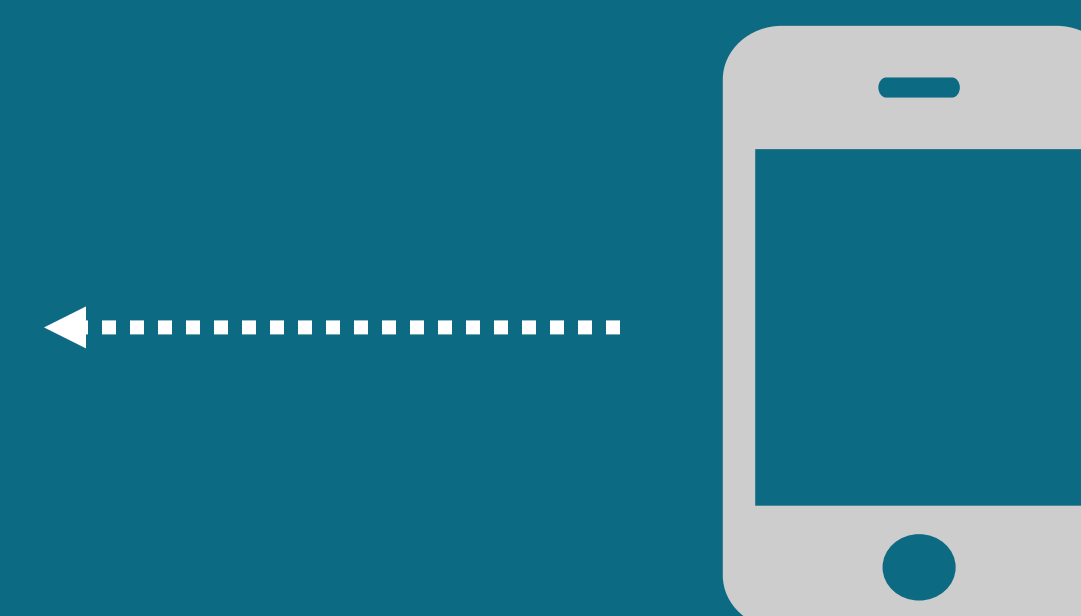
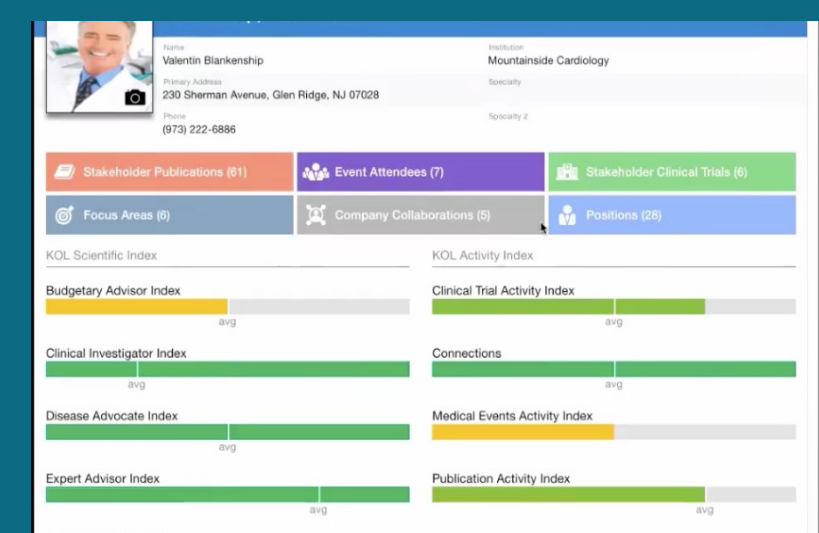
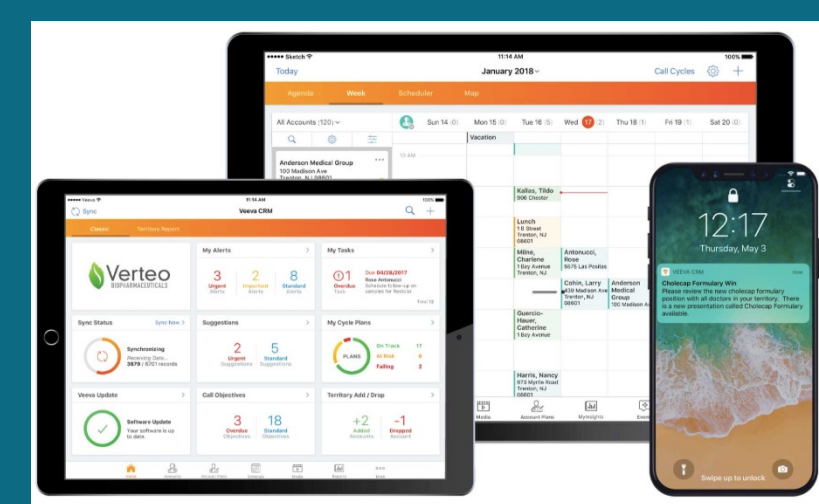
Increase in sophisticated technology

Advanced data analytics

Artificial Intelligence (AI)

Deep prescriber profiles

E-detailing



Conflicts of Interest influences on:

- Continuing Medical Education
- Prescribing guidelines
- Patient Advocacy Org's
- Public policy- legislation & regulations
- Managed Care - access

Pain & Addiction medicine vulnerabilities:

- Newer medical specialties/ insufficient capacity to meet need
- Primary care providers fill gaps in access to specialists
- Patients highly stigmatized
- Pharmacotherapy may include opioids/ physical dependence
- High co-morbidity: patients w/pain + addiction – ~50% ?
- Public policy very influential

Similar industry sales efforts:

- 1) reps = consultative approach: “teach”
- 2) Goals to ↑ access AND ↑ # of providers
- 3) strong public sector /gov't affairs focus

Public Health Policy Interventions:

Increase Transparency /Disclosure: “sunlight” factor

Improve access to “proprietary” industry marketing

- Document Archives, example: USCF opioid industry documents)
- FDA /OPDP could create a **new online database** of pharma RX marketing pieces- to crowd-source scrutiny by researchers, patient advocates, journalists
- Expand Open Payments data- add payments to 3rd parties, e.g. Patient Advocacy Organizations

Marketing restrictions & public health law

- **Bans:** payments to HCPs/ Gifts/ Sampling/ Coupons, Savings Cards
- Data mining by industry- how to regulate?
- Challenge = court precedents- free speech- Supreme Court 2011 decision in Vermont, Sorrell vs. IMS Health

Clinicians/ Prescribers/ Pharmacists

- Require Conflict of Interest policies
- Restrict industry access, i.e. “No see” policies
- Education on industry interactions & ethics

Sales Representatives

- Professional Licensing / Registries (now in Oregon, Nevada, Wash. D.C. & Chicago)
- Ethics codes
- Independent Continuing Education
- Compensation changes? Attempt to change compensation tied to sales targets haven't stuck: Glaxo backtracked on reforms “to be competitive”

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