Pharmaceutical marketing and the abstraction of consumer needs

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By

In my last post, I recounted Merck's reorganization from a research-driven to a marketing-driven company. All of the large companies in the industry underwent a similar transformation starting in about the late 1980s. In that post, I listed a number of environmental circumstances that led to this reorientation, the most significant of which was the state of the competition.

There was also a conceptual development in medicine and public health that prepared the ground for new possibilities in expanding the market for pharmaceuticals, which in turn excited more marketing involvement. This was the shift in focus from the treatment of visible disease (old medicine) to the management of risk (new medicine). In keeping with the growing faith in the universal scientific superiority of quantitative measurements, in medicine too epidemiological studies changed how medicine was practiced. Practitioners became reliant on statistical tabulations of risk and on the use of guidelines and rating scales with which to evaluate the patient sitting in front of them.

This change was already in evidence long before the blockbuster era proper (see Healy 2002, Greene 2007). However, it was the start of a trend that would reach full realization much later, in which abstractions could be deployed as marketing tools for convincing physicians and consumers that increased consumption of pills would lead to improved health. Prescribing by numbers, to use Greene's expression, was uniquely suited to fostering the growth of marketing activities in the pharmaceutical industry.

The abstraction of symptoms to invisible markers allowed the pharmaceutical industry to redefine their work as being not just the treatment of disease, but the management of risk associated with becoming sick. More importantly, from a commercial point of view, curative treatments tend to be of short duration, whereas the management of risk is ongoing. The goose that lays blockbuster eggs is not cure, but maintenance and prophylaxis. Antihypertensive medications are forever; premenstrual dysphoric disorder and hormone replacement therapies are intended to blanket the individual's lifetime; cholesterol-lowering

medication, with the incipient endorsement of the American Academy of Pediatrics, may soon be marketed successfully as a cradle-to-grave protection against cardiovascular risk.

Slowly this logic overtook the rationale for drug development in many sickness categories: osteoporosis, gastritis, arthritis, type-II diabetes, irritable bowel syndrome, insomnia, allergies, and pretty much all psychiatric disorders including ADHD, bipolar disorder, depression, obsessive compulsive disorder, and dementia. Many of these are measured abstractly either because they conform to epidemiological rather than medical inspirations to diagnosis (i.e., you don't feel sick when your triglycerides are high), or because the symptoms are calculated against a rating scale that objectifies the patient from a distance, as when a patient who reports to her primary care physician that she tends to blush, or has experienced poor appetite lately, or is low on energy, or is simply not feeling as good as she used to is prescribed an antidepressant.

Through the abstraction of risk numbers and rating scales, pharmaceutical marketers have found undreamt of reserves of unconscious and invisible "needs" that they have been able to construe as "unmet" and that they are appointed to meet. (If you don't believe me about where some marketers think our unmet needs are waiting, like buried treasure for their excavation, read about Harvard Business School professor Gerald Zaltman's work: http://hbswk.hbs.edu/item/3246.html)

Few people today question the validity of this paradigm of discovering and treating sickness, much less notice that the incidence of most of the above named sicknesses have mysteriously expanded manyfold in recent decades. Are we witnessing progress in medicine? Or is it progress in marketing? Don't just say 'both'. It's true, but saying so diverts us from recognizing that drug marketers are in competition with medicine for ownership of the criteria that measure disease and prescribe treatments.

Often, where we find lifelong or maintenance therapy risk management, the research that resulted in discovery, estimation of prevalence and then treatment was not inspired by medical scientific or epidemiological curiosity, but by sponsored investigation and "condition branding," just one technique in the pharmaceutical marketer's arsenal. Condition branding may sound technical or innocuous to some, who might react to this discussion with: "It's just marketing doing its work and, besides, what's good for marketing is good for America." Most of us have become convinced, not coincidentally through industry propaganda, that disease awareness campaigns might do much good, in that sick people previously untreated might thereby go to the clinic and get treatment.

What a growing critical health studies literature has shown, however, is

that condition branding quite often does not begin with the determinations of medical science, after which marketing takes up the role as conveyor of information and purveyor of solution. Instead, the industry builds its expansion platform on small truths—that some people have clinically significant premenstrual dysphoric disorder (PMDD), restless leg syndrome, or social anxiety, for instance; or that some people are at particular risk for cardiovascular disease and should be treated prophylactically with medicines; or that some populations at large are undertreated for depression. These instances become the kernel of truth on which multibillion dollar forays in tendentious science is launched, packaged, and promoted by "key opinion leader" (KOL) doctors to other doctors and to the public as much more prevalent, indeed blockbuster, truths.

The logic of the abstraction of consumer medical needs as a vehicle for strategic medicalization reaches its pinnacle in relation to fields of medicine such as psychiatry, where the nosology and treatments available remain ambiguous and emergent. In these cases, marketers are free to market needs and position products to serve them without having to obey the strictures of scientific determinations. As David Healy pointed out over a decade ago, "Although there are clearly psychobiological inputs to many psychiatric disorders, we are at present in a state where companies can not only seek to find the key to the lock but can dictate a great deal of the shape of the lock to which a key must fit" (1997:212).

In a recent study called "Alzheimer medications and the anthropology of uncertainty," Annette Leibing traces the expansion in Brazil of the use of pharmaceuticals for treatment in dementia. This expansion is not based on the demonstrated efficacy of existing drugs for halting cognitive deterioration, which they cannot do, but on a redefinition of the disorder to include "non-cognitive symptoms and notions like quality of life or functionality" (Leibing 2009: 188). Leibing explains the influence of pharmaceutical marketing in bringing this change about:

"One of the best-known atypical antipsychotics in the treatment of Alzheimer's disease is risperidone – produced by Janssen Pharmaceuticals, which has been actively involved in the creation and promotion of the new category BPSD… Janssen provided an unrestricted grant for a consensus conference organized by the International Psychogeriatric Association (IPA) in Landsdowne, VA in 1996, the event that was central to the development of the new category BPSD. 'The development of the Consensus Statement on Behavioral and Psychological Symptoms of Dementia (BPSD) represents a first step towards recognizing that these are core symptoms of dementia and that it is as essential to study and treat them as it is to study and treat any other aspects of dementing disorders,' wrote one of the organizers (Finkel,

1996, emphasis added). A second conference followed in 1999, resulting in more publications (IPA, 1996a, 1996b, 1996c, 2000, 2002). Afterwards updated educational materials were regularly mailed to all IPA members, in an effort which gradually changed the way health professionals understand and define dementia." [2009:191]

One of the interesting features of Leibing's case is the contradictory combination of increased backing of and reliance on bioscientific treatments of Alzheimer's disease at the same time that the drugs are promoted to treat less neuroscientifically specifiable aspects of the dementia. "There is a lack of definitions and validated measurements of functionality, and their relation to drug efficacy," she says (2009:192). The drugs have dubious efficacy in preventing cognitive deterioration, so they are promoted to treat behavioral problems associated with dementia. On one level there is the truth of scientific evidence; on another, competing level, there is marketing rationale.

This is not to say that BPSD was invented by drug companies, or that it is an unimportant dimension of Alzheimers, or that the promoted drugs will never show an effect in relation to BPSD. The question rather is whether the manipulated push for scientific validation of the drugs for use in BPSD is resulting in drained budgets and enthusiasm for non-pharmacological therapies that may be much safer and more important for helping to manage people suffering from the disease, or for affording them palliative care that at the same time helps reduce the burden to their family members. Pharmaceutical companies are always competing for share of pocket (i.e., of private and public health budgets) against non-pharmacological approaches to treatment, and they've got more propaganda dollars to spend than is good for any of our health.

Pharmaceutical marketers concern themselves with two activities: Determining unmet needs, and making profits by selling drugs that meet those needs. In many cases, the products available are inadequate to the task because the science is undeveloped. Investor and executive greed for profit, however, operates by a different clock than medical progress. The show must go on. If drug companies are to prosper even in scientifically lethargic times, a rationale for sale must be found and pushed through the system. Broadening the definition of a disorder to focus drugs on more abstract needs (quality of life vs. cognitive function, in the case of dementia) enables the selling to continue.

The question we must ask ourselves is whether all this circus of Wall Street-driven science is derailing the progress of health-driven science. Some bioethicists in key policy positions argue that it is not a research entity's tax status that matters in respect to the integrity with which science is carried out. Non-profit and for-profit research is all the same,

they say. I think it is time to reconsider that position.

Further Reading:

Greene, Jeremy. Prescribing by Numbers. Johns Hopkins University Press, 2007.

Healy, David. The Antidepressant Era. Harvard University Press, 1997.

Healy, David. The Creation of Psychopharmacology. Harvard University Press, 2002.

Leibing, Annette. Tense Prescriptions? Alzheimer Medications and the Anthropology of Uncertainty. Transcultural Psychiatry, 46(1): 180-206, 2009.