SHOW ME THE MONEY

IMAGE: GETTYIMAGES

In the wake of industry's CME cutback, dinner meetings and other kinds of peer-to-peer interaction are grabbing more of its meeting spend. Just how much more, and is this good for medical education? **David Rear** reports

Facilitating good patient care through medical education used to be easy. Until the scrutiny began. During the past decade, government and regulatory bodies have paid a lot more attention to potential conflicts of interest among companies and healthcare providers. Media coverage has only magnified the scrutiny, like when Merck was accused of downplaying the cardiac risks associated with Vioxx in many of its medical education programs.

In response to public pressure and a threat of increased government regulation, the industry began adopting strict guidelines on med ed funding, examining its approach to product promotion, and placing the physician-company relationships under a microscope. When these rules and regulations started to take hold, commercial support for continuing medical education (CME) began decreasing.

70-30 split

Providers accredited to produce CME have had to adjust to less funding: 80% of CME in 2010 had no commercial support. Data from the ACCME also show there was a 14.2% decrease in CME activities in 2010 vs. 2009, and a 27.8% decrease in activities vs. 2007.

Some say the decrease in CME funding is due to more regulation. Others cite the economy, patent cliffs and diminished FDA approval rates. "We don't have as many new blockbusters in the market," says Thomas Sullivan, president of med-ed company Rockpointe.

Meanwhile, Cegedim Strategic Data has found that roughly 30% of industry's 2011 meeting budget was allocated toward CME where doctors associate it with a brand, and 70% toward non-CME programs, based on its sampling of the bigger manufacturers (see chart on this page for the relative spend levels).

Pri-Med, a big producer of CME, has branched into peer-to-peer interaction after its live regional conferences declined from 120 to between 60 and 70. Other med-ed firms anecdotally report an uptick in promotional business from pharma. "We are seeing clients shift budgets once allotted for CMEs toward peer-to-peer promotional programs," observes Brian Budisak, co-founder of HealthLogiX.

"It's hard to ignore the statistics," says Dik Barsamian, EVP for the Haymarket US Medical Division. "It would seem that increased regulations have led to the surge we're seeing."

Some believe that more peer-to-peer education could lessen quality. Physicians Michael Steinman, C. Seth Landefeld, and Robert Baron expressed this concern in a 2012 article in *The New England Journal of Medicine*, writing, "If changes in the CME landscape drive physicians away from accredited events toward…non-accredited activities, the overall state of medical education will not have improved."

But evidence suggests that physicians are not being "driven away" from certified events, asserts Hilary Schmidt, PhD, VP, independent grants & learning, Sanofi US. "In fact, the ACCME annual report shows that over the same period that commercial support has decreased by 31% [2007 to 2010], physician participation in CME activities has increased by about 10%."

Steinman and co-authors add, "Reducing industry funding of CME may also result in increases in nonaccredited medical education, such as dinner lectures at restaurants and satellite symposia at professional society meetings."

Yet the number of satellite events has decreased substantially over time, counters Schmidt, in part due to the high cost of these events, and in part due to the fact that they are typically traditional lecture-based formats that have limited impact in improving practice.

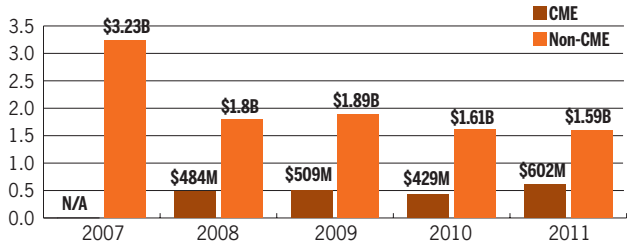
Value in both

Manufacturers like Sanofi remain interested in both forms of education. "When the educational need is related to a product, non-certified promotional education is appropriate. However, when the education need is related to understanding the full scientific information for multiple therapeutic options, or requires discussion of new and emerging research, then CME is appropriate," Schmidt explains.

She points to a 2011 survey by PhRMA that asked HCPs which type of education brings more value. CME was at the top of the list, and company-sponsored peer education programs also scored highly.

Relative funding levels

The following chart, from Cegedim Strategic Data, shows industry's spending on non-CME and on CME sessions, but only those associated with a brand (not a measure of absolute spending).



CME is "even more critical" in fields such as oncology, where data are rapidly evolving, adds Bronte Abraham, principal at BAMA Medical Education Network. "CMEs can provide first hand, non-biased information such as summaries of peer-reviewed presentations from major conferences."

And the potential exists for more investment. Specialty drugs account for 70% of growth in drug spend, focusing in therapeutic areas such as oncology, neuroscience and across the human genome.

Medicines are becoming more complex, and the benefits to patients can only become clear if physicians are properly trained and educated. "Discovery-related information" commands high priority on physicians' information-seeking list, says Mary Manna Anderson, president of Ogilvy CommonHealth Medical Education and SCI Scientific Communications & Information.

Companies, which have a responsibility to inform HCPs about the appropriate use of their products, are investing in medical education to carry out this responsibility. It makes good business sense. But even if the intent is good, public perception of bias rises to the surface.

How do we protect the reputation of promotional med ed? And how can stakeholders prevent the declines in the state of med ed feared by Steinman and colleagues? Says Schmidt: "Both types of education bring value, and it should be the responsibility of the providers, the

industry, and the skeptics to educate healthcare providers on the distinction between CME and promotional education."

That is, non-certified education controlled by a company that discusses a product must be consistent with information that is in the FDA-approved label and based upon FDA standards of substantial evidence or substantial clinical experience, she says. This type of non-certified, on-label information is especially important when a product is new, or the label is updated or revised. By contrast, "CME is unconstrained with respect to dialogue and scientific exchange."

Reinforcing the ethics

It is critical that med-ed companies reinforce ethics. A strong peer-to-peer program starts with good science. Good science facilitates—even requires—collaborative relationships that allow input on content from therapeutic experts. This process ensures that the content is balanced, relevant and based on the principles of good clinical practice.

Situations will arise where content falls beyond the limits of promotional labeling. The need for more information will help identify gaps and opportunities for future clinical trials. This process will direct further research toward patients' needs and provide an advantage to companies facing broad patent expirations on blockbuster drugs, increasing R&D costs and decreasing return on investments.

Grantors must take a leadership role. "Industry may also be driven to redouble its efforts to influence professional societies, policymakers and opinion leaders, all of whom can have major downstream effects on the practice of individual physicians," write Steinman et al.

What types of shifts—professionally, socially, and legally—are needed to facilitate this? We may not have the answers to these questions at the moment. However, keeping them at the forefront as educational and promotional practices evolve may help industry return to the place it once held as a steward of quality medical care. ■

David Rear, RPh, is managing partner at Advanced Clinical Concepts, a medical education company.

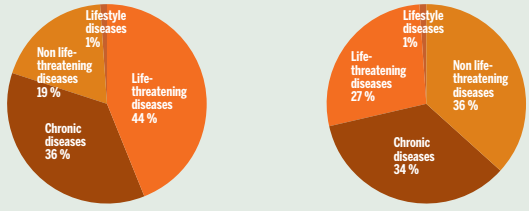
Where the money goes

Pharmaceutical companies spend far more on promotional medical education than on CME, but budgets for both are spread mostly among programs supporting diseases like cancer, depression and diabetes. Drilling down, there are differences in the allocations for each, as show in the following charts compiled by PharmaVoxx based on an analysis of promotional marketing collateral. Its panel spans generalist and specialist offices, pharmacies and hospitals, medical conferences, manufacturer programs, industry journals, consumer publications and online media.

MED ED TYPES, 2011 VS. 2010

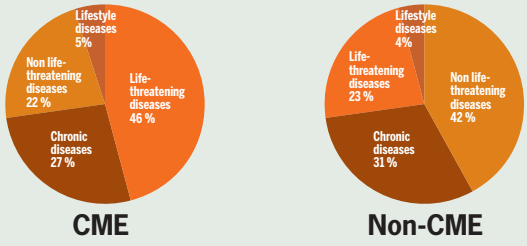
CME-certified activities as a proportion of med-ed activity increased a bit in 2011, but non-CME promotional activities still outnumber CME about three to one. One reason for the uptick: online CME, whose lower cost ensures its durability despite regulatory pressure on commercial support.

TOPICS & OBJECTIVES, 2011



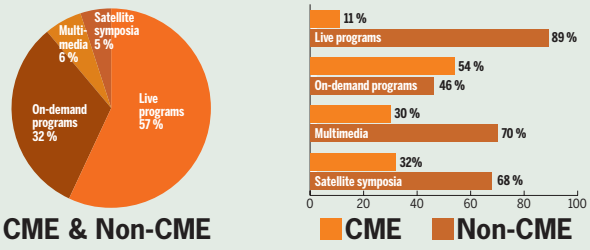
There was little change in volume for pharma-sponsored med ed in 2011. CME activity rose most in the chronic disease category (36% vs. 27% in 2010). On the promo side, there were fewer activities for non life-threatening diseases. Overall, activity for lifestyle diseases dropped by almost half.

TOPICS & OBJECTIVES, 2010



Life-threatening diseases were the topic of 46% of 2010 CME activity. Non life-threatening conditions made up 42% of non-CME activity. The breakdown of topics between CME and non-CME was similar for chronic conditions. More CME programs addressed life-threatening and lifestyle diseases.

ALLOCATION OF FORMATS, 2011



Of four main med-ed formats analyzed, live events/programming made up 57% of activity; only 11% are CME. The next largest subset of med-ed activity, on-demand programs, or those viewable any time (i.e., webcasts, audiocasts), has a more even distribution (46% non-CME vs. 54% CME).