
**OPPOSITION TO HB 1346
By IMS Health and Verispan**

**HB1346 is Wrong Prescription for New Hampshire and Will
Do Nothing to Improve Its Citizens' Well-Being**

Law Compromises Healthcare Quality and Patient Safety

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HB 1346: The Wrong Prescription for New Hampshire

Leading healthcare information organizations IMS and Verispan have been advancing public health for decades. We have done so by responsibly collecting, analyzing and sharing information with a variety of healthcare stakeholders. *The use of this information extends well beyond pharmaceutical marketing* into such areas as drug safety, public health monitoring, and patient treatment variability—all benefiting the public interest, all necessary to improving overall healthcare.

We oppose HB 1346 because it deprives the healthcare system of critical information that is vital to ensuring patient safety and improving healthcare quality. This law will do nothing to improve the well being of New Hampshire citizens, but will have far-reaching, unintended consequences by limiting sources of information for research and other public health purposes. Commercial databases developed by healthcare information companies offer the only comprehensive sources of prescribing information that can be used for a variety of applications that benefit the healthcare system. While HB 1346 recognizes the beneficial public health applications of this information, it effectively takes away the incentive for collecting these data.

In the public and private sectors, demand for evidence-based medicine, accountability, and transparency has never been greater. Healthcare information organizations have worked with clinical, scientific and regulatory organizations around the world, sharing our information to help improve their understanding of critical healthcare dynamics. In today's environment we are seeing a prevailing need among patients, providers and physicians for access to more information, not less, to make *informed* healthcare decisions. HB 1346 will undermine this free flow of information.

The following pages outline some of the unintended consequences of HB 1346 and how a seemingly narrow law can have large-scale public implications. The public good is best served by evidence-based medicine, improved transparency in the healthcare system, and continued responsible use of these data.

Patient Privacy is Not at Issue

IMS and Verispan unconditionally support patient privacy. Our commercial databases are comprised of patient de-identified data. This means that health information companies do not collect, use or transfer information that identifies a patient in any of their subscription services. We do not oppose the provisions of the New Hampshire law that affirm patient privacy; we have been working with similar provisions under federal law since 2003 (the Health Insurance Portability and Accountability Act, HIPAA).

We operate with extensive controls to both (i) protect the privacy of individual patients and (ii) preserve the confidentiality of the information we collect. We remain attuned to our obligation to responsibly handle and use information relating to physicians in their professional capacity, and have worked closely with the American Medical Association and other stakeholders to strike an appropriate balance between information access and reasonable limits to its use and disclosure relating to physicians. And we have contracts and policies with clients to ensure appropriate use of this information.

The Case Against HB1346

While IMS and Verispan have an obvious commercial interest in opposing HB 1346, we also believe the law is bad public policy. It will eliminate many beneficial uses of non-patient identified prescription information and will have unintended consequences that will hinder current and future research and detection efforts that can improve patient care and control healthcare costs. At its core, HB 1346 restricts access to lawfully obtained, commercial information. Specifically the law:

- Adversely Impacts the Healthcare System. Restrictions on the use of prescriber-level information deprive the healthcare system of critical information, hindering current and future research that can ensure patient safety and improve healthcare quality. In an environment where more transparency in healthcare is needed, not less, HB 1346 limits the availability of information used to support many beneficial healthcare applications. Without access to this information various healthcare stakeholders will be limited in their ability to:
 - set and promote public health policy.
 - distribute drug samples, which many physicians provide free to indigent patients.
 - expedite communications to physicians about innovative new treatments and treatment alternatives.
 - drive clinical best practices and identify patient treatment variability.
 - execute drug safety studies.
 - improve compliance programs.
 - fully understand drug interactions.
 - conduct effective drug recall programs.
 - assess drug utilization patterns.
 - recruit physicians for clinical trials.
 - conduct effective continuing medical education programs.

Creates A Special Set of Rights for Physicians. HB 1346 asserts a right of privacy for physicians in their professional capacity. However, U.S. law does not recognize any right to privacy for an individual in their professional or work capacity; the concept of privacy in the United States protects personal matters. Attorneys, accountants, architects, dentists, engineers, home improvement contractors, physicians, stockbrokers and veterinarians, for example, may not prohibit their customers from disclosing information to friends, family and others about the work done on their behalf. We all rely on referrals (and warnings) to make appropriate choices as consumers. If physicians have a privacy right to protect information about their medical practices, then other professionals will also have that right. In the United States, we rely upon the free flow of information to help us learn about the practices of those businesses and professionals who offer their services to the public in order to make informed choices.

- Physician Information Distinct from Patient Information. Access to prescriber-level information, which is part of a *commercial transaction*, should not be confused with access to patient information. A prescriber's transactional information DOES NOT contain patient information. By addressing physician and patient privacy rights in one law, New Hampshire legislators have implied that a physician's commercial information is somehow linked with a patient's personal information, which it is not. They have garnered support and blurred the distinction between the rights of a patient and those of a physician. As written, HB 1346 undermines the ability of patients and other stakeholders to have access to and make use of information needed to make informed healthcare decisions. In addition to establishing privacy rights for physicians, HB 1346 blocks the use of accurate, lawfully obtained information and is therefore an unconstitutional restriction on free speech. After understanding the consequences, 15 states rejected legislation comparable to HB 1346.
- Creates Unnecessary Legislation. HB 1346 is fundamentally about restricting access to prescriber-level information and not about patient privacy. It affords no additional patient privacy rights than current Federal laws. It attempts to legislate the behavior of pharmaceutical sales reps through indirect control of information and alleviate physician concerns about use of prescribing information.

To address this issue, the American Medical Association has developed its Prescribing Data Restriction Program (PDRP). This program gives all physicians the *choice* to block sales reps from seeing prescription information about their prescribing decisions without threatening access to critical healthcare intelligence by others. Physicians also acknowledge there are educational benefits to pharmaceutical sales rep visits and to other applications of prescribing information within the healthcare system. HB 1346 eliminates the benefits of the AMA PDRP program for physicians throughout New Hampshire.

In addition to the AMA PDRP initiative, a pilot program has been initiated with the California Medical Association that will make prescribing information available to member physicians, giving them better insight into their own prescribing behaviors and that of their peers—ultimately driving better patient care. Without being legislated, the industry is already taking appropriate, proactive steps to address physician concerns, while preserving access to prescriber-level information.

Conclusion: HB 1346 Deprives the Healthcare System of Critical Information and Offers No Clear Benefits

Recent trends all point to the increasing need for high-quality, objective health data to address key policy issues such as patient safety, risk management, cost management and patient choice. The new models of healthcare require that all involved stakeholders – physicians, pharmacists, consumers, pharmaceutical companies, government – have access to data in a meaningful and transparent way to ensure accountability. While we cannot predict some of the future uses of information, we are certain that access to more data, not less, from many stakeholders in healthcare will be needed to improve patient outcomes (*see pages 6-7 for examples*).

Healthcare information organizations offer the only comprehensive, timely source of vital prescribing information—across geographies and payers—that can be used for a variety of applications benefiting the healthcare system. There is no other way to access a complete set of prescriptions in a timely and meaningful way. We provide physician prescribing data to government agencies, public health organizations, academic institutions, health researchers and many others whose work directly benefits the public. All of these beneficial uses rely upon the timely availability of this information, which would not be possible without the existence of large commercial databases.

HB 1346 restricts the free flow of this critical information, which undermines research, analysis, development and implementation of practice guidelines and public health policy for the purpose of advancing patient health, and in the end, does nothing further to protect patient privacy. It has no clear benefit to the healthcare system or to New Hampshire consumers, and will have far-reaching, unintended consequences. ***The public good is best served by evidence-based medicine, improved transparency in the healthcare system, and continued responsible use of and access to these data.***

How Prescriber-level Information is Used

By covering a wide and deep array of U.S. prescription data, healthcare information organizations are able to provide various healthcare constituents with a *central* repository of pharmaceutical knowledge. This knowledge is critical to understanding the interrelation among prescription sales, dispensing, promotion and pricing, as well as medical diagnoses and treatment. All of this is at risk with legislation such as HB 1346.

Using prescriber-level information obtained from pharmacies, we are able to assist the medical, scientific, government, pharmaceutical and health care management communities in conducting outcomes research, implementing best practices, and applying health economic analyses. In addition to other noted uses in this paper, our databases of prescription drug transactions are essential to:

- Drug Utilization Studies. Physician prescribing patterns have wide-ranging variances. Over time, analysis of this variability in physician treatment patterns offers better insights into areas of best practice and identifies those who may benefit from additional exposure to those clinical “learnings.”
- Concomitant drug interaction. The increased number of drugs on the market (currently over 100,000) and thousands of adverse drug events reported to the FDA has elevated the importance of efficiencies in data searching. Prescriber-level data are used to quantify prescribing volume and better understand concomitant drug interactions.
- Drug safety and product withdrawal. By correlating national prescription, sales and medical data, the industry is able to conduct more reliable and accurate drug safety studies and product withdrawal programs.
- Long-term drug effects. Records of drug usage in primary care go back to 1958. Such information is critical to the study of long-term effects of pharmaceutical products. Prescribing data have been used to complete studies on such chronic, high-cost conditions as diabetes, asthma and cardiovascular disease.
- Orphan drug analyses. Research and development for orphan drugs (less-profitable products that target rare diseases) is needed for disease management in economically disadvantaged populations. Prescription information has been used by the FDA and the Drug Information Association (DIA) to study the essential questions surrounding R&D for rare diseases.

In addition to pharmaceutical manufacturers, clients who use prescription information include the U.S. Food & Drug Administration, the Department of Defense, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, and other government agencies. These data are also used by the U.S. Department of Labor to calculate the Consumer Price Index and the Producer Price Index, and have been used in connection with state investigations into illegal prescribing practices.

Examples of Academic/Public Health Use of Prescriber-Identified Prescription Data

Healthcare information organizations are important sources of data for researchers and policy analysts worldwide. Here are some examples of recent studies that have used prescriber-level data:

- Asthma in Low Income Areas. A study in New York used prescriber-level information to examine physician-prescribing patterns in underserved urban areas to determine patterns of under-treatment of patients with asthma. There was substantial evidence that asthma controller medications were underutilized, which reflected issues in both physician education and public perceptions. Feedback on the study findings was provided to physicians to engage them in implementing appropriate public health solutions.
- Regional Impact of Bioterrorist Threats on Prescribing. Wisconsin researchers at the Marshfield Clinic Research Foundation used IMS prescriber-level information to determine if the public demand for fluoroquinolones, such as Cipro, after post-9/11 bioterrorist threats would spread to communities not directly affected by anthrax scares in New York, New Jersey, Connecticut, Pennsylvania, Virginia, Maryland and Florida.
- Educational Approach to Community Antibiotic Utilization. A community education program called “*Do Bugs Need Drugs?*” was instituted by the University of Alberta, the Capital Health Region, Dynacare Kasper Medical Laboratories, and others to address inappropriate antibiotic use for respiratory tract infections—causing antimicrobial resistance in children. Using prescriber-identifiable information, the organizations were able to demonstrate that an educational campaign directed at physicians and pharmacists, and then to school children and the public were effective in decreasing the overall number of antibiotic prescriptions for infections not requiring drug therapy.
- Use of Antidepressants in Adolescents. The Center for Pediatric Pharmacy Research in London completed a nine-country study with prescription data to examine the prescribing trends of psychotropic medications such as antidepressants, stimulants, antipsychotics, benzodiazepines and other anxiolytics among children. Studies in the U.S. had shown that the use of psychotropic medications in children was rapidly increasing and a similar trend was being reported in Europe. The study indicated that there was improved diagnosis and use of these medications among children, but also suggested that while abundant research had been conducted on adults, little had been done with children—suggesting a cautious approach to use of these drugs.
- Community Intervention to Reduce Overuse of Antibiotics. A research team at the Marshfield Clinic Research Foundation relied on prescriber-level data to complete a pediatric study on the judicious use of antibiotics. The objective of the study was to assess the impact of parent and clinician education on antibiotic prescribing and carriage of penicillin-nonsusceptible *Streptococcus pneumoniae* in children. The study resulted in a multifaceted education program that led to community-wide reductions in antibiotic prescribing.

Case Study No. 1:

Asthma in Low Income Areas

The issue

Asthma is a common disease among children and adults in urban areas such as New York City. People with asthma experience chronic lung inflammation and episodes of airway tightening that cause wheezing, coughing and shortness of breath. Asthma is the leading cause of missed school among children, and is the most common cause of hospitalization in children 14 years and younger.

How The Information Helped

Although asthma afflicts individuals in many parts of the country, it is particularly prevalent in urban settings. Prescriber-identifiable information was used as part of the New York City Asthma Project to identify prescribing patterns in various boroughs of the City. The project's goal was to determine if asthma medications were being under prescribed, particularly in low income areas of New York City, and whether or not asthma education within the community and among physicians could improve the health and well being of those suffering with asthma.

Outcomes & Benefits

Physician-prescribing patterns in underserved, low income areas of the City were examined to determine patterns of treatment among patients with asthma. There was substantial evidence that asthma medications were being underutilized, which reflected issues in both physician education and public perceptions. Feedback about the study results was provided to physicians serving various neighborhoods within New York City to engage them in implementing appropriate solutions. The program is ongoing.

Case Study No. 2:

Regional Impact of Bioterrorist Threats on Prescribing

The Issue

Media reports had suggested increased public demand for anthrax prophylaxis after the intentional anthrax cases in 2001, but the magnitude of anthrax-related prescribing in unaffected regions was not assessed. An ABC News/Washington Post poll found that 65% of respondents were worried about receiving letters contaminated with anthrax bacteria, and 54% were worried about an anthrax attack on themselves, friends or relatives. Did this fear increase the public demand for and the dispensing of fluoroquinolones, such as Cipro, to patients in areas where no anthrax cases or exposure occurred?

How The Information Helped

Researchers sent an anonymous survey to physicians in Wisconsin and Minnesota requesting information on anthrax-related requests from patients for fluoroquinolones. Those noting that they prescribed or distributed anthrax-related medications were asked to specify the number and types of people who received drugs, and the specific drugs that were used. Both prescription drug sales and prescriber-identifiable information were used as independent measures of fluoroquinolone use for the states of Wisconsin and Minnesota.

Outcome & Benefits

The results of the study confirmed that public demand for anthrax-related antimicrobial agents was substantial in Wisconsin and Minnesota, with one fourth of the primary care physicians receiving requests for these drugs. Despite strong requests, relatively few drugs were dispensed for anthrax prophylaxis, demonstrating that most physicians in these states managed public and patient expectations without dispensing unnecessarily. However, social factors clearly have an influence on prescribing decisions and effective public and physician communication is *essential* to promoting rational prescribing behavior if similar situations arise in the future.

Authors: Edward A. Belongia, M.D., Burney Kieke, Ruth Lynfield, Jeffrey P. Davis, Richard E. Besser

Case Study No. 3:

Educational Approach to Community Antibiotic Utilization

The Issue

Inappropriate antibiotic use for respiratory tract infections has contributed to the current global crisis of antimicrobial resistance. The University of Alberta, the Capital Health Region, Dynacare Kasper Medical Laboratories, Abbott Laboratories, the Alberta Lung Association and the Clinical Practice Guidelines program of the Alberta Medical Association, joined together to determine whether or not an educational approach to community antibiotic utilization would be successful in improving oral antibiotic use.

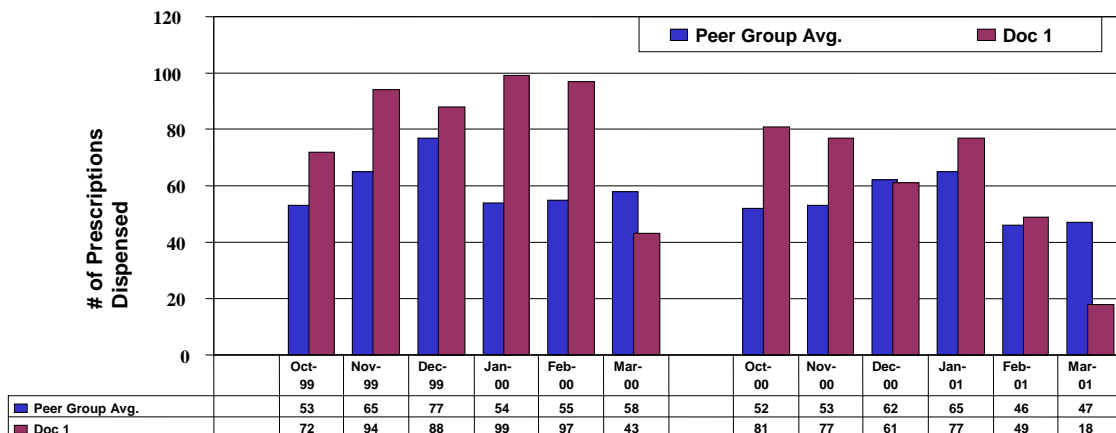
How The Information Helped

The objective of the program, entitled *"Do Bugs Need Drugs?"*, was to demonstrate that an educational campaign directed at physicians, pharmacists, school children and the public would be effective in: decreasing the overall number of prescriptions for an antibiotic; increasing the relative use of first-line agents; and increasing awareness and knowledge of three key program messages: 1) the importance of hand washing; 2) the differences between bacteria, viruses and the effect of antibiotics; and 3) bacterial resistance and the need to use antibiotics wisely. Prescriber-identifiable information was used by the organizations to identify prescribing patterns among physicians who used antibiotics to treat children with respiratory tract infections and to measure what impact targeted community and professional education had among patients and physicians.

Outcomes & Benefits

The study demonstrated the effectiveness of a community educational campaign, aimed at physicians, pharmacists and the public, in addressing the serious problem of antimicrobial resistance. With increased knowledge and awareness, patients were willing to do without unnecessary antibiotic prescriptions, and professional guidelines for appropriate antibiotic selection were followed more closely. This helped address the Canadian mandate to decrease antibiotic use in respiratory tract infections. Access to IMS prescriber-identifiable data was part of the solution to the long-term health risk posed by antimicrobial resistance – ultimately saving lives in Canada. The program has had such success that Dr. Blondel-Hill is launching a similar initiative in British Columbia.

Total Antibiotic Prescriptions Dispensed: Month 6



The prescription rate for oral antibiotics to treat respiratory tract infections (otitis media, bronchitis, pneumonia, pharyngitis and sinusitis) was 12% lower than the corresponding period the previous year, and decreased more in the study community than in the control communities. The use of first-line agents to treat respiratory tract infections was significantly higher than the corresponding national statistics, and all groups showed increased levels of awareness and knowledge of the problem of antibiotic resistance and the importance of hand washing.

Project Team Leader: Dr. Edith Blondel-Hill

Case Study No. 4:

Use of Antidepressants in Adolescents

The Issue

The Center for Pediatric Pharmacy Research in London completed a nine-country study to examine the prescribing trends of psychotropic medications such as antidepressants, stimulants, antipsychotics, benzodiazepines and other anxiolytics among children. Studies in the U.S. had shown that the use of psychotropic medications was rapidly increasing and a similar trend was being reported in Europe. However, there was little information on the prescribing trends in other countries and it was unknown whether this was a global trend or a trend in English speaking countries.

How The Information Helped

Prescribing insights were used to examine prescribing trends in nine countries (U.K., France, Germany, Spain, Argentina, Brazil, Mexico, Canada and U.S.) between the years 2000 and 2002. Trends in seven countries rose significantly from year 2000 to 2002, with the UK having the highest increase (68%).

Outcome & Benefits

The results of this study showed that the increase in psychotropic prescribing in children was not confined to the U.S. but was also evident in other non-English speaking countries. The increase probably indicates the improved recognition of pediatric psychopathology, but could also suggest that these drugs are replacing non-drug treatments. The study mirrored the dramatic increase in antidepressant prescriptions that occurred between 1992 and 2001. The correlation between the two increases indicates the strong possibility that the rationale behind the choice of which drugs to prescribe is based on the evidence completed in adult trials and not on evidence garnered through research in children—proving the need for more well-designed clinical trials to investigate the safety and efficacy of these medications in children.

Authors: I C K Wong, M L Murray, D Camilleri-Novak and P Stephens

Case Study No. 5:

Community Intervention to Reduce Overuse of Antibiotics

The Issue

Respiratory tract and invasive infections caused by *Streptococcus pneumoniae* are a major source of morbidity among children and older adults in the U.S. During the past decade or so, the prevalence of antibiotic-resistant pneumococci has increased dramatically, due in large part to children under age 15 receiving antibiotics for conditions not requiring drug therapy—building up their resistance to certain medications.

How The Information Helped

A controlled intervention trial was conducted in Northern Wisconsin to determine if a multi-faceted educational program for physicians and parents would lead to community-wide reductions in antibiotic prescribing. Educational materials and small-group presentations were conducted with parents and physicians through clinics, child care facilities and community organizations. Prescription drug sales data and prescriber-identifiable prescribing information were used for baseline purposes and to measure the impact of this community intervention on antibiotic prescribing behaviors related to children.

Outcome & Benefits

The results of the study demonstrated that community-based educational intervention programs in the U.S. can reduce unnecessary antibiotic prescribing for children, but it did not demonstrate a reduction among children who attended child care.

Authors: Edward A. Belongia, M.D. Bradley J. Sullivan, M.S., PhD., Po-Huan Chyou, PhD., Elizabeth Madagame, M.D., Kurt D. Reed, M.D., Benjamin Schwartz, M.D.

Use of Prescription Information By Academic Institutions, Government Agencies and Non Profit Organizations

Healthcare information organizations have worked with researchers and health policy analysts from these organizations in connection with the use of prescription data:

American Red Cross	Attorney General offices (over 20 states)
Brown University	Centers for Disease Control
Centers for Medicaid and Medicare Services	Columbia University
Cornell University	Drug Enforcement Administration
Emory University	Federal Trade Commission
Food and Drug Administration	Fordham University
General Accounting Office	Global Alliance for Tuberculosis Drug Development
Harvard University	Institute of Medicine of the National Academy of Sciences
Jacksonville University	Kaiser Family Foundation
Mayo Clinic	Memorial Sloan-Kettering
MIT Sloan School of Management	National Foundation of Science, Biotechnology and Medical Research
New York University	Northwestern University
Penn State University	Rutgers University
Southern Illinois University	St. Joe's University
Stanford University	State University of New York, Stony Brook
Temple University	Tufts University
Tulane University	U.S. Congress
U.S. Department of Justice	U.S. Department of Labor
University of Arizona	University of California
University of Chicago	University of Connecticut
University of Maryland	University of North Carolina
University of Pennsylvania	University of Pittsburgh
University of Rochester	University of Wisconsin
Vanderbilt University	Virginia Commonwealth University
Wake Forest University	World Bank
World Health Organization	Yale School of Management

Note: Each of these organizations benefited, directly or indirectly, from the use of prescribing data to support studies, research and other applications.