EDITORIAL

Conflict of interests driven by pharmaceutical incentivisation: risks to the medical fraternity in Pakistan

Muhammad Naveed Noor[1], Afifah Rahman-Shepherd[2], Amna Rehana Siddiqui[3]

Conflict of interest (COI) in medical practice, and how it affects healthcare delivery and quality, is a poorly studied issue in Pakistan. COI can broadly be defined as a situation that arises when the opportunity for personal gain takes primacy over an individual's professional responsibilities.[1] In medicine, trust is the cornerstone of the doctor-patient relationship. Doctors hold an authoritative position based on their knowledge and expertise and are entrusted by the healthcare system and patients to put the patients' best interests first. This means that to maintain trust, not only doctors are required to appropriately diagnose, treat and/or manage patients' illnesses, but also consider their social and financial circumstances.

In this editorial, we draw attention to a prime example of how COI manifests in medical practice as a result of the interactions between doctors and pharmaceutical sales representatives (PSRs). While PSRs are a source of knowledge on existing and new pharmaceutical products, this relationship can turn into an apparatus of financial corruption, when, in their efforts to maximise profits, PSRs incentivise doctors for prescribing. We refer to this as incentive-linked prescribing (ILP) whereby doctors accept some form of incentive in exchange for prescribing to meet pharmaceutical sales targets, without considering the added financial burden on patients and adverse health outcomes.

In 2021, the Drug Regulatory Authority of Pakistan (DRAP) published rules by which pharmaceutical companies are prohibited to offer incentives to doctors for prescriptions, however, these rules are poorly enforced.[2] The absence of concrete legislation, clear-cut guidelines, sound monitoring, and regulation mechanism paves the way for the establishment of the unethical profit-driven relationship between doctors and the pharmaceutical industry.

[1]Aga Khan University, Karachi, Pakistan; [2]London School of Hygiene and Tropical Medicine, London, UK; [3]Jinnah Sindh Medical University, Karachi, Pakistan.

Correspondence: Muhammad Naveed Noor. e-mail: naveed.noor@aku.edu

Consequences of ILP to patients, doctors, and the healthcare system

There is growing attention to ILP and its consequences to medical practice and public health in Pakistan. Research has shed light on the well-entrenched influence of PSRs on physicians prescribing practices.[3] This level of influence is achieved with the help of incentives, which foster dependent relationships between physicians and the pharmaceutical industry. Alarmingly, much of the research concludes that ILP has become normalised within the medical fraternity and how they interact with pharmaceutical companies.[3,4]

ILP can lead to several negative consequences for patients, doctors, and the healthcare system, and it is critical that doctors are made aware of these consequences. Patients may be aware of the unethical profit-driven relationship between doctors and pharmaceutical companies, and for this reason, lose trust in doctors. Doctors may prescribe most costly and/or unnecessary medications than what would otherwise have been prescribed. This can put patients under additional financial pressure and subject them to potential adverse health outcomes. Indeed, ILP is one of the largest contributors to the consumption of antibiotics in Pakistan, in addition to over-the-counter medications.[5] The abuse and misuse of antibiotics is the leading reason for antimicrobial resistance (AMR) worldwide, which is one of the top ten threats to global health and is estimated to cause ten million deaths each year by 2030.[6] These consequences have significant negative implications for the healthcare system, in terms of burden of disease, financing, and quality of care provided.

Explaining ILP in the Pakistan context

Since 2019, we have been investigating the perceptions of private doctors, PSRs, and policy in Pakistan with regards to ILP. First, we found ILP to be a widespread practice that all stakeholders who we interviewed for our research were aware of.[7,8] We documented five broad categories of incentives exchanged between doctors and PSRs: financial (e.g., cash, cheques), material (e.g., gifts, medical equipment), professional or educational (e.g., training, conferences), social or recreational (e.g., dining, holidays), and familial (e.g., children's tuition fees).[8]

Second, we examined the factors contributing to ILP in Pakistan. Several factors were identified at the individual (i.e., a desire for profit-maximisation), interpersonal (i.e., growing family needs), contextual (i.e., the use of incentivisation as a tool to compete in the market), and policy levels (i.e., weak governance and regulation).[9] Through this research, we were also able to highlight how key stakeholders benefit from ILP, making it even more challenging to address.

Third, we compared ILP in practice with key policies designed to regulate physician-pharma interactions in Pakistan. We found three main policy weaknesses that create an enabling environment for ILP: 1) weak enforcement of policies, with insufficient consequences in cases were noncompliance is identified; 2) policies differ in the extent to which they prohibit or permit different types of incentives, sometimes contradicting one another; and 3) some types of incentive are largely unaddressed across all policies, these include clinic improvements (material) and children's tuition fees (familial).

Our ongoing research indicates that relevant legislation, clear policies and guidelines, and appropriate monitoring mechanisms are essential towards creating an environment that reinforces the principles and standards of ethical physician-pharma interactions.

Ways forward to address ILP

ILP is an unethical practice that negatively impacts patients, doctors, and the healthcare system. In order to prevent its catastrophic effects in future, legislators, regulators, and the medical fraternity must take immediate action to break the unethical profit-oriented nexus between doctors and the pharmaceutical industry in Pakistan. We propose the following areas for urgent attention:

1. Monitoring and response mechanisms should be implemented with the ultimate agenda of benefit to the general public.

2. Introduction of educational reforms targeting both the undergraduate and postgraduate levels, such as doctors' continuing education on the consequences of ILP, clear guidelines on the relationship between doctors and pharmaceutical companies, and regulatory controls are critical.

3. Development and implementation of these reforms will need multipartisan political support and continued engagement with influential stakeholders from the healthcare commissions, medical associations, pharmaceutical industries, policymakers, and consumers.

4. In parallel, renewed research to identify barriers and enablers of ethically sound practices among the pharmaceutical industry, healthcare organizations, and physicians in Pakistan and other LMICs is critical to allow development and refinement of contextual solutions.

In short, unless ILP is addressed, achieving superior quality care is likely to continue to be a problem in the first line of healthcare for Pakistani citizens.

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References

1. Rahman-Shepherd A, Balasubramaniam P, Gautham M, Hutchinson E, Kitutu FE, Marten R, et al. Conflicts of interest: an invisible force shaping health systems and policies. The Lancet Global Health 2021;9:e1055-e56.
2. DRAP. Ethical Marketing to Healthcare Professionals Rules, 2021 (S.R.O. 1472(I)/2021). In: Pakistan DRAo, ed. Islamabad, 2021.
3. De Andrade M, Jafarey A, Shekhani SS, Angelova N. The ethics of pharma–physician relations in Pakistan:"When in Rome". Ethics Behav. 2019;29:473-89.
4. Ahmed RR, Saeed A. Pharmaceutical drug promotion practices in Pakistan: Issues in ethical and non-ethical pharmaceutical practices. Middle-East Journal of Scientific Research (MEJSR) 2014;20:1630-40.
5. Malik F,Asif M, Khan S, Hakeem L,Ilyas S, . How pharmaceutical marketing manipulates the prescription pattern of physicians? A grounded theory study. Int. J. Innov. Creativity Chang. 2021;15:735-53.
6. Sugden R, Kelly R, Davies S. Combatting antimicrobial resistance globally. Nat. Microbiol 2016;1:1-2.
7. Noor MN, Liverani M, Bryant J, Rahman-Shepherd A, Sharif S, Aftab W et al. The healthcare field as a marketplace: general practitioners, pharmaceutical companies, and profit-led prescribing in Pakistan. Health Sociol. Rev. 2022; 32:1-15. DOI: 10.1080/14461242.2022.2139628
8. Khan M, Rahman-Shepherd A, Noor MN,Sharif S, Hamid M, Aftab W, et al. Incentivisation practices and their influence on physicians' prescriptions: A qualitative analysis of practice and policy in Pakistan. PLOS global public health 2023;3:e0001890.
9. Noor MN, Rahman-Shepherd A, Siddiqui AR, Aftab W, Shakoor S, Hasan R, et al. Socioecological factors linked with pharmaceutical incentive-driven prescribing in Pakistan. BMJ global health 2023;6(Suppl 3):e010853.