► ***a-*** *Eflornithine was not effective in the treatment of cancer but, like cytotoxic agents, caused hair loss. This effect led to development of Vaniqa° in hirsutism (1).*

b- *The re-emergence of African trypanosomiasis, a disease that had become rare in 1960, resulted from the virtual disappearance of mobile screening and treatment teams, as well as marked economic deterioration and wars in countries such as Congo, Angola and Sudan. According to the World Health Organisation (WHO), 60 million people have been exposed to the infection and about 500 000 are infected and will die if left untreated (6,7).*

c- *Treatment was then based on pentamidine and suramine sodium in the lymphatic-blood phase of the disease, and melarsoprol in the terminal meningoencephalic phase (4,7).*

d- *During the same period, melarsoprol production became unreliable, as did suramine production; the price of pentamidine (reformulated to prevent Pneumocystis carinii pneumonia) rose 10-fold (1,4).*

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ADVERTISING

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"Compliance support programmes": a Trojan horse

● **France may soon legalise company funded "compliance support programmes", using the transposition of a European Directive that does not even mention this issue as a smokescreen. Drug companies' covert goal is simply to increase the use of their products.**

Direct-to-consumer advertising of prescription drugs is permitted in the United States, where public protests led pharmaceutical firms to adopt a specific code of conduct (1). This practice is forbidden in Europe, but drug companies, hand in hand with the European Commission, are continually seeking to "soften up" this prohibition (2).

A Trojan horse. Drug companies use "compliance support" as a key argument in favour of direct-to-consumer advertising (3).

According to a report written for drug company executives, "*Pharma companies have good reason to be concerned that so many patients with chronic conditions are dropping out of therapy prematurely. Not only does that drastically decrease the campaign's potential return on investment, but a commonly used advertising statistic maintains that it costs six times more to gain a new patient than to retain a current one*" (4). Non-compliance is estimated to "cost" companies more than 30 billion dollars per year (5).

Drug companies have already launched compliance support programmes in many countries.

Improper "transposition" of a European Directive in France. Legalisation of "compliance support programmes" was introduced along with a government bill meant to transpose a European Directive, even though the Directive does not even mention these programmes (see page 115 of this issue) (6). In fact, the European Parliament, along with national governments, rejected Commission proposals supporting direct-to-consumer advertising of prescription drugs.

Resist! The draft bill states that drug companies will be able to use physicians to set up individualised tools (telephone reminders, toll-free numbers, tailored patient education, home nursing visits, etc.)" (6). This is nothing more than door-to-door sales, and will further undermine physicians' and pharmacists' relations with the public.

Patients often have good reasons for stopping treatment. How could these company-sponsored measures possibly promote impartial reassessment of a drug's risk-benefit balance? How could they possibly lead to more effective pharmacovigilance? How could they lead to less costly treatments?

While the principle of "compliance support" is an interesting one, how can anyone believe that drug companies, with obvious conflicts of interest, should provide this service?

Budget restrictions are weighing heavily on many sectors of the healthcare system, but pharmaceutical companies still expect society to pick up the tab (through drug refunding) for home visits by nurses whose unstated goal is to increase prescription drug use.

If we fail to take action on this issue, public interests will yet again be given lower priority than making a profit.

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