# Perspective

## Bringing The DERP To Consumers: 'Consumer Reports Best Buy Drugs'

A leading consumer organization extends evidence-based medicine findings to ordinary consumers.

**by Steven D. Findlay**

**ABSTRACT:** Consumers Union, publisher of *Consumer Reports* magazine, has used the drug class reviews of the Drug Effectiveness Review Project (DERP) as one critical component of a free public information project on the comparative effectiveness, safety, and cost of prescription drugs. The project translates the DERP findings for consumers. Drawing on other sources and adding information on drug costs, the project chooses Best Buy drugs in each category it evaluates. This guidance can help consumers save up to thousands of dollars per year, and it has the potential to reduce overall drug spending. [*Health Affairs* 25 (2006): w283–w286 (published online 6 June 2006; 10.1377/hlthaff.25.w283)]

Peter Neumann accurately portrays the Drug Effectiveness Review Project (DERP) as a bold experiment in evidence-based medicine (EBM).[1] At Consumers Union, publisher of *Consumer Reports* magazine, we have initiated our own experiment, based on the DERP. This commentary describes our project and briefly discusses the challenge of bringing consumers along on the EBM voyage.

In December 2004, Consumers Union and *Consumer Reports* launched *Consumer Reports Best Buy Drugs*. The project is largely funded through grants.[2] Its overriding purpose is to translate the DERP's findings for consumers and, combining that with drug price and cost data, to produce an independent and unbiased resource on the comparative effectiveness and value of prescription drugs. We emphasize that consumers should use the information to talk with their doctors about their prescription drug needs and choices. Like the DERP, the project analyzes drugs by therapeutic category. As of March 2006, we had published reports on twelve drug classes.[3] These classes comprise many of the most widely prescribed medicines and accounted for about 40 percent of total drug sales in 2005.[4]

The decision to marry drug price and cost data to the DERP's reviews is consistent with the participant states' use of the DERP's evaluations. As Neumann notes, the DERP's sponsoring states and organizations declined to factor drug costs into the DERP reviews. There would be neither formal nor informal cost-effectiveness analysis. Instead, as Neumann explains, state Medicaid programs would be free to interpret the DERP's systematic drug-class reviews as they saw fit and adapt them to each state's circumstances and priorities (including budgetary priorities).[5]

We adopt that same approach on behalf of and for consumers. We don't do cost-effectiveness analysis. Instead, we present price and

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cost data alongside the DERP's effectiveness, safety, and side-effect data.[6] And then we let consumers—in consultation with their doctors—interpret and adapt these data according to individual preferences, clinical circumstances, and priorities (including budgetary).

■ **Not like rating cars or TVs.** In keeping with the tradition of *Consumer Reports*, however, we go a step further. Although taking care to note important caveats, we choose Best Buy drugs in each category we evaluate. These are the drugs that emerge as equal or better in clinical effectiveness, safety, or side effects, or some combination, yet either cost roughly the same or less than other drugs in the class. Not surprisingly, in many drug classes, generics are the Best Buys—with choosing or switching to one (from a more expensive brand-name drug) yielding from hundreds of dollars per year in savings to $2,000 or more.[7]

The world is now catching on to the value (clinical and monetary) of generic drugs. But we think that the DERP and *Best Buy Drugs* are bringing data and analysis to bear on this. Moreover, *Best Buy Drugs* (but not the DERP) has the intention of giving consumers an alternative to brand-name pharmaceutical marketing and advertising. We believe that many brand-name drugs provide important clinical benefits to patients; however, we also believe that many are overpromoted to both physicians and consumers and that drug marketing has resulted in a skewed, economically inefficient pharmaceutical marketplace. Clearly, we don't have the enormous reach of drug company marketing, but you have to start somewhere.[8]

I note that when our analysis in several categories found some brand-name drugs to be clearly more effective or safer for some patients, we did not hesitate to choose them as Best Buys despite their higher cost. For example, in the statins class, we chose Lipitor (atorvastatin) as a Best Buy for people at high risk of heart disease, based on its superior track record as a life-saving drug after heart attack and in other circumstances.[9]

Importantly, our Best Buy choices are not tantamount to "rating" prescription drugs, the way *Consumer Reports* rates cars, TVs, and hundreds of other products and services. Nor does it involve testing drugs in *Consumer Reports* labs, as we do with many products. Instead, our Best Buys emerge from the following confluence of inputs: (1) the DERP's assessment of comparative drug effectiveness, safety, and side effects; (2) other systematic reviews from reliable sources; (3) dosing convenience factors; (4) relevant safety analyses, such as those by the U.S. Food and Drug Administration (FDA); (5) the comparative monthly costs of individual drugs; and (6) peer review.

■ **Importance of peer review.** This last factor deserves special attention. All of the *Consumer Reports Best Buy Drugs* reports undergo peer review. The process is similar to professional journal article review, except that our peer reviewers are paid an honorarium for their time, the turnaround time is much shorter (one to three weeks), and peer reviewers are publicly identified on our Web site. From two to four reviewers screen every report, and a different group screens each report. Most are physicians who practice medicine and prescribe the drugs being evaluated. Many have been leading researchers in their respective fields. The peer reviewers receive a draft with the Best Buy choices made. They are not specifically charged with evaluating (agreeing or disagreeing) with our Best Buy picks, nor are they accountable for those choices. In several drug categories, the peer reviewers have not commented on our picks. However, for most of the categories we have evaluated, the peer reviewers have become part of the discussion around the Best Buy picks. And in several of the categories, reviewers have objected to a choice or suggested additional drugs as Best Buys based on their interpretation of the evidence being presented, their assessments of the research, and their clinical experience. Thus, although the process of choosing the Best Buys is driven in large part by scientific evidence and objective data (including costs), it is also based on subjective judgments and human weighing of the evidence.

This reflects the broader conundrum of EBM and its practical application. As

Neumann notes, EBM exists in the real world of the human practice of medicine; it always will. That is both good and bad. The bad part, of course, is that human judgment (and weighing of the evidence) can be terribly flawed. In medicine, it has led to inconsistent quality of care, now widely acknowledged. On the other hand, value judgments, clinical insights born of experience, and even intuition have received validation from many quarters. Most recently, research in neuroscience and social psychology indicates that human decisions based on informally assessed (and even spontaneous) data and knowledge input ("gut decisions") can be robust.[10]

In addition, social psychology research is finding new meaning in the "wisdom of crowds." A new book by James Surowiecki asserts that collective human judgment—arrived at informally and sometimes chaotically—has underappreciated value.[11] This research suggests that thousands of doctors in clinical practice (in theory, and left to their own devices, free of drug marketing) might produce a better "judgment" about the comparative clinical value of a drug than a single "expert" doing a review article for a journal, for example, or even perhaps than a team of experts conducting a systematic review.

That said, I hasten to add, the wisdom-of-crowds concept also strongly supports the DERP and *Consumer Reports Best Buy Drugs.* Both attempt simply to put more evidence and data into the public domain in a more systematized way, and let others (users, the crowd) make the value and clinical judgments. And neither sees itself as the final or definitive word.

All of this gets at one of the main criticisms leveled at the DERP and *Consumer Reports Best Buy Drugs*: that they ignore the individual patient and the importance of variable responses to drugs. This is an often-stated concern by the pharmaceutical industry. We at *Best Buy Drugs* reject this critique. First, our reports and Web site content tell consumers clearly that our Best Buy picks might not always be the right choice for every patient and that clinical circumstances might compel use of another drug. We also clearly communicate the notion that one's physician should play the lead role in deciding the right treatment.

We strenuously reject the notion that systematically evaluating the comparative effectiveness and safety of medicines—as assessed primarily in randomized controlled clinical trials—undermines the clinical practice of medicine, which focuses, as it should, on individual patients. This is a bizarre argument on its face. Nothing about the DERP or *Best Buy Drugs* is meant to compel doctors to prescribe the same drug for every patient. It is a given that people respond differently to drugs, and assessing that is a critical (and under-practiced) component of care. However, we at Consumers Union believe that the burden is on the drug industry to show (rather than just to say over and over) how wide the variation of response is in many classes of drugs, and to draw any implications about how such variation should influence prescribing decisions.

■ **Bringing consumers to the party.** We support efforts now under way in the public and private sectors to more deeply entrench EBM in the U.S. health care system, first and foremost by changing physicians' behavior. But we also believe strongly that we will not get where we really need to go unless consumers understand, embrace, and help push EBM. Polls show that most people now think that their care is evidence based. They do not always discern the difference between medicine as a science and its application and practice as a science. And when failures occur, they hardly ever blame the system; the lack of use of organized knowledge; or the careful, deliberate, and consistent application of evidence. That's the leap we must try to create in the public mind in coming years.

It won't be easy. Scientific literacy in the United States is shockingly low. And even among the highly educated, there is often resistance to evidence-based decision making. We are prone to choice by anecdote or expediency if the science and evidence are confusing and present too many complex choices.[12]

But things might be changing. Consumers are flocking to the Web to find health information, and sites are increasingly meeting a de-

mand for guidance in treatment decision making.[13] In that context, consumers' response to *Best Buy Drugs* provides reason for optimism. About 610,000 drug-class reports were downloaded from our Web site in the twelve months ending February 2006. And several consumer focus groups held in Atlanta and Sacramento yielded largely positive views of the value of the information. Consumers understood that it compared drugs on both effectiveness and cost; they appreciated the unbiased nature of the analysis; they found the information highly useful; and they were nearly unanimous in expressing a desire for more medical information along these lines.[14]

For obvious reasons, prescription drugs are an easier arena of medical care in which to present comparative information to consumers. We hope, however, that *Consumer Reports Best Buy Drugs* is helping lay a foundation for a broader-based consumer understanding and appreciation of EBM. We could not have done it without the DERP. We hope that its sponsors preserve and expand it, and we urge policymakers to keep consumers in mind as they ponder how best to expand EBM's reach.

*For a funding acknowledgment, see Note 2. The author thanks Gail Shearer for comments on the initial draft of this paper.*

## NOTES

1. P.J. Neumann, "Emerging Lessons from the Drug Effectiveness Review Project," *Health Affairs* 25 (2006): w262–w271 (published online 6 June 2006; 10.1377/hlthaff.25.w262).
2. *Consumer Reports Best Buy Drugs* (CRBBD) is supported by two grants. Both are unrestricted educational grants. One is from the Engelberg Foundation, a private philanthropy. The other is from the National Library of Medicine (NLM) of the National Institutes of Health (NIH). Neither the NLM nor NIH is responsible for the content or advice contained on the CRBBD Web site or in any of the Best Buy Drugs reports. Under both grants, *Consumer Reports* has complete editorial responsibility for the content of the reports. All of the project's reports and analyses are available free at http://www.CRBestBuyDrugs.org.
3. Antidepressants; antihistamines; Alzheimer's disease drugs; attention deficit hyperactivity disorder (ADHD) drugs; beta-blockers, calcium-channel blockers, and angiotensin-converting enzyme (ACE) inhibitors to treat heart disease and high blood pressure; hormones to treat menopause; nonsteroidal anti-inflammatory drugs (NSAIDs) for arthritis and pain; proton-pump inhibitors; statins to treat elevated cholesterol; and the triptans to treat migraines.
4. The total for these classes was $96 billion out of $239 billion in 2005 sales; calculation based on data from Wolters Kluwer Health, Pharmaceutical Audit Suite.
5. See, most recently, M. Bergman et al., "Using Clinical Evidence to Manage Pharmacy Benefits: Experiences of Six States," Commonwealth Fund Issue Brief no. 899, March 2006, http://www.cmwf.org/publications/publications_show.htm?doc_id=362300 (accessed 12 May 2006).
6. Our reports give consumers an average monthly "cash price" cost for each drug. These are derived from data provided by Wolters Kluwer Health, Pharmaceutical Audit Suite. We conduct our own data extraction and analysis.
7. In addition to drug-class reviews, the project has produced several studies of the savings achievable by switching to Best Buy drugs, especially for Medicare beneficiaries. All of these are available free at the project's Web site (see Note 2).
8. The *Best Buy Drugs* project has an educational outreach component in five states: California, Maryland, Minnesota, Georgia, and Pennsylvania. This effort primarily targets low-income seniors. Printed *Best Buy Drugs* materials are distributed through intermediaries.
9. Lipitor's status as a Best Buy could change in 2006; two other brand-name statins are due to become available as less expensive generics.
10. See A.R. Damasio, *Descartes' Error: Emotion, Reason and the Human Brain* (New York: G.P. Putnam's Sons, 1994); and M. Gladwell, *Blink: The Power of Thinking without Thinking* (New York: Little, Brown and Co., 2005).
11. J. Surowiecki, *The Wisdom of Crowds* (New York: Doubleday, 2004).
12. See especially B. Schwartz, *The Paradox of Choice: Why More Is Less* (New York: HarperCollins, 2004).
13. *Consumer Reports* has its own such site, http://www.medicalguide.org.
14. The *Best Buy Drugs* project is being evaluated by a team of researchers from Harvard Medical School, the Massachusetts General Hospital Institute for Health Policy, and the University of Pittsburgh. The focus groups were convened as part of that process.