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Used well, prescription drugs can reduce the burden of disability for older Americans and lengthen their lives, and can be very cost-effective. Unfortunately, they can also cause preventable drug-induced illness, especially in the elderly. Affordability is another growing problem; many patients are prescribed medications that are far more expensive than others that would work just as well – a cost that is rising faster than necessary, damaging both public and private budgets. And some drugs, like those to manage cholesterol or blood pressure or osteoporosis, are actually under-used in the elderly. I am here today to discuss with you an approach that can improve the quality and accuracy of medication use, as well as containing its spiraling costs.

An important gap exists between the best knowledge available about medications and the prescriptions that many patients get from their doctors. There are several reasons for this. Each week, medical journals publish so much new information about drugs that it is nearly impossible for even the most diligent doctor to keep up with it. Important findings may be reported in any of a hundred journals, and it is no-one's job to make sure we see them – or to monitor how appropriate or up-to-date our prescribing is. But into that void rush tens of thousands of attractive, articulate people who come and visit us in our offices each week, nicely dressed and often bearing gifts, to "teach" us how to prescribe for our patients. These are not researchers or medical school faculty; most of them don't even have any formal scientific training at all. They are drug company salespeople, or "detailers," who are paid based on how much they can increase sales of their company's products. For most primary care doctors, information about prescription drugs – especially new ones – comes mostly from these and other commercial sources.

These sales reps are smooth, cordial, and concise; they come to where the doctor is, and chat interactively with us about their products and those of their competitors; the materials they give us and the ads backing them up that fill the medical journals are slick, engaging, and easy to understand. And there is always a clear final "take-home point" at the end of their presentation, encouraging use of their company's (usually costly) product.

This informational playing field is not level. Manufacturers of generic drugs, who make just fractions of a penny on each pill, don't have the funds or incentive to come to the doctor's office and present their side of the story, even when the evidence is on their side. And those of us on medical school faculties, I must admit, are often not very good communicators. We give our continuing education courses in big lecture halls, drone on for hours in a darkened room, showing slides that are as visually interesting as the Congressional Record. The articles we write in medical journals may be erudite and contain vital data, but they're often boring to read, and cover only a sliver of a clinical topic.

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As a result, doctors more and more prescribe the drugs that are the most heavily promoted, not necessarily the ones that would be the safest, or best, or most cost-effective for their patients. The pharmaceutical industry spends at least $30 billion per year on such promotion, a higher proportion of revenues than it spends on meaningful research and development. There's a huge financial incentive for them to do so. Every time a doctor prescribes an expensive new blood pressure or diabetes pill that costs the patient over $1,000 a year, every year, instead of a generic drug that costs under $50 a year, that's like an annuity for the company – even if the generic drug has a better track record of safety or effectiveness than the new, more expensive drug. We've seen that happen with Vioxx, Avandia, Vytorin, and many other widely used drugs, with substantial negative economic and clinical consequences. Americans spent billions of dollars a year on those drugs, even though less overpriced alternatives would have worked as well or better. Ironically, much of that was taxpayer money – enough to pay for more balanced drug education programs dozens of times over.

Back in 1979, I wrote a grant to the federal government proposing the following idea: What if we could take the very sophisticated communications and behavior-change tools that the drug companies deploy so effectively, but instead use them to give doctors the latest and best facts about drugs' comparative efficacy, safety, and cost-effectiveness? My colleagues and I trained pharmacists in four states to go visit physicians as "un-sales reps," so they could provide doctors with educational outreach about several common prescribing topics. I named the approach academic detailing because it used the "detailer" approach of sending someone to meet with a doctor in his or her own office to discuss a given drug topic, but we did it from a non-commercial, "academic" perspective.

We showed that the concept worked in a large four-state randomized trial involving over 400 doctors. As we reported in *The New England Journal of Medicine,* 92% of the doctors who were offered this service accepted it, and those who were randomized to the academic detailing group significantly improved their prescribing. In a formal benefit-cost analysis, we found that such a program could save $2 for every $1 it cost to run. This was not a surprise; it's how the drug companies move prescribing in the directions they want. They know exactly what they're doing.

Since then, many additional studies have shown that academic detailing programs can improve the use of a wide variety of drugs, from antibiotics to sedatives, in settings from primary care offices to teaching hospitals to nursing homes. Some of these programs have also tracked clinical outcomes, and have found that patient outcomes also improve – as expected – with more evidence-based prescribing. Today, academic detailing services have been set up in England, the Netherlands, several Canadian provinces, and the entire nation of Australia. In the U.S., some integrated health care systems, particularly Kaiser, have mounted their own academic detailing services, and programs of varying size have been established or legislated in Pennsylvania, South Carolina, the District of Columbia, Vermont, New Hampshire, Maine, and other states.

The Pennsylvania program, which that state's Department of Aging asked us to establish in 2005, is the largest publicly funded service. Supported by that state's PACE program, we train pharmacists and nurses to meet with doctors in their offices to provide commercial-free educational outreach about the best treatments for several common conditions in the elderly. The program is conducted on a completely non-profit basis. My colleagues and I at Harvard Medical School develop the materials based solely on the best evidence in the medical literature, with no interference from the state – as is the case in nearly all such programs. Sometimes we encourage greater use of expensive drugs, if that's what the clinical trials show is the best thing to do. Physicians can get continuing medical education credit from Harvard, and have received the program with enthusiasm. They find it to be a user-friendly and time-efficient way to keep up with the medical literature, without having to sit through any slanted sales pitches. We put everything we produce on the Internet for free, non-commercial use by anyone, at www.RxFacts.org .

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In an ongoing evaluation, we examined the prescribing of doctors who were offered the program compared to similar physicians in counties where it is not in effect. That analysis found that the module on gastrointestinal drugs alone – which addressed overuse of "purple pills" such as Nexium – is estimated to have saved over $500,000 per year through the PACE program alone, not counting the savings to other payors such as Medicaid and private insurers. Economic analyses of other programs, such as Australia's continent-wide service, have likewise shown that their costs are largely offset by savings from reducing excessively costly prescribing, not even counting the benefits resulting from improved clinical care.

In sum, academic detailing is not a "Just Say No To Drugs" program. It begins with the assumptions that prescribing is one of the most useful and challenging things we doctors do, and that we doctors crave accessible, unbiased data about the drugs we prescribe. If war is too important to be left to the generals, then drug information is too important to be left primarily to the pharmaceutical industry. Proactively getting current, non-commercial, evidence-based drug information to doctors is an important public good, like good roads, primary-school education, and clean air. I commend the Committee for considering making such services to doctors a reality on a larger scale. Now that Medicare has become the nation's single biggest payor of drug bills, it would be fiscally irresponsible *not* to equip doctors with the information we need to make the best choices for our patients. The marketplace has not done this adequately, and will not. Over 25 years' worth of experience and data show that a well run academic detailing service would be welcomed by physicians, and can enhance both the clinical quality and affordability of the drugs we prescribe, particularly for our older patients.

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