The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

25 August 2026

Komiti Whiriwhiri Take Petihana | Petitions Committee
Parliament Buildings, Wellington

By email: parliamentary.petitions@parliament.govt.nz

Tēnā koutou

The Royal New Zealand College of General Practitioners (the College) thanks the Petitions Committee for its invitation to submit on the petition of Aly Cook.

Our position

The College supports the prohibition of direct-to-consumer advertising of prescription medicines (DTCA-PM) in Aotearoa New Zealand. We maintain this position from our 2017 position statement, and re-stated it in March 2023 within our own, and the Council of Medical College's (CMC), submission on the Therapeutic Products Bill.[1,2,3] DTCA-PM is demonstrated to cause harm[4,5,6], drives prescription requests, pressures prescribers,[7,8] and shifts demand towards newer, branded medicines at the expense of cheaper and potentially equally effective alternatives.[9,10] We recommend that the Government prohibit DTCA-PM through the Medical Products Bill across broadcast, print, outdoor, digital, social media and influence channels. This prohibition should extend to all medicinal cannabis products. Regulation-making power in the Medical Products Bill should be able to respond to digital, algorithmic, and influencer-based promotion due to its increasing use as a communication tactic[11,12]. Finally, we support the recommendation for investment in independent, evidence-based medicines information for the public free of commercial interest, to replace what advertising purports to provide.

Introduction and scope of support

The College is the professional body and postgraduate education provider for vocationally registered specialist general practitioners and rural hospital specialists in Aotearoa New Zealand. We are the largest medical college in the country with over 6000 members working across the motu delivering the majority of first-contact care.

General practice is where the effects of pharmaceutical advertising are absorbed. When an advertisement is broadcast to the public, the resulting question, request or expectation arrives in a fifteen-minute consultation with a specialist GP, pressuring an already time-poor workforce. The College supports the central request of the petition insofar as it concerns prescription medicines (including medicinal cannabis) and recommends that all direct-to-consumer advertising of prescription medicines (DTCA-PM) be prohibited by statute in New Zealand.

We make no comments on the petitioner's arguments that pharmaceutical advertising revenue may influence editorial independence in New Zealand media, as this falls outside of our clinical remit. Our submission rests solely on the clinical, prescribing, health literacy, and equity grounds set out below.

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Why we oppose direct-to-consumer advertising

1 - Advertising pressures prescribing, distorts consultations, and the doctor-patient relationship

Advertising works, that is its purpose. The evidence that it works within healthcare is long-standing, illustrating that consumers exposed to DTCA-PM are more likely to ask about the advertised medicine, request a prescription, and influence clinician prescribing, even when medication is not clinically indicated.[7,8,10]

The consequence for general practice is twofold. Where the GP declines a request, consultation time is spent unpicking a commercial claim rather than addressing the patient's actual presenting problem, and the therapeutic relationship is placed under avoidable strain. Where the GP accedes, the patient may receive a medicine that is not clinically indicated, and which may and has resulted in iatrogenic harm.[4,5,6] Neither outcome serves the patient.

The CMC has estimated that New Zealand doctors spend approximately 48,000 hours a year dealing with queries that arise solely due to this advertising.[13] The College asks the Committee to weigh that figure against the state of the workforce that absorbs it. New Zealand has approximately 74 GPs per 100,000 people, against 116 in Australia and 122 in Canada.[14] In 2024, 35 percent of GP respondents to the College's 2024 Workforce intended to retire within five years and 70 percent rated themselves moderately to highly burnt out.[15] Clinical time is the scarcest resource in the health system. Advertising consumes it and returns nothing.

2 - Advertising works against health literacy — and hardest on those least well served

Advertising is designed to persuade, not to inform. Analysis of DTCA has shown that not all pharmaceutical advertisements provide evidence to support their efficacy claims, and that when evidence is provided, benefits are often overstated and have unclear, or a high risk of bias.[16,17,18]

The burden of navigating persuasive commercial health information does not fall evenly. New Zealand research suggests that DTCA-PM has greater behavioural effects among populations already experiencing poorer health outcomes and socioeconomic disadvantage, including Māori.[10,19,20] This should not be understood as an individual health literacy deficit; rather, it reinforces the responsibility of the health system to ensure people can access trustworthy, comprehensible and independent medicines information.

The health system already fails to prevent more than half of the avoidable deaths of Māori, and just under half for Pacific People.[21] The Waitangi Tribunal has found the Crown in breach of Te Tiriti o Waitangi in relation to the way the primary health care system has been funded and held to account, contributing to persistent Māori health inequities.[22] A regulatory environment that permits commercial pharmaceutical advertising to compound those inequities is difficult to reconcile with the Crown's obligations to actively pursue equitable health outcomes for Māori. Prohibiting DTCA-PM is a low-cost, high-leverage step towards reducing avoidable harm, advancing health equity and upholding Te Tiriti o Waitangi obligations.

3 - Advertising drives cost without driving value

Medicines advertised directly to consumers are typically new, branded, and premium-priced. Demand generated for them displaces cheaper generic alternatives and funded options, imposing cost on patients and on the public system without necessarily corresponding clinical gains.[9,10] In a system where PHARMAC's role is to secure value for a fixed budget, permitting commercial campaigns to steer demand towards unfunded or higher-cost branded products works directly against the public interest.

4 - Current regulatory settings do not work and cannot be made to work

Advertising of medicines in New Zealand is governed by the Medicines Act 1981 and Medicines Regulations 1984, supplemented by industry codes administered by the Advertising Standards Authority[23], Medicines New Zealand[24] and Medsafe. These codes have no legal effect. Enforcement is retroactive and complaint-driven, rather than proactive or through regular monitoring.[10] Furthermore, a complaint can only be made by someone who already knows that an advertisement is misleading; knowledge which may not be available to the general public. The Advertising Standards Complaints Board has no power to impose penalties[9], and a non-member

complainant to the Medicines New Zealand code faces a $7,500 (plus GST) administration fee, forfeited if the complaint fails.[24]

This regulatory gap is widening rather than narrowing. Promotion has moved into podcasting, streaming and social media, and into paid patient-influencer content, where micro- and nano-influencers with small but highly engaged audiences deliver commercial messages that do not read as advertising at all.[11] The Medicines Act 1981 was drafted for a media environment that no longer exists.

The College's conclusion is that the problem is not one of insufficient regulation but of an unregulatable practice. Vetting every claim in a market of New Zealand's size, without access to complete trial data, is not achievable. Prohibition is the only proportionate response.

5 - New Zealand is an outlier

New Zealand and the United States are the only OECD countries that permit DTCA-PM;[9,10] however the United States is actively dismantling it. In September 2025, the US Department of Health and Human Services and the U.S. Food and Drug Administration announced a major reform requiring full safety disclosure in pharmaceutical advertisements and issued a wave of enforcement letters to manufacturers.[25,26] If Cabinet's October 2025 decision to maintain DTCA-PM stands, New Zealand risks becoming the sole developed nation with an unreformed DTCA advertising regime.[27]

What should replace advertising

The College does not argue that patients should have less information about medicines. We argue that they should have better information, from a source with no commercially vested interest. Patients in the many countries that prohibit DTCA-PM continue to have access to, and seek out, information about treatment options; the argument that prohibition deprives consumers of information is a fallacy. The College's position is that prohibition should be paired with investment in an independent, publicly funded medicines information service that is free of commercial interest.

Conclusion

Choices about a patient's treatment should be made between the patient and their doctor based on the best available evidence, not by a marketed campaign. The College supports the petition's central request as it applies to prescription medicines and asks the Committee to recommend a statutory prohibition of DTCA-PM, given effect through the Medical Products Bill and paired with investment in independent medicines information.

Nāku noa, nā

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