INTRODUCTION

The major 5 European markets and Japan operate generally socialized healthcare systems. The USA has a mixed system of healthcare funding involving public, private, and insurance based systems. Each system has different structures and organizations to assess the value of medical interventions, with a high level of administrative controls which vary according to the care setting.

DATA

Data were drawn from the Adelphi Real World Diabetes Disease Specific Programme (DSP) conducted across France, Germany, Italy, Spain, UK, USA and Japan in Q2 2015. The DSP is a real-world, cross-sectional survey of physicians and their consulting patients.

METHODS

The data drawn from the DSP included 390 endocrinologists and 560 primary care physicians (PCPs) who complete physician-reported patient record forms for their next 10 consulting T2DM patients. In addition to clinical considerations, physicians were asked to record the impact of administrative controls on their prescribing and the processes they followed. For analysis, the responses were grouped into standardized sets to allow for international comparisons. Three categories were devised for this analysis:

1. Control had no impact on prescribing
2. Controls influenced prescribing
3. Controls lead to non-preferred prescribing

A Fisher’s Exact test was used to test the null hypothesis that the differences between markets were due to chance, with Bonferroni adjustment to account for multiple testing.

RESULTS

We recorded information on 16,209 individual prescribing decisions across the 5 EU markets, Japan and the USA. Table 1 shows their distribution.

Table 1: Number of prescribing decisions recorded

<table>
<thead>
<tr>
<th>Country</th>
<th>Prescribing decisions recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>2,147</td>
</tr>
<tr>
<td>Germany</td>
<td>1,733</td>
</tr>
<tr>
<td>Italy</td>
<td>1,687</td>
</tr>
<tr>
<td>Spain</td>
<td>2,045</td>
</tr>
<tr>
<td>UK</td>
<td>2,119</td>
</tr>
<tr>
<td>USA</td>
<td>3,992</td>
</tr>
<tr>
<td>Japan</td>
<td>2,486</td>
</tr>
<tr>
<td>Total</td>
<td>16,209</td>
</tr>
</tbody>
</table>

Administrative controls were identified as influencing >70% of prescribing decisions in USA, Germany and the UK; 40-60% in France; Italy and Spain; and just over 30% in Japan. These differences were statistically significant (p<0.0001) except between France and Spain. (Figure 1).

Figure 1: percentage of decisions where payer controls observed to affect prescribing

Physicians were less likely to report that their decision was influenced by payer or administrative controls than was the case for judges, which are a different population of prescribers. International variations in the level of agreement were observed (Figure 2).

Figure 2: extent to which payer controls were perceived by prescribers to affect decisions

Physicians indicated that they would have preferred to prescribe an alternative product (i.e. the outcome was a non-ideal prescription) in fewer than 1 in 100 cases in most markets (Figure 3).

Figure 3: Percentage of prescribing decisions where the decision was considered non-ideal as a result of payer controls

Conclusions

This research demonstrates that prescribing in all countries studied is influenced by administrative controls to which payers contribute, with differences between countries or therapy areas observed, regardless of payer controls. The greatest impact was seen in Germany, the USA and UK.

In diabetes, although prescribers commonly take account of formulary and other payer restrictions, in the majority of cases, they do not remove these restrictions from their choices, and in very few cases do they feel that they have not been able to prescribe an appropriate treatment.

The primary conclusion for these observations is that payer controls are generally aligned with what prescribers see as good clinical practice. It may also reflect a situation in which controls do not generally influence the ability to prescribe a given drug class, instead focusing on indicating which product within a class is preferred. This is further supported by the low number of cases where prescribers report being unable to use a drug that they consider to be appropriate.

Despite apparently good alignment between payers and prescribers, we have observed that in a small number of cases payer controls can lead to prescribing of diabetes treatments considered non-ideal by prescribers. This was seen more in the UK and USA than in other markets.

Further research will help to establish whether differences between markets reflect actual differences in the nature and impact of administrative controls during levels of alignment between prescribers’ and payers’ objectives or opinions.

In either case, further insights into this issue have the potential to inform discussions between prescribers and payers about rational use of medicines and patients’ access to medicines. Understanding national funding and control dynamics is likely to be important in framing these discussions.

It is interesting to observe that these findings are in agreement with those that we have previously reported in Multiple Myeloma in Europe and to observe that in diabetes the degree to which prescribers feel they have been compelled to make a non-ideal or non-preferred prescribing decision is lower.

IMPLICATIONS:

It has been shown that payer-based controls drive treatment selection in the majority of patients; these controls should thus be designed and implemented with great care and due clinical consideration.

There is room for greater alignment between prescribers and payers to ensure that the former understand why formulary decisions reflect the best clinical practice for their patients.

Enhanced and refined insight tools to capture these influences on prescribing behavior with a focus on interpretation based in national contexts will help to illuminate this dynamic further and inform future decisions.

References

1. Silvey et al. Oncology ISPOR poster from 2015 EU meeting
2. Anderson et al. Real-world physician and patient behaviour across the 5 EU markets, Japan and the USA

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