Is physician price sensitivity sufficient to reduce healthcare spend or are stricter payer-led controls required?

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Introduction

As price pressure intensifies in crowded therapy areas, healthcare systems are increasingly reliant on the introduction of generics and biosimilars in order to reduce spending.

In this research, we test if physicians' price sensitivity is sufficient to drive cost reductions alone, or if payer-led controls and guidelines must be implemented to effect this change.

Methodology

Online quantitative surveys with conjoint analysis were performed using a sample of 256 EU5 physicians identified using screening criteria to ensure a homogeneous cohort allowing for statistical analysis and representativeness. A conjoint is a powerful statistical technique to probe the value physicians place on drug features in prescribing decisions. Physicians were instructed to allocate patients to treatment scenarios based on a number of coverage, economic attributes and clinical attributes including variations in formulation (IV, subcutaneous, oral). Analysis was then performed to probe how changing the price of a new treatment impacted preference share relative to more established therapies and their corresponding biosimilars.

The conjoint exercise allows estimation of a physician's price sensitivity in a controlled environment. However in reality this is not the only contributing factor to their decision-making and it does not account for their awareness and interest in price versus other attributes. Therefore self-assessed ratings of price "awareness" (A) and "interest" (I) were comparatively analysed with the conjoint price sensitivity (overall impact of price on prescribing decisions (D)) output to identify the real life potential for price to be used as a lever to increase uptake.

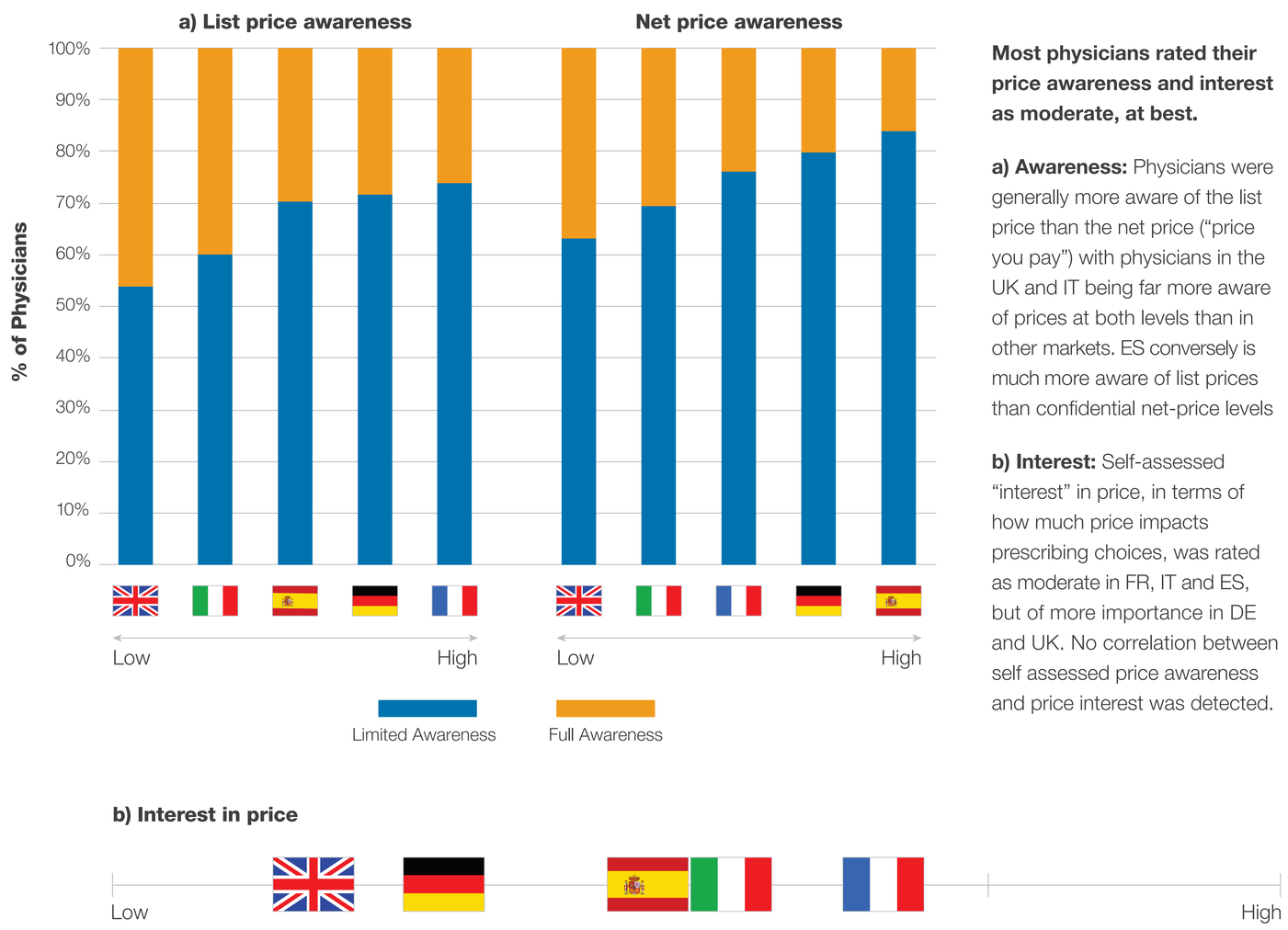
Results

Through the conjoint exercise, physicians exhibited little price sensitivity, irrespective of how they rated their own price awareness. Only in the UK and DE was a significant amount of price sensitivity identified. This is due to the significant amount of pressure on cost containment in the UK and DE where physicians manage their own budgets.

Significant reductions in the price of the oral drug was not associated with similarly significant increases in preference share. Even when discounted to biosimilars, preference was not shifted away from the established biologics, and most movement in share was within classes rather than between classes.

This is driven in part by the relative importance of familiarity versus price. Familiarity is a driver of physician preference, in most markets, which may limit current uptake of the test oral product.

Figure 1: Price awareness (A) and interest (I)



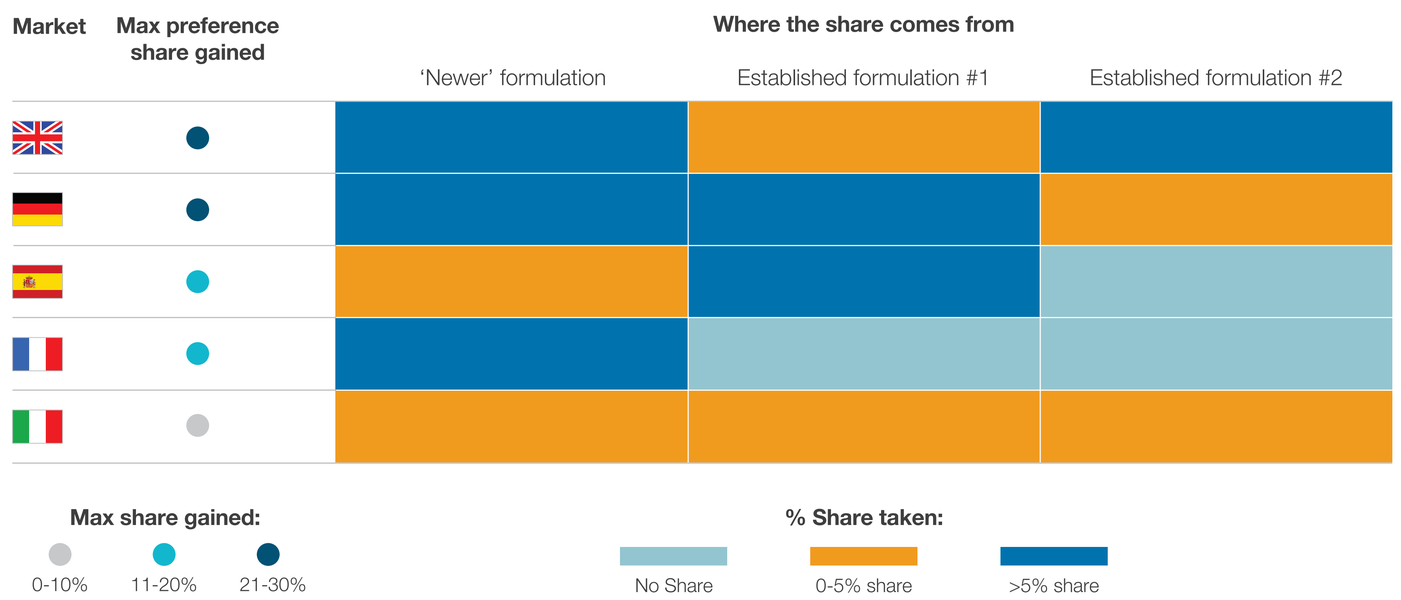
Most physicians rated their price awareness and interest as moderate, at best.

a) Awareness: Physicians were generally more aware of the list price than the net price ("price you pay") with physicians in the UK and IT being far more aware of prices at both levels than in other markets. ES conversely is much more aware of list prices than confidential net-price levels

b) Interest: Self-assessed "interest" in price, in terms of how much price impacts prescribing choices, was rated as moderate in FR, IT and ES, but of more importance in DE and UK. No correlation between self assessed price awareness and price interest was detected.

Figure 2: Impact of price on prescribing decisions (D)

Upon discounting, preference share is redistributed within the available new formulation in all markets, but movement of share from existing therapies and formulations varies considerably. The highest increase in preference is seen in price-sensitive DE and UK, where shares from both new and existing therapies are redistributed to the most cost-efficient option. Conversely, physicians in FR appear reluctant to change their preferred treatment option, only redistributing share between the new therapies, even when the test therapy is discounted versus existing therapies.



Conclusions

Despite voiced concern over the cost of treatment, physicians actually show limited awareness and sensitivity to the actual cost associated with treatment. Physicians are not yet instinctively using the most cost-effective treatment options and prescribing is instead steered by familiarity with established therapies. For the potential saving to be realised on one or more cost effective treatment options, relying on physicians' price sensitivity will not be sufficient, and stricter payer management will also be necessary to drive this change.

For price to have an influence on uptake, first a physician must have price awareness (A), have an interest in price (I) and finally change their clinical decision in correlation to price (D). The methodology becomes particularly important in crowded therapy areas where familiarity is a key driver of choice. For policymakers this methodology can be used to help design policy to ensure use of more cost effective treatments, while for industry this methodology can be leveraged to determine the feasibility and ultimate success of pricing strategies in crowded therapy areas.