Health economics: implications for novel antirheumatic therapies

A Kavanaugh

This paper discusses the pharmacoeconomics issues relating to the use of the newer therapies for rheumatoid arthritis (RA), namely the tumour necrosis factor (TNF) inhibitors. Results of recent studies have provided some evidence regarding the cost effectiveness of these agents. However, as the use of TNF inhibitors evolves—including their use in other systemic inflammatory diseases—this will be influenced by several factors including treatment of patients with early RA, longer term treatment, problems related to toxicity, quality of life, productivity, and market forces. Thus, pharmacoeconomic considerations are likely to remain a central factor in the use of novel therapies in rheumatology, and awareness about these will aid clinicians to select the most favourable therapies for their patients with arthritis.

Rheumatoid arthritis (RA) is a chronic autoimmune condition that exacts a considerable toll from affected patients. The joint destruction and progressive functional disability characteristic of uncontrolled RA are associated with substantial economic costs not only to the patients and their families, but also to society. In recent years, significant progress in understanding the immunopathogenesis of RA combined with advances in biotechnology has led to the development of agents that therapeutically target specific components of the dysregulated immune system. Such “biological agents”, particularly the inhibitors of the key proinflammatory cytokine tumour necrosis factor α (TNFα), have proved highly effective not only in improving the signs and symptoms of disease, but also in attenuating the progression of joint damage, improving quality of life, and preserving functional status. The introduction of TNF inhibitors has engendered a dramatic change in the therapeutic approach for RA. Thus, the ability to improve clinical outcomes in such a meaningful way has resulted in the goals of treatment being raised. Remission is now considered not only highly desirable, but also an appropriate goal for treating RA patients. In addition, biological agents have been shown to have impressive utility in systemic inflammatory diseases other than RA, including psoriatic arthritis, ankylosing spondylitis, psoriasis, and inflammatory bowel disease.

A worldwide concern that has impacted on the clinical use of biological agents is their relatively high acquisition costs. In the USA, the May 2005 average wholesale price (AWP) for one year of therapy with standard RA dosages of either etanercept or adalimumab was approximately US$15,680; the cost of infliximab is comparable (US$10,450–18,110, for two vials/treatment on maintenance schedule to three vials/treatment including an initiation regimen; exclusive of administration costs). Although costs slightly lower than AWP may be available by discounting and other means, the costs of the three currently available TNF inhibitors still far exceed those of older therapeutic agents. The AWP for one year of treatment with generic methotrexate at a dose of 17.5 mg/week is approximately US$500. With healthcare costs rising globally, and with newer therapeutics consuming a greater portion of healthcare budgets, there has been increased attention towards pharmacoeconomic analyses as a means to justify therapy with these newer, more expensive agents. Although health economic assessments are thus critically important, characteristics of such analyses can make them seem imprecise. For example, there can be substantial heterogeneity in the methods employed, the perspective chosen, the outcomes assessed, and the time-frames used, among other factors. In rheumatology, there has been both substantial interest as well as strong debate about the most appropriate methods for pharmacoeconomic assessment of rheumatic diseases. A point upon which there is agreement is that pharmacoeconomic considerations should be an integral part of the decision to use biological therapies.

PHARMACOECONOMIC ANALYSES

Various methods of health economic analyses can be used. Cost identification analyses simply measure particular components, such as the cost of a new therapy, or the cost of hospitalisations. This simple approach does not include valuation of efficacy. Cost benefit analyses express all components and outcomes in monetary terms. As outcomes are implicitly comparable, such analyses allow some economic comparison of different strategies. Cost effectiveness analyses have become the standard method for attempting to measure the value of newer therapies. In this type of assessment, the clinical benefit of the newer treatment is compared with a standard therapy, as are the costs. The metric used can be any relevant clinical outcome, such as number of deaths or 1 kg change in weight. However, cost per quality adjusted life year (QALY), sometimes referred to as a cost utility analysis, has become widely used. Cost per QALY, particularly if the analysis is conducted over a sufficiently long time line, has the advantage of allowing comprehensive assessment of the impact of a treatment. Such analyses also allow comparisons among disparate medical conditions and their treatment. For example, the cost per QALY for chemothapeutic treatment of a type of cancer can be compared with the cost per QALY of surgical treatment of a damaged blood vessel.

Central to any pharmacoeconomic analysis is a comprehensive collection of costs related to the disease being assessed (box 1). Total costs are commonly subdivided into direct costs, indirect costs, and intangible costs. The direct costs of a disease should include all healthcare resources related to the disease, including costs for all related office visits and hospitalisations, and also the medications used. Although seemingly straightforward, different studies can arrive at distinct results for such costs, depending on how the assessment was performed. In RA, hospitalisations for orthopaedic surgery are quite expensive. This is a key
the value of healthy humans cannot necessarily be entirely relatively utilitarian in its viewpoint; it could be argued that indirect cost of the disease. This method of assessment is disease, multiplied by the affected person’s salary yield the from employment. The time missed from work due to the in work due to disease related disability and absenteeism ‘human capital approach’ considers the loss of productivity related to their disease. This so-called ‘presenteeism’ is not usually included in indirect cost assessments, and is relevant to patients with arthritis. Also, from the patient’s perspective, arthritis can interfere with career advancement and comitant increases in income that would otherwise have been expected had he or she not developed RA. Such costs, although important to patients and their families, are hard to quantify, and hence seldom accounted for. In addition to costs related to work outside the home, lack of productivity related to home care must also be assessed. This is of course relevant to the RA population, with a female preponderance and an age at onset that results in a fewer patients working outside the home than would be expected in a young population with a greater proportion of men. Attempts have been made to value the indirect costs related to impaired ability to function within the home, for example by assessing the costs to hire outside help to perform tasks around the house.

Other costs that are relevant to a discussion of newer RA treatments are “failure costs” and intangible costs. Failure costs refer to those costs generated by therapies that a patient is currently taking, but that could be discontinued if a newer therapy were very effective. Thus, if a newer therapy allows discontinuation of other treatments for the same disease, then the direct and indirect costs related to those medications ought to be accounted for. In RA, use of the TNF inhibitors has been shown to allow reduction in the use of glucocorticosteroids and non-steroidal anti-inflammatory drugs (NSAIDs). Although the acquisition costs of these medications are relatively low, the treatment of adverse effects related to their use can be costly. For corticosteroids, this would include glucocorticoid induced osteoporosis and accelerated atherosclerosis, and potentially myriad other side effects. For NSAIDs, this would include any costs related to the diagnosis, treatment, and prevention of gastrointestinal bleeding related to the use of these medicines. Intangible costs, such as those related to pain and depression due to the impact of the disease, are seldom directly accounted for, as there is not a useful metric for doing so. However, measuring the impact of disease on functional status and overall wellbeing does allow the calculation of changes in QALYs related to the disease and to its treatment.

THE COSTS OF RHEUMATOID ARTHRITIS

Considering the basic principles of pharmacoeconomic analysis, the health economic argument related to the value of newer therapies for RA can be laid out in a relatively straightforward manner (box 2). A wealth of literature attests to the severity of RA, in terms of substantial morbidity and even accelerated mortality. Without effective treatment, the expected course of RA is one of progressive functional disability. Comprehensive studies from diverse countries have consistently shown progressive work disability among patients with RA. A recent systematic review of the literature showed a linear relation between disease duration and work

---

**Box 1: Pharmacoeconomic analyses in rheumatoid arthritis (RA): costs**

**Direct costs**
- Medications (including administration costs)
- Hospitalisations (related to RA or its treatment)
  - Orthopaedic surgery
  - Extended care/rehabilitation facilities
  - Outpatient surgeries
- Clinic visits
  - Physicians
  - Other healthcare providers (for example physiotherapists)
  - Urgent care/emergency room
- Laboratory monitoring
- Imaging
- Toxicity (diagnosis, treatment)
- Medical assist devices

**Indirect costs**
- Productivity/opportunity costs
  - Lost employment/wages
  - Replacement household help
- Failure costs (direct and indirect costs for alternative treatment)

**Intangible costs**
- Quality of life
- Pain, depression/anxiety

---
disability. The related implication of functional disability is costs. Again, in the rheumatological literature there is a plethora of assessments clearly demonstrating that RA is a costly disease, and that the costs vary directly with functional disability. Heterogeneity among the studies precludes meaningful averaging to yield a single dollar assessment. However, in a number of studies, total yearly costs per RA patient were approximately US$10 000 (US 2005 dollars). It should be noted that there are studies in which costs were either lower or greater than this, attesting to heterogeneity of the assessments. The studies varied as regards geographical locale, the year in which they were conducted, characteristics of the RA populations included, the methods used to collect data, and other factors.

Despite some variation in absolute costs of RA noted among the studies, there are several consistent key themes across them. Indirect costs typically exceed direct costs, not infrequently by a factor of two. It should be noted that this was not true in all studies; also, with higher acquisition costs for medication, it would be expected that direct costs would increase. Importantly, in most of the studies, the costs of disease were not uniformly distributed among the RA population. This skewing, evidenced by the common finding that mean costs far exceed median costs, reflects the substantially higher costs incurred by a subset of the RA patients assessed. A key observation was that patients with the most severe RA incurred the highest costs. Relevant to pharmacoeconomic assessments of TNF inhibitors, patients with the most severe disease have been the type of RA patient for whom these agents have been most commonly used. The relatively higher acquisition costs of novel biological agents has brought pharmacoeconomic considerations to the forefront in rheumatology. Fortunately, as regards RA, there are myriad data confirming the substantial cost implications of this pernicious disease. For the TNF inhibitors, the notable clinical efficacy observed needs to be factored into a comprehensive assessment of their value. Results from a number of studies have begun to make a compelling case that these agents may indeed be cost effective.

**CONCLUSION**

The relatively higher acquisition costs of novel biological agents has brought pharmacoeconomic considerations to the forefront in rheumatology. Fortunately, as regards RA, there are myriad data confirming the substantial cost implications of this pernicious disease. For the TNF inhibitors, the notable clinical efficacy observed needs to be factored into a comprehensive assessment of their value. Results from a number of studies have begun to make a compelling case that these agents may indeed be cost effective.
As the use of TNF inhibitors evolves, additional health economic issues may also come into play. For example, when considering treatment of patients with early RA, a topic gaining wider discussion each year, distinct pharmacoeconomic issues might arise.\(^7\) If patients with early RA achieved incremental or sustained efficacy with new agents, that could make them more cost effective. However, the need for longer term treatment or longer term implications of toxicity could make them less cost effective. As the use of TNF inhibitors extends to other systemic inflammatory diseases, such as psoriatic arthritis and ankylosing spondylitis, additional specific pharmacoeconomic assessments will need to be performed.\(^8\) Of note, these conditions typically affect a younger population, many of whom are in their prime working years. In the case of psoriatic arthritis, the impact of skin involvement on productivity and quality of life also needs to be factored into any pharmacoeconomic assessment.

Additional factors may impact on the health economic implications for TNF inhibitors. For example, as more agents are brought to the clinic, will markets force their price to decline? This has certainly been the case with other classes of medication, such as proton pump inhibitors, where competition has resulted in drastically lowered prices. Similarly, will there ever be cheaper generic versions of these factors such as variable costs? Some factors have been shown to affect both the efficacy and toxicity of biologicals; these considerations will certainly impact regulatory approval and, ultimately, cost.

Given the current healthcare environment, pharmacoeconomic considerations are likely to remain a central factor affecting the use of novel therapies in rheumatology and in other disciplines. Understanding these issues will help clinicians choose the optimal therapies for their patients with arthritis.

**Competing interests:** none declared

---

**REFERENCES**


6. **Maini RN, Breedveld FC, Kalden JR, Smolen JS, Furst D, Weinman MH, et al. Anti-Tumor Necrosis Factor Trial in Rheumatoid Arthritis With Concomitant Therapy Study Group. Sustained incremental or sustained efficacy with new agents, that could make them more cost effective. However, the need for longer term treatment or longer term implications of toxicity could make them less cost effective. As the use of TNF inhibitors extends to other systemic inflammatory diseases, such as psoriatic arthritis and ankylosing spondylitis, additional specific pharmacoeconomic assessments will need to be performed. Of note, these conditions typically affect a younger population, many of whom are in their prime working years. In the case of psoriatic arthritis, the impact of skin involvement on productivity and quality of life also needs to be factored into any pharmacoeconomic assessment.

Additional factors may impact on the health economic implications for TNF inhibitors. For example, as more agents are brought to the clinic, will markets force their price to decline? This has certainly been the case with other classes of medication, such as proton pump inhibitors, where competition has resulted in drastically lowered prices. Similarly, will there ever be cheaper generic versions of these factors such as variable costs? Some factors have been shown to affect both the efficacy and toxicity of biologicals; these considerations will certainly impact regulatory approval and, ultimately, cost.

Given the current healthcare environment, pharmacoeconomic considerations are likely to remain a central factor affecting the use of novel therapies in rheumatology and in other disciplines. Understanding these issues will help clinicians choose the optimal therapies for their patients with arthritis.

**Competing interests:** none declared
Implications for novel antirheumatic therapies


Health economics: implications for novel antirheumatic therapies

A Kavanaugh

Ann Rheum Dis 2005 64: iv65-iv69
doi: 10.1136/ard.2005.042440

Updated information and services can be found at:
http://ard.bmj.com/content/64/suppl_4/iv65

These include:

References
This article cites 58 articles, 16 of which you can access for free at:
http://ard.bmj.com/content/64/suppl_4/iv65#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/