A Survey of Barriers to Treatment Access in Rheumatoid Arthritis

Country Annex Report: Germany

October 2009

1 Interviews

In Germany, five rheumatologists were interviewed. The physicians comprised three hospital-based and two office-based specialists. The interviewees came from Cologne, Hannover, Erlangen, Berlin and Munich.

2 Environment

Germany has a total population of 82 million, with an adult population of 68 million (82%) [1]. German health insurance is based on the Bismarckanian social insurance system, first established as a social health insurance for workers in 1883. Today, more than 200 private and statutory sickness funds collect contributions and purchase proactively – or pay for retroactively – member health services. Since 2004, decision-making in statutory health insurance has been integrated into a trans-sectoral federal joint committee (G-BA) supported by an independent institute for quality and efficiency in healthcare, the German IQWiG. Since passage of the Competition Enhancement Act in 2008, the IQWiG has the mandate to evaluate the cost-benefit ratio of pharmaceuticals in Germany.

In 2005 health expenditure in Germany comprised 10.7% of GDP, and 79% was covered by public funds.

Within the statutory health insurance system, a risk-compensation scheme among sickness funds aims to level out differences in the age, sex and (since 2009) the health status of those insured through the different schemes. This system has been complemented by a high-risk pool since 2001 and by incentives for disease-management programmes for the chronically ill since 2003. Prior to 2009 the risk compensation scheme covered differences in age and sex only. In 2009, a new morbidity-adjusted risk-compensation scheme covering up to 80 different diseases was introduced, which added health status to the list. The rate of contribution to all statutory sickness funds was set by the government in July 2009 at 14.9% of gross income (divided between employer and employee).

The federal physician association (KBV) negotiates contracts with the head association of health insurances (GKV Spitzenverband Bund). The association distributes the funds among GPs and specialists who claim reimbursement mainly on a fee-for-service basis. Limitations apply to the volume of service.

Hospitals are financed on a dual basis: investments are planned by the governments of the 16 Bundesländer (federal states), and subsequently co-financed by the Bundesländer and the government. Sickness funds finance recurrent expenditures. Since January 2004, a German adaptation of the Australian diagnosis-related group

(DRG) system has been the sole system of paying for recurrent hospital expenditures, except for psychiatric care where *per diem* charges still apply. In 2009, a new healthcare reform act will be established to redefine the hospital financial system, while the DRG base rate will be harmonised on a state level.

3 Market access

In contrast to the majority of other healthcare systems, market access for most of the pharmaceuticals approved by the European Medicines Agency (EMEA) or the German Federal Institute for Drugs and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte, BfArM) is immediate and covered by the German statutory sickness funds. The Federal Ministry of Health is ultimately responsible for healthcare in Germany. Following marketing authorization, costly hospital products must be listed as 'Zusatzentgelt' for additional reimbursement.

The IQWiG has been mandated by the G-BA to conduct cost-effectiveness analyses to support the decision-making process of the G-BA. Reference prices can be set for a group of therapeutic or generic substitutes. Maximum prices can be set for drugs protected by patent, if a negative cost-benefit assessment is obtained.

4 Features specific to RA

A national treatment registry (Rheumatoide Arthritis: Beobachtung der Biologika-Therapie [RABBIT]) [2] monitors experience with biologics in RA.

- As of 1st November 2009 [3], RABBIT contains data on 5,183 patients treated with biologics and 2,325 controls. The following treatments are included: adalimumab (n=1,638), abatacept (n=211), etanercept (n=1,474), infliximab (n= 681), rituximab (n=934), anakinra (n=89), certolizumab (n=1) and tocilizumab (n=155). Its objectives are to evaluate long-term efficacy and safety, the pattern of and reasons for treatment switches, and the direct and indirect costs of treatment.
- 'Kerndokumentation' (core data set) is a health services research tool in RA, run by the Competence Network on Rheumatoid Arthritis in Germany and with its management and analysis centre at the Deutsches Rheuma Forschungszentrum (DRFZ) in Berlin. Kerndokumentation has collected data since 1993 in 22 centres covering approximately 100 treatment sites, and has a total of 250,000 data sets, of which up to 40% contain longitudinal data.

5 Guidelines

The first national guidelines for the management of early RA were published by the National Society of Rheumatology in 2004 (DGRh) and updated in 2006. The next update will be published in October 2009. No guidelines currently exist for advanced or severe RA.

6 Provision of care

Access to specialists is direct and unlimited; although since 2003 there is a fee of €10.00 per quarter to discourage direct specialist consultations. The fee is typically collected by the GP who then refers patients to specialists.

Special training for rheumatologists takes 3 years after a 5-year specialisation in internal medicine. The total number of licensed rheumatologists, 37% of whom are hospital based, is estimated at 1,200, including specialists in internal medicine currently being trained in rheumatology (n=600). This represents a ratio of around one rheumatologist per 68,000 in the population, or one per 57,000 of those aged over 18 years. Considering only certified rheumatologists, the ratio is one rheumatologist per 114,000 members of the adult population. This ratio is considered insufficient by German specialists. They see a requirement for at least 800 more rheumatologists. Lack of specific requirement planning hinders settlement of new rheumatologists; and a lack of educational capacity means that the education of a sufficient number of new young rheumatologists cannot be ensured.

Remuneration of office-based physicians under statutory sickness funds (EBM) is regulated by a practice budget, which limits the overall fee of the physician. The budget is specific to specialisation and to the number of cases to account for office size and budgetary requirements. The office budget has two implications that both drive cost-conscious behaviour among practitioners: first, retrospective calculation leads to uncertainty about whether payment will be made; and, second, practitioners remain liable for budget over-runs.

7 Diagnosis

Diagnosis is mainly established by RA specialists (60–80%), but GPs also diagnose patients. Time from symptomatic onset to a consultation with a rheumatologist may take up to 1 year or more according to the Germany patient association and respondents of

this survey. Estimates from respondents on time from symptoms to diagnosis range from 3–4 months to 1—2 years, but diagnosis is achieved within 1 year for most patients.

Diagnosis is supported by a range of procedures cited by the EULAR recommendations, i.e. physical examination and blood tests (ESR, CRP, rheuma factor, anti-CCP) and, rarely, MRI and ultrasound and X-ray if indicated. The DGRh Guidelines recommend an anti-CCP test for early RA as it is a more sensitive marker than RF. However, this test is only funded for the privately insured patients (11%). MRI is not used due to cost considerations; ultrasound and X-ray are used instead.

Some of the respondents in our study segment patients into a 'poor prognosis' category according to the intensity of pain, high degree of swelling, erosions (X-ray, ultrasound), high titre for RF and high markers of inflammation.

8 DMARDs

Treatment is initiated by rheumatologists immediately after a confirmed diagnosis. If the diagnosis was established by a GP then the patient is referred to a rheumatologist for initiation of treatment. All patients receive DMARDs as first-line treatment, e.g. MTX (10—25 mg), sulphasalazine (2 g/d) and anti-malaria treatments like hydroxychloroquine. Steroids are recommended as symptomatic treatment and used as a bridging therapy (75—90%). Once DMARD treatment is initiated steroids are tapered off to a low dose and are used continuously (50% of patients).

MTX is the first treatment for 70–90% of patients as recommended by the national guidelines [4]. Other first-line treatments include leflunomide and sulphasalazine each prescribed to approximately 10% of patients after diagnosis. One respondent indicated that he uses salazopyrine in women seeking to become pregnant, and chloroquine sulphate in mild disease.

MTX is mostly used as adjunct to NSAID and low-dose continuous steroid treatment. Treatment is changed immediately upon severe side effects, but patients are typically treated for 3 months until efficacy is assessed. If there is insufficient effect the dose may be increased or patients may be switched to another DMARD. Tolerability issues also motivate treatment switches.

Results from a population survey by Westhoff and colleagues [5] suggest that despite improvements in healthcare for RA patients there are still unmet needs related to starting and increasing DMARDs. This seems to be the case for RF-negative patients in particular.

9 Biologics

Biologics are considered third-line treatments for most patients and are used mainly to improve efficacy. Interviewees estimated that biologics are used in around 10–30% of patients, but actual usage figures put this percentage below 10%. This is consistent with the guideline recommendations that ask that small molecules – MTX in particular – are used in first-line treatment and, where necessary, another DMARD should be tried before switching the patient to biologics.

Anti-TNFs are the first treatment option after small molecule DMARDs. Typically, biologics are used in patients with severe RA or who fail to sufficiently respond to DMARDs – typically 10–30% of MTX recipients. Efficacy considerations drive the choice of drug, with priority given to agents with fewer side effects and longer clinical experience. In general, respondents did not report issues with current infusion capacity, but mentioned that this is partly due to efficient planning.

- First line: Adalimumab (Humira), etanercept (Enbrel) and infliximab (Remicade) are the most frequently used biologics. Efficacy and long-term experience with them are the main reasons given by interviewees.
- Second line: Abatacept (Orencia), rituximab (MabThera) and tocilizumab (RoActemra) are used subsequently, due to different mechanisms of action and different efficacy and safety profiles.
- Further options depend on the treatment history of the patient.

10 Treatment consistency with EULAR recommendations

The consistency with which the diagnosis and treatment of RA in Germany follows key EULAR recommendations is shown below (Table 1) for information gathered from desk research and from the interview panel.

Table 1. Consistency of German RA practice with EULAR recommendations

		National practice consistent with EULAR recommendations		
	EULAR recommendations	**Desk research**	**Interviews**	**Comments**
Diagnosis	Patient presenting with arthritis is referred to and seen by a rheumatologist ideally within 6 weeks of symptomatic onset	Yes	50% No 50% Yes	May take up to 1 year for many patients
	Clinical examination for detecting arthritis includes ultrasound, power Doppler and MRI	No	No	X-ray is standard
	Diagnosis requires at least the following laboratory tests: complete blood cell count, urinary analysis, transaminases, and antinuclear antibodies	Yes	Yes	
	Measurement of the following factors for patients presenting with early arthritis: number of swollen and tender joints, ESR and CRP, level of RF and anti-CCP antibodies, and radiographic erosions bodies	Yes	Yes	Funding of anti-CCP restricted for publicly insured patients
Treatment	Patients developing persistent or erosive arthritis should be started with DMARDs as early as possible	Yes	Yes	
	Use of patient information and education programmes about coping with pain and disability and maintaining work	Yes	Yes	Program by DGRh
	NSAIDs are considered in symptomatic patients	Yes	Yes	
	Systematic glucocorticoids to reduce pain and swelling are considered as a (mainly temporary) adjunct to DMARD treatment	No	Yes	No information
	Among DMARDs, MTX is considered the anchor drug and should be used first in patients at risk of developing persistent disease	Yes	Yes	

		National practice consistent with EULAR recommendations		
	EULAR recommendations	**Desk research**	**Interviews**	**Comments**
	The main goal of DMARD treatment is to achieve remission. Regular monitoring of disease activity and adverse events guide decisions on the choice or change of DMARDs and biologics used	Yes	Yes	
	Non-pharmaceutical interventions, such as dynamic exercises, occupational therapy and hydrotherapy, are applied as treatment adjuncts	No	Yes	
Monitoring	Disease monitoring includes tender and swollen joint counts, ESR and CRP assessment at 1 to 3 months	No	Yes	3 months
	Structural damage is assessed by X-ray every 6 to 12 months. Functional assessment is used to complement disease activity and structural damage	No	Yes	But 12–24 months cycle

Note: The specific wording of the recommendations has been shortened in some instances for editorial reasons

11 Sources

In addition to the references listed in the text the following sources were used in compiling German details in this monograph.

Epidemiology

- http://dgrh.de/gelenkschmerz_morbus.html
- http://dgrh.de/fileadmin/media/Qualitaetssicherung/Leitlinien/3_KAP1.PDF

Registries

- http://dgrh.de/jumbo-forschung.htm
- http://www.biologika-register.de/index.php?page=home&lang=de
- http://www.rheuma-online.de/news/artikel/rabbit-vergleicht-basismedikamente-und-biologicals.html
- http://www.agkjr.de/320.html

Delivery of care

- http://www.bundesaerztekammer.de/page.asp?his=0.3.6097.6098&all=true
- http://content.healthaffairs.org/cgi/content/full/23/3/56
- http://www.euro.who.int/Document/E85472.pdf
- http://www.svr-gesundheit.de/Gutachten/Gutacht03/Kurzf-engl03.pdf
- http://www.svr-gesundheit.de/Startseite/Startseite.htm

Guidelines

- http://dgrh.de/leitliniefruehera.html

Medical Treatment

- http://www.svr-gesundheit.de/Gutachten/Gutacht03/Kurzf-engl03.pdf
- http://rheumatology.oxfordjournals.org/cgi/content/full/39/5/542

12 References

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2. Listing J, Strangfeld A, Rau R, et al. Clinical and functional remission: even though biologics are superior to conventional DMARDs overall success rates remain low--results from RABBIT, the German biologics register. *Arthritis Res Ther* 2006; **8**:R66

3. Rheumatoide Arthritis: Beobachtung der Biologika-Therapie (RABBIT) website. http://www.biologika-register.de/index.php?page=ergebnisse&lang=de (Accessed 11 Nov 2009)

4. Schneider M, Lelgemann M, Abholz HH, et al. Interdisziplinäre Leitlinie - Management der frühen rheumatoiden Arthritis. Steinkopff-Verlag, Darmstadt, 2006 (ISBN 978-3798517103).

5. Westhoff G, Schneider M, Raspe H, et al. Advance and unmet need of health care for patients with rheumatoid arthritis in the German population--results from the German Rheumatoid Arthritis Population Survey (GRAPS). *Rheumatology (Oxford)* 2009; **48**:650-657.