



# **A Survey of Barriers to Treatment Access in Rheumatoid Arthritis**

*Country Annex Report: Spain*

October 2009

### 1 Interviews

In Spain three rheumatologists and two patient representatives were interviewed. The interviewees came mainly from regions that have a higher density of specialists.

### 2 Environment

Spain has a total population of 45.3 million with an adult population of 36.9 million (81.5%). The Spanish healthcare system has been set up as an integrated NHS (SNS – Sistema Nacional de la Salud), which is publicly financed and provides nearly universal healthcare free of charge at the point of use. All of the Spanish population is thus insured through the SNS and approximately 25% have additional private insurance.

The SNS is coordinated and supervised by the Ministry of Health and Social Policy (Ministerio de Sanidad y Política Social [MSYPS]). Since the recent decentralization of healthcare to the 17 autonomous regions, the MSYPS focuses on pharmacovigilance, product approvals, cost containment and long-term policies.

Provision is mostly publicly owned and managed: this applies to all GPs and primary healthcare centres, to clinics and physicians specialised in treating outpatients, and to 80% of hospital care. Governance of the system is decentralised, with local organizations within each of the 17 regions that comprise the Spanish state. These regions are responsible for the delivery and financing of healthcare [1].

The general principles of the SNS as defined by the 1978 Constitution and the 1986 General Health Care Act are:

- ◆ universal coverage with free access to healthcare for all citizens
- ◆ public financing, mainly through general taxation
- ◆ the integration of different health service networks under the SNS structure
- ◆ political devolution to the Autonomous Communities and region-based organisation of health services into health areas and basic health zones
- ◆ the development of a new model of primary healthcare, emphasizing the integration of promotion, prevention and rehabilitation activities at this level.

These principles have resulted in far-reaching changes, a process which is not yet complete. The SNS presents a complex panorama as it evolves away from its origins as a centralised system rooted in a social security scheme towards one of universal coverage delivered through 17 Autonomous Communities.

Difficulties remain in guaranteeing equal access to deprived social groups, consolidating a stable system of financing, controlling the increase in health expenditure, decentralizing services to all Autonomous Communities, and coordinating and integrating the various services within the SNS.

Health professionals are employed within the system only after passing an entrance examination, through which they acquire a special status similar to that of civil servants.

### 3 Market Access

When marketing authorization is granted the Agencia Española del Medicamento provides approval for local packaging materials. The MSYPS initiates a procedure to decide on reimbursement of the new product via its inclusion on the national reimbursement list. The manufacturer is then invited to provide all relevant information to allow the Inter-ministerial Pricing Commission CIPM (La Comisión Interministerial de Precios de los Medicamentos), led by the MSYPS, to make a decision. If the outcome is positive for inclusion in the list, this decision applies throughout the country.

Where reimbursement is approved, pricing is decided at the same time. If the reimbursement decision is negative, however, the product will be put on the list of unreimbursed drugs under the SNS and free pricing is determined by the manufacturer. The pricing and reimbursement process should not take longer than 180 days. However, studies have indicated that longer times are not unusual.

### 4 Features specific to RA

There is no national strategy plan for RA. However, as discussed below, the national guidelines (Guía de práctica clínica para el manejo de la Artritis Reumatoide [GUIPCAR]) and several regional guidelines are very complete and extensive and may be considered as a strategy plan, and the Spanish Society of Rheumatology (SER) has also developed a protocol for early diagnosis in general hospitals that has had an important impact.

Several RA and patient organizations conduct programmes to support the self-management of patients to cope with pain and maintain work. Information is found on their websites:

- ◆ CONARTRITIS (Coordinadora nacional de Artritis; <http://www.conartritis.org>),
- ◆ Liga Reumatológica de España (<http://www.lire.es>)

- ◆ Asociación Madrileña de Pacientes con Artritis Reumatoide (<http://www.amapar.org>)
- ◆ Asociación Artritis Reumatoide de la Rioja (<http://www.artritisrioja.com>)
- ◆ Liga de Enfermos Vizcaínos de Artritis Reumatoide ([http://www.levar.es/actividades\\_esp.htm](http://www.levar.es/actividades_esp.htm)).

There is a nationwide safety registry sponsored by several pharmaceutical companies (Abbott, BMS, Roche, Schering-Plough, Wyeth).

- ◆ BIOBADASER (Spanish Registry of Adverse Events of Biological Therapies in Rheumatic Diseases) actively collects information on relevant adverse events occurring during long-term treatment with biologics. The registry is a joint project of Spanish rheumatologists, the Research Unit of the Spanish Foundation for Rheumatology, the Spanish Agency for Medicines and Medical Devices and the SER. From the beginning of the registry in 2002 through to 2008 a total of 9,352 patients were included, comprising over 12,000 treatment cycles, with 59% of the patients having a diagnosis of RA. Infliximab is the most frequently used first option in the registry (55%), followed by etanercept (47%). Note, however, that publicly available reports do not differentiate between different rheumatology diagnoses and the use of biologics.

## 5 Guidelines

There are several guidelines in Spain at both the national and regional levels.

- ◆ *National guidelines*

GUIPCAR is a national guideline issued by the SER and endorsed by the National Guidelines Clearinghouse and by Guíasalud from the Ministry of Health in 2007. In addition, the SER has also developed a protocol for a 2000 initiative to promote early diagnosis in general hospitals, which assists rapid referrals to specialists. There are also complementary documents available, such as the Consensus Document for the Treatment with Biologics.
- ◆ *Regional Issues*

Although the national guidelines are implemented throughout Spain, local hospital protocols may affect access to biologics. In the case of Andalucía, each hospital in the region has its own local Biologics Committee which must approve all biologic treatment for RA, and a Regional Committee to which cases are escalated should a local decision not be reached.

## 6 Provision of care

GPs are the first contact the population has with the health system. They should screen patients and provide both diagnosis and treatment if appropriate. They may also refer patients on to specialised services if necessary. Despite the gatekeeper role of the GP, a referral is not needed by patients wishing to see an obstetrician or a dentist or, in certain cases, an ophthalmologist.

In general, patients who have received specialist care are expected to return to the primary care physician, who then assumes responsibility for follow-up treatment, repeat prescriptions, etc. Since 1986, patients have had the right to choose their physician within the health area. In addition, in 1993, this choice was extended to physicians working in other health areas, under the sole requirement that the GP chosen actually accepts the new patient on his or her list. However, there are important practical difficulties in making this right effective. In addition, although GPs receive a capitation fee, its size is rather small. For these reasons, they tend to reject patients from other health areas.

Primary healthcare is delivered through two distinct networks – the traditional model and the reformed model – which offer a slightly different range of services and have their own funding formula. The traditional model is the oldest, and increasingly less common, network of care. The reformed model represents a team-based, multidisciplinary approach to primary healthcare problems, and is the result of an extension of the 1984 primary care reforms. However, both types of models have coexisted for almost two decades, and still coexist today.

Special training for rheumatologists takes 4 years after an MD degree. There are 1,300 rheumatologists registered with the Spanish Society of Rheumatology and thus there is one specialist per 34,800 members of the population, or one per 28,400 of the adult population. However, 50% of the respondents felt that the number of rheumatologists is insufficient and all think that there is great variability across the Spanish regions and that adding specialists to underserved regions would make a great difference.

## 7 Diagnosis

The final diagnosis is always established by the rheumatologist, but GPs and other specialists (orthopaedic surgeons, internists) play a role in the diagnostic process (10–20% of cases). Diagnosis is made within 6 months after first symptoms in an estimated 15% of cases, within 12 months in 25% of cases and after 1 year in 60% of cases. While the situation in some regions may promote a short time to diagnosis (3 to 6 months), the assessment by patient organizations is that the time to diagnosis is typically

longer (8 to 18 months) in most cases. This pattern of responses reflects regional differences in medical practice and capacity.

Diagnosis is supported by a range of procedures supported by the EULAR recommendations, i.e. physical examination, blood tests (ESR, CRP, RF, anti-CCP), and rarely MRI and ultrasound and X-ray if indicated. Inflammatory markers (ESR, CRP anti-CCP), RF and imaging (MRI, ultrasound and X-ray) are fully funded under the SNS. However, imaging is not used routinely due to funding policies (MRI) and lack of facilities or training (ultrasound).

Most respondents in our study differentiate between patients with 'poor prognosis' and 'other patients' using the following criteria: early onset, disease severity, high titre of RF, high markers of inflammation (anti-CCP) and erosions (X-ray, ultrasound). More aggressive therapies are used in patients with poor prognosis.

## 8 DMARDs

Treatment is initiated by rheumatologists immediately after confirmed diagnosis. For more than 80% of patients the first treatment choice is MTX, as recommended by GUIPCAR. Other first-line treatments include leflunomide, cyclosporine, cyclophosphamide and sulphasalazine. In approximately 70% of patients MTX is used as monotherapy and in the remainder it is used as an adjunct to leflunomide, anti-malarials or cyclosporine after an initial treatment period of 3 to 6 months. Steroids are used in 20–50% of patients. Once DMARD treatment is initiated steroids are withdrawn.

Treatment is changed immediately for severe side effects, but patients are typically treated for 3–9 months before being switched, mainly due to insufficient treatment response.

## 9 Biologics

Biologics are used in less than 1% of patients as a first-line strategy. According to a report by CONARTRITIS an estimated 10–13% of patients receive biologics, the majority after two (30–60%) or three (15–40%) DMARDs.

In line with regional guidelines, anti-TNFs are the first treatment option after small molecule DMARDs. Typically, biologics are used in patients with severe RA, in those who fail to sufficiently respond to DMARDs after 3 months, or in patients with special needs (such as those whose profession is based on manual dexterity and strength). Efficacy considerations drive the choice of drug, with priority given to drugs with fewer side effects and longer clinical experience.

The choice of which biologic to use is guided by a number of individual and geographical variables. These include the availability of infusion chairs, the experience and history of the service, the capability of the patient to auto-administer subcutaneous medicine, the distance between the patient's residence and the hospital, etc.

- ◆ First line: Adalimumab (Humira), etanercept (Enbrel) and infliximab (Remicade) are the most frequently used biologics. Efficacy and long-term experience are the main reasons given by interviewees.
- ◆ Second line: Cycling of another anti-TNF, or drugs with a different mechanism of action (rituximab, abatacept, tocilizumab) are used as next options, motivated by efficacy and safety considerations.
- ◆ Further options – such as switching or repeating anti-TNFs or moving to biologics with a different mechanism of action – depend on the treatment history of the patient, with enrolment into clinical trials mentioned as a possible option.

Most respondents did report capacity issues with current infusion facilities. However, while waiting time is not substantial (1 to 2 days) the infusion is generally given in suboptimal conditions, such as waiting rooms or shared facilities, and is therefore seen as a patient burden.

## 10 Treatment consistency with EULAR recommendations

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

Table 1. Consistency of Spanish RA practice with EULAR recommendations

National practice consistent with EULAR recommendations				
	EULAR recommendation	Desk research	Interviews	Comments
<b>Diagnosis</b>	Patient presenting with arthritis is referred to and seen by a rheumatologist ideally within 6 weeks of symptomatic onset	Yes	60% No 40% Yes	Takes 6 months
	Clinical examination for detecting arthritis includes ultrasound, power Doppler and MRI	Yes	No	Ultrasound, Doppler, MRI, hardly used in the initial evaluation. X-ray more frequent
	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, OK? level of RF and anti-CCP antibodies, and radiographic erosions bodies	Yes	Yes	Anti-CPP only assessed in 70–80% of patients
<b>Treatment</b>	Patients developing persistent/erosive arthritis should initiate DMARDs as early as possible	Yes	Yes	
	Use of patient information and education programmes about coping with pain and disability and maintaining work	Yes	60% Yes 40% No	No systematic/rigorous programme. There are information brochures and other publications produced by associations or pharmaceutical companies that are available. Nurses are not available everywhere. About 50% of the patients receive this kind of information and only 20% understand it
	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	Yes	Yes	



## Barriers to RA treatment access across Europe: Spain

National practice consistent with EULAR recommendations				
	EULAR recommendation	Desk research	Interviews	Comments
	Among DMARDs, MTX is considered the anchor drug and should be used first in patients at risk of developing persistent disease	Yes	Yes	
	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/or biologics used	Yes	Yes	
	Non-pharmaceutical interventions, such as dynamic exercises, occupational therapy and hydrotherapy, are applied as treatment adjuncts	Yes	No	Only 50% of the patients receive these kinds of interventions. Availability depends on hospital capacity. Often through private healthcare and used only once
<b>Monitoring</b>	Disease monitoring includes tender and swollen joint counts, ESR and CRP assessment at 1 to 3 months	Yes	Yes	
	Structural damage is assessed by X-ray every 6 to 12 months. Functional assessment is used to complement disease activity and structural damage	Yes	Yes	Can also be 6 months to 2 years

*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 Spanish details in this monograph.

### Delivery of care

- ◆ Instituto Nacional de Estadística, data provided by the Consejo General de Colegios de Médicos de España (CGCOM), <http://www.ine.es/jaxi/tabla.do> accessed on November 17th, 2008. All registers up to December 31st, 2007.
- ◆ Fousté *et al.* *Gac Sanit* 2005; 19:15–21
- ◆ <http://www.euro.who.int/Document/E89491.pdf>
- ◆ González-Álvaro *et al.* *Med Clin (Barc)* 2002; **118**:771–776.

### Guidelines

- ◆ Guía de práctica clínica para el manejo de la Artritis Reumatoide 2007; produced and updated in 2007 by the Sociedad Española de Reumatología, and endorsed by the National Guidelines Clearinghouse and by Guiasalud, from the Ministry of Health.

### Patient Associations

- ◆ Coordinadora nacional de Artritis (<http://www.conartritis.org/>)
- ◆ Liga Reumatológica de España (<http://www.lire.es/>)
- ◆ Asociación Madrileña de Pacientes con Artritis Reumatoide (<http://www.amapar.org/>)
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## 12 References

1. International Society for Pharmacoeconomics and Outcomes Research (ISPOR). ISPOR global health care systems road maps: Spain - Health policy decision process. Last modified 2009. *Available at:* <http://www.ispor.org/htaroadmaps/SpainHP.asp> (Accessed 02 Oct 2009).