Arthritis and Musculoskeletal Alliance

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Ms Lori Farrer
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25th September 2013

Dear Ms Farrer,

The Arthritis and Musculoskeletal Alliance response to Multiple Technology Appraisal (MTA): Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, abatacept and tocilizumab for the treatment of rheumatoid arthritis (review of TA guidance 130, 186, 224, 234 and part review of TA guidance 225 and 247) [ID537]

The Arthritis and Musculoskeletal Alliance (ARMA) welcomes the opportunity to contribute to the above appraisal. ARMA is the umbrella body for the musculoskeletal community in the UK. We have 40 member organisations, ranging from specialised support groups for rare diseases to major research charities and national professional bodies.

We fully support the responses to the above appraisal by the British Society for Rheumatology (BSR) and the National Rheumatoid Arthritis Society (NRAS).

We are very concerned at the prospect of potentially restricting access to biologics, which have had a demonstrably life-changing effect for vast numbers of people living with rheumatoid arthritis (RA). We completely share the concerns expressed by the BSR and NRAS regarding the modelling and the evidence base underpinning the recommendations in the report, as well as the potential impact - both personal and economic - of restricting rather than improving access to the best available treatments for people with RA, which clearly is also a restriction of patient choice.

As we've emphasised in the past on many occasions, the cost-effectiveness of biologic therapy – and indeed of any therapy - needs to be considered in a broad sense, taking account not only the cost of the treatment itself but the benefits it produces, in terms of better patient outcomes and longer-term savings to the NHS and to society as a whole - and, conversely, the associated personal, economic and societal costs of not providing the treatment. Once all factors are taken into account,

it is clear to us that there is significant evidence that biologic treatment for RA is indeed cost-effective, as outlined by the BSR and NRAS.

The NHS Constitution makes it clear that the NHS “belongs to the people”, and it follows that any decision regarding the cost-effectiveness or availability of specific treatments which has improved patient outcomes at its heart must start by considering benefit to the patient. In this respect, the benefit of early intervention and greater access to biologic treatment for the patient with RA is already clearly evidenced. As the BSR notes, biologic treatments have revolutionised the treatment and management of RA, and as NRAS’ response in particular illustrates very clearly, biologic treatment has improved patient outcomes in RA enormously. This is not only better for the individual patient, but for the NHS and society at large, as, among other things, it helps keep people healthy, independent, self-sufficient and in work for longer, thereby remaining both socially and economically active – and therefore, less reliant on the NHS and on disability benefits.

In this respect, it should also be noted that RA is a complex condition and associated with a large number of co-morbidities, including depression and obesity - conditions which have an enormous impact on the quality of life of millions of people in England. The associated loss of productivity is not isolated to the patient, but extends to their family members and carers, who may find it necessary to restrict their paid employment to be able to provide the required care.

It is also clear from existing evidence that the outcomes for people with RA in England are substantially worse compared to other European countries. As highlighted by NRAS in particular, the treatment currently afforded to people with RA in England is simply too little, too late. We therefore fully support the BSR’s and NRAS’s recommendation to improve the eligibility criteria for biologic treatment by lowering the DAS threshold as articulated in their responses, and to not require patients with RA to undergo two separate measurements one month apart.

We urge NICE to take full account of all of the above considerations, as outlined in greater detail by the BSR and NRAS in their responses, in the interests of delivering improved patient outcomes, greater value, and indeed cost-effectiveness - in the full sense of the word.

Yours sincerely,

[redacted]

[redacted], ARMA