

Biologic Drug Access and Juvenile Idiopathic Arthritis in Canada: Improving Collaboration Between Clinician Experts and Funders

To the Editor:

We read with great interest the article by LeBlanc, *et al*, "Access to Biologic Therapies in Canada for Children with Juvenile Idiopathic Arthritis"¹. We congratulate the authors for highlighting the challenges for Canada's healthcare system in delivering equitable drug access across the country when healthcare is provincially delivered and there is still no national pharmaceutical program. This is particularly important in areas such as juvenile idiopathic arthritis (JIA), where because of the rarity of the underlying condition, the development of different funding decisions across provinces and territories leads to inefficient drug policy. Provincial governments should be encouraged to review the advice of national organizations such as the Canadian Agency for Drugs and Technologies in Health (CADTH) and the pan-Canadian Oncology Drug Review (pCODR). These organizations provide evidence-based information about health technologies, including drugs, with the goal of harmonizing drug funding across the country.

We would like to clarify a few misconceptions in the LeBlanc article. First, the authors stated that no pediatric rheumatologists are involved in provincial drug advisory committees. In Ontario, Canada's most populous province, where we serve on one such committee (the Committee to Evaluate Drugs, which advises the Ministry of Health and Long-Term Care on drug-related policy issues), biologics as a class have been reviewed for JIA with substantial input from the Ontario Rheumatology Association. In situations where no drug policy exists for a request for a particular rheumatologic drug or indication, rheumatologists are frequently contacted to provide expertise in making decisions on what the authors describe as a case-by-case basis. Second, the authors mention that funding decisions sometimes conflict with advice from published treatment guidelines by professional organizations such as the American College of Rheumatology. While true, this is not unique to rheumatologic diseases. Public (and private) funders consider a myriad of factors such as cost-effectiveness, therapeutic need, safety, and feasibility of drug delivery (e.g., use of other healthcare resources such as laboratory testing and hospitals) when making informed decisions about drug coverage. An additional major concern is the potential conflict of interest of not just industry and individual clinicians, but also professional organizations and the journals read by their members. We note, for instance, that the downloaded version of the LeBlanc article included an advertisement for one of the biologic agents used to treat JIA.

Lastly, and probably most important, is the context of drug funding policy in Canada. Over the past 10 years, prescription drugs have been the fastest rising expenditure in Canada's health system², and this is likely true in many other nations. Given the limited healthcare resources available, it is not possible to fund every drug that may have some benefit for patients. Every funding body must weigh the evidence for the decision around a drug not just within the disease of interest but across all different diseases. Thus, funders must be able to contrast the benefits of a biologic for JIA with the evidence for a biologic for inflammatory bowel disease and with the evidence for a totally different drug for another disease, all while considering the challenges of collecting high-quality evidence for certain conditions (e.g., rare diseases). From a societal perspective, this systematic approach helps avoid the perception that certain diseases unjustifiably take priority over others. This is why the use of standard health economic metrics across disparate interventions and conditions, such as

quality-adjusted life-years and incremental cost-effectiveness ratios as outcome measures, is an essential tool to help inform funding decisions. In 2002, a Health Technology Assessment report from the UK National Health Service concluded that there was insufficient information available to assess the cost-effectiveness of biologics in the treatment of JIA³. Unfortunately, 10 years on, the situation remains the same: estimates of value for money for treating JIA with biologic drugs are still limited and do not incorporate such standard metrics⁴.

Policy makers certainly should incorporate the expertise of pediatric rheumatologists (as well as their patients) in making funding decisions, but it is not realistic to expect that all drugs will be funded. Some cost more than others, and the clinical evidence for each (both effectiveness and safety) is certainly not equal across multiple indications. We would also advise the pediatric rheumatology community to focus more on comparative cost-effectiveness in research protocols and in advocacy to help funders arrive at the rational decisions that ultimately improve the health of not just children with JIA, but society at large.

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Dr. Cohen and Dr. Coyle are paid as members and Dr. Grill as the chair of the Committee to Evaluate Drugs by the Ontario Ministry of Health and Long-Term Care (MOHLTC). Dr. Grill is also paid as a member of the pan-Canadian Oncology Drug Review Expert Review Committee. Dr. Coyle is a former member of the Canadian Expert Drug Advisory Committee. The opinions reported here are those of the authors and are independent from all funding sources. No endorsement by the Ontario MOHLTC is intended or should be inferred.

REFERENCES

1. LeBlanc CM, Lang B, Bencivenga A, Chetaille AL, Dancey P, Dent P, et al. Access to biologic therapies in Canada for children with juvenile idiopathic arthritis [letter]. *J Rheumatol* 2012;39:1875-9.
2. Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2011. [Internet. Accessed November 26, 2012.] Available from: <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1671>
3. Cummins C, Connock M, Fry-Smith A, Burls A. A systematic review of effectiveness and economic evaluation of new drug treatments for juvenile idiopathic arthritis: Etanercept. *Health Technol Assess* 2002;6:1-43.
4. Ungar WJ, Costa V, Hancock-Howard R, Feldman BM, Laxer RM. Cost-effectiveness of biologics in polyarticular-course juvenile idiopathic arthritis patients unresponsive to disease-modifying antirheumatic drugs. *Arthritis Care Res* 2011;63:111-9.

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