Dr. Johnson and Dr. Bahçe-Altuntaş reply

To the Editor:

We appreciate the interest in our editorial[1] regarding Dr. Stamp's study of joint replacement rates in New Zealand[2], as expressed by Dr. Boers[3]. We are happy to have opened an international dialogue regarding barriers to access to biologic disease-modifying antirheumatic drugs (bDMARD). We agree with Dr. Boers that the high price of bDMARD is a barrier to access. As 2 physicians working in a safety-net hospital in an inner city, we share his concern for the uninsured in the United States and care for many such patients.

As we outline in our article, there is wide variability among countries on how easily a patient can receive a bDMARD. Our objection in the case of New Zealand's policy is withholding bDMARD treatment until the patient has erosions. We thank Dr. Boers for identifying our unintentional omission of methotrexate (MTX) failure prior to bDMARD use, as stated in American College of Rheumatology and European League Against Rheumatism (EULAR) guidelines. However, both favor early start of bDMARD after MTX failure in many situations[4,5]. Our argument remains that earlier access to bDMARD in insufficient responders leads to better outcomes.

Dr. Boers argues that the cost of bDMARD does not outweigh the benefit. However, the cost to society of disability from undertreated rheumatoid arthritis (RA) is far more than just the cost of joint replacement surgery. EULAR 2016 recommendations echo this, stating: "RA incurs high individual, medical and societal costs… effective RA therapy — in spite of its direct costs — will reduce the economic burden … which includes direct medical costs and indirect costs such as work disability and premature retirement."[4]

Cost is clearly the largest barrier to access. We hope that the advent of biosimilars decreases this barrier on a global level.

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