



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

***Country Annex Report: Argentina***

**August 2010**

1	INTERVIEWS.....	3
2	ENVIRONMENT.....	3
	2.1 Health care system.....	3
	2.2 Market access and reimbursement .....	4
3	FEATURES SPECIFIC TO RA .....	6
4	GUIDELINES .....	6
5	PROVISION OF CARE .....	7
6	DIAGNOSIS .....	8
7	TREATMENT .....	8
	7.1 DMARDs.....	8
	7.2 Biologics .....	9
	7.3 Treatment consistency with EULAR recommendations.....	10
8	CONCLUSIONS.....	12
9	REFERENCES.....	13
	9.1 Sources .....	13
	9.2 References .....	13
10	ACKNOWLEDGEMENT .....	13

### 1 Interviews

Six respondents were interviewed in the Argentinean part of the study. Four of the respondents were doctors whilst two were patient representatives. All doctors were hospital based, three from public Hospital and one from a private Hospital. The two patient representatives were from an NGO which provides counsel to RA patients.

### 2 Environment

Argentina is an upper-middle income country in Latin America with a population of 38 million with the majority living in large cities. Like many other countries in Latin America, it has major health care problems related to both equity and efficiency.

#### 2.1 Health care system

Argentina's healthcare system consists of a multi-tier system divided in three large sectors: public, social security and private. The publicly-funded sector is decentralized, giving the federal Ministry of Health (MH) a rather limited role in national health policy stewardship. In effect, the scheme of decentralization devolves the financing and delivery of healthcare from the national level to the provinces or municipalities. As a result, the federal level accounts for a minimal expenditure percentage of 2% out of 9.5%, of the total health expenditure as a proportion of the Gross Domestic Product (GDP). The health care spending represents a per-capita health expenditure of US\$455 at peso-dollar parity, or US\$1274 in purchase power parity (PPP) dollars, making it the leading spender in health care in Latin America. A significant portion of the health expenditure, 34%, is channelled through the Obras Sociales (OS), which was established to cover specific groups of formal workers. However, the private sector (private providers and private insurances) is also important and accounts for 44% of total health expenditure, almost two thirds of which comes from out-of-pocket payments from households (63 %), which in turn account for 28 % of the total health expenditure.

Public hospitals provide coverage to the population on demand and, in fact, act as reinsurance for the health insurance plans since they maintain a flow of free care for the insured population. About 34% of the Argentine population has no insurance and relies solely on the public health sector of each province or district [2]. In addition, the public hospitals are sometimes used by insured individuals requiring more complex and expensive diagnostic or therapeutic procedures.

The social health insurance sector (Obras Sociales) consists of many different funds, mostly managed by trade unions and generally composed of workers within the same labour activity. This sector consists of about 300 OS, diverse in scope and size, which covers more than 50% of the population. The National OS are primarily funded by a compulsory payroll contribution from employees who each contribute with 3% of their salary while employers contribute with 6 %. Each fund covers the employee and their direct dependents with the option to extend coverage to other family members. As a result, there are important

differences among the OS, depending on the average wages and the number of dependents for each worker, which in turn vary following a social gradient. In brief, the contributions from wages of employers and employees are collected by the Federal Administration of Public Revenues (AFIP in its Spanish acronym) who in turn allocates about 85-90% of the monies back to the OS. In order to compensate for the differences that may result in potential health inequities due to the disparities in earnings for each of the OS, a “redistribution fund” (FSR) composed of 10 - 15% of each payroll contribution, transfers money from the more wealthy to the poorer OS. The minimum package guaranteed to all formal workers is called “Compulsory Medical Plan” or PMO in its Spanish acronym. As many of the social health insurance funds are too small to provide services directly, they subcontract private health plans, private clinics and hospitals, giving rise to a large private provision sector. In summary, the PMO establishes the essential basic medical services and drugs that must be ensured to the entire beneficiary population by the OS and the insurance agents. It is under the sphere of the Superintendence of Health Services (SSS), an agency of the Ministry of Health.

About 3.5 million elderly, as well as some people with disabilities are generally covered by a nation-wide social health insurance fund for retired workers called PAMI, broadly comparable to the Medicare in the USA. The private insurance sector covers approximately 4 million people, about 10% of the population, while 56% [2] is contracted individually and the remaining is derived from social health insurers’ provision and supplementary coverage plans. Private health insurance is funded through direct and voluntary pre-payments by insured members. Benefit packages depend on the contribution of the people insured. Unlike the Social Security sector, the private insurance sector still lacks an effective regulatory framework to define benefits and plans but same laws applies to them as to OS whenever there is a conflict about coverage.

### 2.2 Market access and reimbursement

The Drug, Food and Technology National Administration (ANMAT) is the national regulatory body responsible for drug marketing and authorization. It is a decentralized agency of the Ministry of Health that regulates licensing of new technologies. Like most regulatory agencies, drug approval and marketing is based on quality, safety and efficacy. It is only recently that cost-effectiveness has began to be considered, but not yet required by the Superintendence of Health Services (SSS) of the Ministry of Health as a fourth requirement between the drug marketing authorization and the coverage or reimbursement of new pharmaceuticals or devices. There is no formal drug price regulation in Argentina, and sale prices are set according to market demands. Argentina does not currently have cross-referencing pricing mechanisms. Nevertheless, there are several mechanisms that actually regulate drug prices. Regarding national reference pricing, around 200 essential drugs are included in the mandatory positive list regulated by the SSS. Also, generic prescribing has been strongly enforced by congressional law enacted in 2004.

One of the problems to follow drug prices is that not all prescription drug costs are provided to publicly available sources (Manual Farmacéutico, Kairos, IMS). For example, high cost

drugs are handled by direct sales and as such escape any price control or monitoring (i.e. imatinib, saquinavir, bevacizumab, soranefib). A recent proposal by the SSS of MH was to create a drug observatory of the National Health Insurance System. Over the last few years, some agreements between the government and pharmaceutical industry have led to reducing the price of more than 200 drugs, and regulating gradual increases over time. Nevertheless, there is no clear evidence that these agreements have resulted in lower drug prices but maybe have decreased the rate of price escalation seen in other biomedical products.

Pharmaceuticals and other medical technologies are reimbursed depending upon the source of financing. In the tax-funded public system, hospital and ambulatory services are generally free at the point of care and delivered on demand, with a large variation in the complexity and the quality of services according to each district, where wealthier provinces have better quality services than poorer ones. In 2002, the Minister of Health passed a law stating a new national policy for medicines including a reference price for essential drugs covered by the social security system and an obligation for physicians to prescribe by generic name and not brand name. Additionally, a nation-wide program (program REMEDIAR) was established to guarantee the supply of essential drugs among public primary care centers. Through this program, more than 6,000 essential drugs are included in a positive list. For the Social Security sector, there is a compulsory package of benefits (PMO) which all funds are obliged to guarantee its coverage to their beneficiaries. Ambulatory drugs are subsidized in a proportion depending on the condition treated and may vary from 40% (some acute conditions) to 100% of a reference price. Since 2004, the coverage of most drugs for chronic conditions was increased from between 40% to 70% of a reference price. In addition, more than 87 drugs (only 20 before 2004) are now under a subsidy of 100% (i.e. insulins, antiretrovirals, cancer drugs and biologics).

In 2003 the government enforced a law to provide full coverage through the actual health providers to people with different level of handicap, in order to assure access to medical care. To be entitled to this benefit, patients should require a “disability certificate” that allows them to have an extensive and comprehensive coverage for their disease. Examples of conditions included are: Stroke, Cerebral Palsy and RA. Hence, the only full coverage for patients within RA that is guaranteed by law is when patients have received a disability certificate. A recent survey performed at a public hospital showed that only 17% of RA patients have asked for a disability certificate. The main reason why patients had not asked for one was unawareness of the benefits associated to the certificate by both physicians and patients, as well as a fear by the patients to loose their job if a disability certificate was obtained. This system may hence limit the access of drugs for patients not having a certificate (for whatever reason). However, different OS and health maintenance organizations (HMOs) can decide to cover care for patients without a certificate (further discussed under section 4). As stated earlier though, for the social security sector biologics are under 100% subsidy. Still, none of the health institutions (private or public) have demonstrated a specific budget for RA or continuous purchase of treatments, instead it is bought in a case by case manner. This may lead to a delay in receiving treatment of up to 8 months after prescription. The request for reimbursement also needs to be renewed every three months, potentially further delaying continuous treatment.

The Special Programs Administration (Administración de Programas Especiales - APE) is a decentralized agency under the sphere of the Ministry of Health which was created to provide trade union HMOs (those managed by trade unions) of a mechanism of "compensation" in order to cover drugs and health services of those diseases considered of "low incidence and high cost". Treatments indicated for HIV and transplant patients, among others, are included in the coverage funded by the APE. In this sense, the mechanism by which the APE covers the treatment of RA is also through the presentation of a disability certificate. Moreover, in most cases coverage is obtained through what is called, in legal terms, "way of exception". In consequence the disability certificate does not always ensure timely and continuous access (without interruptions) to the treatment prescribed by a specialist.

### 3 Features specific to RA

A study on the prevalence of RA in Tucumán Province in the North West of Argentina [1] indicated a total prevalence rate of 1.97 per 1000 of the adult population (0.2%); 0.6 for men and 3.2 for women. The study also presented a female:male ratio of 6:1. Similar data was observed in another study conducted in the Italian Hospital at Buenos Aires, reporting a prevalence rate of 0.24% (0.33% for women and 0.009% for men) [3]. The incidence was also estimated in this study at 24/100,000 person-years (33 and 11 for women and men, respectively) [3]. There are no patient registers or other information to provide the number of RA patients in the country.

### 4 Guidelines

The first national guidelines for RA care were published by the Argentinean Society of Rheumatology (SAR) in 2003 ([www.reumatologia.org.ar](http://www.reumatologia.org.ar)). Taking into account changes in therapies, national guidelines were actualized in 2006 and updated in 2008. The main points of these guidelines were:

- ◆ Early access to specialized care
- ◆ Regular and objective assessment including: disease activity, functional capacity, quality of life, patient reported outcomes, hands and feet x-rays and acute phase reactants budget constraints
- ◆ Early suppression of inflammation
- ◆ Early identification of severe patients in order to start aggressive therapy

Regarding use of biologics, SAR guidelines stated that anti-TNF therapy is recommended for patients with active RA who failed to respond to 3 to 6 months of Methotrexate (up to 25mg/week) or who were intolerant to that drug. Anti-TNF should be discontinued if patients did not respond favorably after 6 months, at which the patient should be switched to another anti-TNF, abatacept or rituximab.

However, these guidelines are not mandatory for health care systems and they are not directly linked to reimbursement or health care coverage. However some OS and HMOs use the guidelines or reports from local Health Technology Assessment Agencies to decide whether or not to cover expensive drugs in RA patients since they are not yet included in the PMO for mandatory coverage. For 100% coverage they usually base the decision to cover the expensive treatment in the existence of a disability certificate, whenever evaluating the case of RA patients.

### 5 Provision of care

Access to specialized care is the first and main barrier to quality care. Albeit Argentina has approximately 800 physicians who care for patients with rheumatic diseases (rheumatologists and clinicians with expertise), they are mainly located around big cities such as Buenos Aires, Córdoba and Rosario. Responses from hospital and rehabilitation based interviewees gave varying numbers of rheumatologists ranging from 300 – 700. There was a general consensus amongst the interviewees that GPs were the first contact for all patients before being referred to a specialist. It appears that geographical location is a significant factor in accessing a rheumatologist. Some of the interviewees were satisfied with the number of rheumatologists in their area whereas others were of the view that the local number did not meet local needs. This study found around 30-40% of RA specialists located in Buenos Aires. Patients in small towns around the country travel several miles to get an appointment. According to the respondents, mean time to see a rheumatologist for the first time is 8 months, and mean time to get the first DMARD is up to 12 months. SAR, on the other hand, estimates the mean time to see a rheumatologist for the first time to 12 months and 13 months to get the first DMARD.

It has been acknowledged that the success of a health care system that has a large proportion of patients attended by a GP in the first instance the number and qualification of GPs is as important as that of specialists. There are 26,669 GPs who diagnose RA in addition to 450 rheumatologists [4]. This represents 34.6 GPs per 50,000 inhabitants and 0.58 rheumatologists per 50,000 inhabitants.

Rheumatologists can take 36 months to train after completing their medical training, but this differs between regions. A main requirement is, however, to have basic training in pediatrics, internal medicine, general medicine and family medicine. After completing training and passing examination, specialists are licensed by the government. There are no other national requirements for potential candidates such as a specified number of years working in rheumatology before specializing.

## 6 Diagnosis

Information obtained from interviews showed that between 40% and 70% of patients are diagnosed by GPs; 15 to 50% by rheumatologists, and 10 to 30% by other physicians in internal medicine and orthopedics, dependent by region. The diversity of the answers makes it hard to draw any stable conclusions, but the largest proportion of patients was diagnosed by GP, followed by rheumatologist and other physician in most of the regions. Two of the respondents stated that the majority of patients had been diagnosed by a rheumatologist. After reporting the first signs of symptoms to a health practitioner, it takes at least one to twelve months to establish a diagnosis.

Physical examination, lab tests (e.g. rheumatoid factor, anti-CCP, ESR, CRP) and x-rays are the main methods used for diagnosis. Ultrasound is rarely used for diagnosis as there is no universal access and few trained rheumatologists or interested radiologists. The ESR/CRP and rheumatoid factor are 100% funded for public insured patients. Funding for anti-CCP for public funded patients is unclear but for private patients, the funding varies. Financial restrictions and insufficient imaging facilities make it less possible for medical practitioners to explore other diagnostic equipments, according to the respondents. There are 0.36 MRI scanners per 50,000 populations. MRI scanners and radiography equipment are 100% funded. Desk research indicated that Doppler machines were 100% covered (but not always available in public system), but it is scarcely used.

Hospital and rehabilitation based respondents indicated that RA patients with poor prognosis were differentiated from RA patients with a better prognosis. Poor prognosis was determined by a combination of factors such as disease activity, and number of joints affected. After a patient has been diagnosed, treatment is initiated immediately or the patient is referred to a rheumatologist or orthopaedic specialist.

Conformity with EULAR guidelines was investigated as part of this study. All respondents except one patient representative were familiar with the guidelines. The study revealed that even though there was awareness to refer patients to a rheumatologist within six weeks of disease onset, this did not always happen in reality. It is possible that the delayed referral period is dependant on the number of RA specialists in a location. Respondents in the study confirmed that some of the recommended laboratory tests were in use. Patients presenting early arthritis are likely to have a number of swollen and tender joints, ESR or CRP measured except for anti-CCP which is more expensive than the others.

## 7 Treatment

### 7.1 DMARDs

Rheumatologists have the responsibility of deciding when and which DMARDs to prescribe. Methotrexate has been identified as the first line of treatment in addition to anti-malarials like hydroxychloroquine, chloroquine diphosphate and chloroquin phosphate. According to the PANLAR and GLADAR study, the low cost of anti-malarials (mainly chloroquin) have made them the most frequently used drug in Latin America [5]. Ocular toxicity such as blurred

vision, maculopathy and corneal deposits are the most feared adverse events of anti-malarials. It is recommended that chloroquine and hydroxychloroquine should not be given at doses above 4mg/kg/day and 6mg/kg/day respectively to avoid adverse effects.

About 70% to 95% of patients are prescribed methotrexate in the first instance within 6 -12 months of starting treatment. At least 90% of patients prescribed methotrexate are also on monotherapy and approximately 75% are receiving it as an adjunct with steroids and NSAIDs. Corticosteroids, which have proved effective in controlling the main signs and symptoms are given to 60% to 90% of patients for a short duration. They have shown to be a useful bridge therapy to control symptoms of disease, especially disease flares and improve patients' quality of life until effects of specific DMARDs are achieved. However, it is recommended that corticosteroids should not be prescribed as a single therapy.

The length of time that a patient has been on a particular DMARD treatment before switching to another varies between 4 and 12 weeks. Reasons cited for the switch are low efficacy, low safety/ tolerability and cost.

### 7.2 Biologics

Biologics are rarely used as the first line of treatment, however, there was a reported 5% usage of biologics as first line by one respondent from the study. The vast majority of patients are prescribed a biologic first after failing DMARDs. There were, however differences in responses whether patients needed to fail one or more DMARDs before initiating biological treatment. Biologics can then be prescribed as second, third or fourth line treatment, most often in combination with a conventional DMARD. In Argentina, the first biologics prescribed are usually anti-TNFs and first after they have proven ineffective, patients with severe RA can be prescribed other biologics (see Table 1 below on treatment line of biologics). The reasons for discontinuing biologics are most often lack of safety, efficacy and tolerability.

**Table 1: Biologics used for RA treatment**

Treatment Level of biologics	Biologic	Reason for change
First Line	Adalimumab & Etanercept	Safety, efficacy and tolerability
Second Line	Rituximab, Infliximab & Abatacept	Safety, efficacy and tolerability
Third Line	Abatacept, Rituximab & Etanercept	Failure of TNF treatment, safety and tolerability

### 7.3 Treatment consistency with EULAR recommendations

There were strong indications from the interviews that patients are treated according to guidelines. However, in some cases adherence to meet guidelines proved difficult due to unavailability of equipment or inadequate number of rheumatologists in some geographical areas. Patients living in large cities such as Buenos Aires were more likely to be referred to a rheumatologist nearer to the recommended time of 6 weeks. Those living in remote and rural areas have a longer referral time with less access to more efficient diagnostic equipment. The table below summaries responses from interviewees regarding adherence to EULAR guidelines:

**Table 2: Comparison of EULAR guidelines with practice**

EULAR Guidelines	Adherence to Guidelines
Reference to specialists within 6 weeks of disease onset	Varied between 1 month to 12 months depending on geographical location
Ultrasound, Doppler & MRI for disease diagnosis	Only limited numbers of MRI scanners available, ultrasound rarely used
Lab tests required for diagnosis	All tests provided in most cases
Recommended measurement factors for patients with early arthritis	All except CCP
Patients receiving DMARDs within recommended timeframe	Most patients received DMARDs within 6 – 32 weeks of diagnosis
Methotrexate considered as first line	Evidence of adherence to this guideline
Disease monitoring and events guides decision for switching of DMARDs	In some cases, guideline adhered to but in other cases socio-economic status of patients determines switch.
Non-pharmaceutical intervention recommended to complement pharmaceutical intervention	Physiotherapy and Psychotherapy recommended

Overall, there was a strong indication that EULAR guidelines were followed during treatment and management of RA patients, but not always in diagnosing the patients.

Table 3 below further expands on all EULAR recommendations and how Argentinean clinical practice adheres to them. Overall, clinical practice seems to adhere to the guidelines although some inconsistencies are shown between desk research and interviews. These inconsistencies are seen in referral to specialists and education programs, mainly explained by regional differences and segmentation of patient groups.

## Barriers to RA treatment access across Latin America: Argentina

**Table 3: Consistency of Argentinean 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	No	Yes	For patients with severe symptoms
	Clinical examination for detecting arthritis includes ultrasound, power Doppler and MRI	No	No	Physical and lab exams mainly used
	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 or CRP, level of RF and anti-CCP antibodies, and radiographic erosions bodies	Yes	Yes	Anti-CCP not done in public system
<b>Treatment</b>	Patients developing persistent/erosive arthritis should initiate DMARDs as early as possible	Yes	Yes	As soon as diagnosis is confirmed
	Use of patient information and education programmes about coping with pain and disability and maintaining work	Yes	No	Some local programs exist but not in all areas
	NSAIDs are considered in symptomatic patients	Yes	Yes	
	Among DMARDs, MTX is considered the anchor drug and should be used first in patients at risk of developing persistent disease	Yes	Yes	In moderate to severe RA
	Systematic glucocorticoids to reduce pain and swelling are considered as a (mainly temporary) adjunct to DMARD treatment	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	Yes	
<b>Monitoring</b>	Disease monitoring includes tender and swollen joint counts, ESR and CRP assessment at 1 to 3 months	Yes	Yes	For active disease
	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	

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

## 8 Conclusions

The results from this survey indicate that the main barriers to RA treatment access in Argentina are:

- ◆ Availability of rheumatologists and equipment

Access to rheumatologists is specifically scarce in rural areas since most of the specialists are situated in urban areas. This leads to a longer time for the patients to actually see a specialist (referral). If a patient gets referred, the actual distance to the specialist may impede on the accessibility in when to access and the number of possible visits (for example follow-ups). There is also a lack of equipment (MRIs, Doppler machines), especially in rural areas, to be able to make a correct RA diagnosis in a timely manner (although maybe a less critical barrier to treatment than the availability of rheumatologists). The consequence is that patients in urban areas are more likely to be diagnosed earlier in the course of the disease than patients in rural areas. This also has an effect on the time to receiving treatment and the availability of monitoring the disease, since the decisions of treatment and monitoring are the responsibility of the rheumatologist.

- ◆ Reimbursement of treatment

The results from this study indicated that treatment was only fully covered (by law) if patient has a disability certificate. However, there is a shortage of RA patients receiving a disability certificate and thereby receive a 100% coverage of treatment. Unawareness of the benefits of the certificate and fear of losing their jobs were the main reasons of not seeking one. Although OS can cover the costs for patients without the certificate, they most often demand it for a full coverage. There is also a difference in treatment received dependent on which health management scheme the patient belongs to, although 100% of the population are covered by a health plan and thereby have formal access to treatment. Still, RA as a disease is not covered by most reimbursements schemes (PMOs and APE for example) as it has not been prioritized in national public policies.

- ◆ Bureaucracy

The disability certificate does not always ensure timely and continuous access to the treatment prescribed by a specialist. Administrative obstacles, both in public and private systems, delay the access to the prescribed treatment, especially in the case of biologics. Additionally, none of the health institutions (private or public) have demonstrated a specific budget for RA or continuous purchase of treatments, instead it is bought in a case by case manner. As a consequence, some patients take an average of 8 months to receive medication once it is indicated by the rheumatologist and the request must be renewed every 3 months. This means that receiving the first treatment does not assure the continued smooth delivery of the following treatments.

## 9 References

### 9.1 Sources

**Argentinean Society of Rheumatology (SAR)** [www.reumatologia.org.ar](http://www.reumatologia.org.ar)

**National Formulary** [www.alfabeta.net](http://www.alfabeta.net)

### 9.2 References

1. Spindler A., Bellomio V., Berman A., et al. Prevalence of rheumatoid arthritis in Tucuman, Argentina. *J Rheumatol* 2002;29(6):1166-70.
2. Maceira D. Inequidad en el acceso a la salud en la Argentina. *CIPPEC Documento de Políticas Públicas Análisis No 52* 2009.
3. Soriano E., Carrio J., Schpilberg M., et al. Incidence and prevalence of rheumatoid arthritis (RA) in a health management organization (HMO) in Argentina. *Rheumatology (Oxford)* 2003;42 (suppl 1):130.
4. Abrahamzon M., Human resources in the Argentinan health sector, 1st ed. 2005.
5. Cardiel M.H. First Latin American position paper on the pharmacological treatment of rheumatoid arthritis. *Rheumatology (Oxford)* 2006;45 Suppl 2:ii7-ii22.

## 10 Acknowledgement

We are thankful for the contribution from the researchers at IECS, Argentina, who performed both desk research and interviews for this report.