ISPOR WWW.ISPOR.ORG

Speaker

First Plenary Session

HEARING THE PATIENT'S VOICE IN HEALTH CARE DECISION MAKING IN ASIA

Hsiao-Yi Lin, MD

National Yang-Ming University
Taipei, Taiwan

Assuring Quality Health Care Delivery in Asia

How to Improve Better Life for RA Patients Beyond Hurdles

Hsiao-Yi Lin, MD, FACR
Executive Board of TaSPOR
Chief, Allergy & Rheumatology Division
Taipei Veterans General Hospital
National Yang-Ming University

Outline

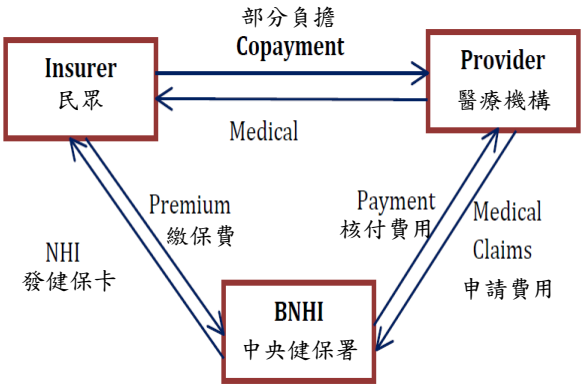
- **Taiwan Profile**
- **Debrief Healthcare System in Taiwan**
- **Patients Involved in Decision Making**
- **Hurdles to Access Biologics Treatments**
- **Benchmarking Studies**
- **Conclusion**

Taiwan: The Formosa-NHI

Bureau of National Health Insurance
responsible for health since 1995

- **Population: 23.2 million (12')**
- **Area: 36,188 km^2**
- **Population density: 642 per km^2**
- **GDP per capita (est. 13')**
  - **$20,930 (exchange rate)**
  - **$39,767 (PPP)**
- **Health expenditure (%GDP)**
  - **6.6% (12')**
  - **$2,479 per capita (12') (USD PPP)**
- **Life expectancy:**
  - **Male: 75.7**
  - **Female: 81.53**

NHI Administrative Framework

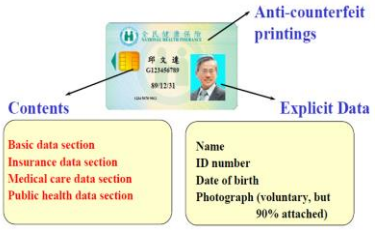


National Health Insurance (I)

- National Health Insurance established in 1995
- Mandatory & universal enrolment:
  - It covers 99% of population, 86% of hospitals, 65% of all hospital beds, and 91% of doctors
- Comprehensive benefits:
  - It covers inpatient & outpatient care, laboratory tests, prescription drugs, dental services, Chinese medicine, day care, mental health and preventive medicine
- Three main objectives:
  - Equal access to health care
  - Quality and efficiency of health care delivery to all
  - Right to choose providers, treatments or therapies

National Health Insurance (II)

- Financing
  - Single payer (Monopsony)
  - Pay-based premiums shared by employer, employee and government
    - Premium rate**: 5.17%** of monthly salary
  - Co-payments required for outpatient care, inpatient care and drugs
- Provider payment system
  - National fee-for-service schedule
  - Global budget introduced since 2000 to contain expenditures
  - DRG, quality-based-payment scheme and RBRVS are introduced to increase providers' financial-risk sharing
- Healthcare service center
  - Predominantly private (70%)
  - Closed hospital system
  - No gate-keeper system
  - NO service delivery points



Major Achievements of NHI

- **Universal coverage**
- **Easy access**
- **Affordable cost**
- **High public satisfication**
- **Up-to-standard quality**

Taiwan NHI Wins International Acclaim

- In 2000, the Economist Intelligence Unit rated the medical care in Taiwan t he second best among all developed Countries, next only to Sweden
- Article in BMJ, by Prof. Uwe E. Reinhardt

The worth safe net of NHI experiences in Taiwan might be learned by USA

BMJ Humbled in Taiwan
Uwe E Reinhardt
BMJ 2008;336:72-
doi:10.1136/bmj.39450.473380.0F

ATLANTIC CROSSING **Uwe E Reinhardt**

Humbled in Taiwan

Taiwan's highly efficient system of national health insurance should humble and inspire the US

Tagging along with Tsung-Mei Cheng, an expert on Taiwan's health system, on her recent visit to Taiwan's Bureau of National Health Insurance, turned out to be a bit humbling for me as someone who focuses mainly on the US health system.

The bureau is the government agency that administers Taiwan's single payer national health insurance system. Its staff members fret when hospitals and walk-in clinics fail to submit completed claims within the required 24 hours after delivery of service. Private health insurance companies in the United States count themselves lucky if high

the previous year. Taiwan's bureau can track almost in real time what goes up

had only with the aid of a multimillion dollar, highly sophisticated health services research industry. It is a safe bet that Taiwan will have an electronic medical record system that connects all providers of health care to the same data bank long before that will be feasible in the US's pluralistic and highly fragmented healthcare system—whose myriad computing platforms make for an electronic tower of Babel.

Taiwan introduced its national health insurance system on 1 March 1995, after less than a decade of planning that went ahead in textbook fashion. After visiting the health systems of numerous other nations, Taiwan's policy planners used the insights gained to develop what has been described as "a car made from many parts produced abroad but assembled in Taiwan." It took only 18 months for the plan to make its way through the legislative chambers in 1993-4. At the behest of Taiwan's then president, Lee Teng-hui, it was implemented in less than a year. Overnight, health insurance coverage

In Taiwan jumped from roughly 57% of the population before 1 March 1995 to virtually the entire population. For US policy makers and presidential contenders—who for half a century now have engaged in a perpetual "national conversation" on universal health insurance, only to see the number of uninsured people grow apace over the years—the speed of Taiwan's move to a national health insurance system seems downright surreal.

Taiwan's system is financed in roughly equal share by the government, employers, and households in a complex scheme that includes subsidies, payroll taxes, and premiums

profit hospitals, and public hospitals, among which patients have full freedom

some untoward side effects and should be replaced with more flexible tools to control costs.

Although in opinion surveys some 70% of the population declares itself satisfied with the system—a very high satisfaction rate by US and European standards—the national insurance system has its critics, especially among doctors and hospital executives, who predictably chafe under its global budgets. The accusation is that the system begets low quality care. Often these claims are based on comparisons with top tier health care in the US, which now spends over 16% of its gross domestic product on health care (Taiwan spends 6.2%).

But the proper comparison is not between Taiwan and top tier US health care but between health care in Taiwan today and that before the national health insurance system was created. Without national health insurance Taiwan would today probably have a highly stratified healthcare system, with

> Loss of health insurance and fear of bankruptcy over medical bills is growing among millions of Americans; it has not been in Taiwan since 1995

top tier, US style care for the rich funded by private insurance, a social insurance system for the employed middle class with highly variable quality of care, and much less or nothing for millions of uninsured poorer citizens.

Taiwan could much improve its health system by allocating an additional, say, 1-2% of its gross domestic product to health care. Some of the additional funds could be used to reduce patients' own spending, which is still higher than that in most European nations. Furthermore, much more should be allocated to the administrative budget of the Bureau of National Health

premium commercial insurers in the US spend on administration, in addition to another 6% or so for marketing and profits. Recent research indicates that Taiwan's healthcare system devotes too much of its tight budget to relatively trivial complaints, at the expense of upgrading the quality of more critically needed interventions. With its powerful IT platform it should be easier for Taiwan than it is in the US to enhance the cost effectiveness and the quality of Taiwan's health care.

Loss of health insurance and fear of bankruptcy over medical bills is a growing fear among millions of Americans; it has not been in Taiwan since 1 995. In a globalised economy that subjects Taiwan's low skilled workers to ever fiercer foreign competition from low cost labour elsewhere in Asia, the safety net of the national health insurance system represents a major public asset.

Uwe E Reinhardt is James Madison professor of political economy, Princeton University, Princeton, New Jersey reinhardt@princeton.edu

This article was coauthored with Tsung-Mei Cheng, of the International Forum at Princeton University, on whose work it draws.

Best Health Care Systems in the World

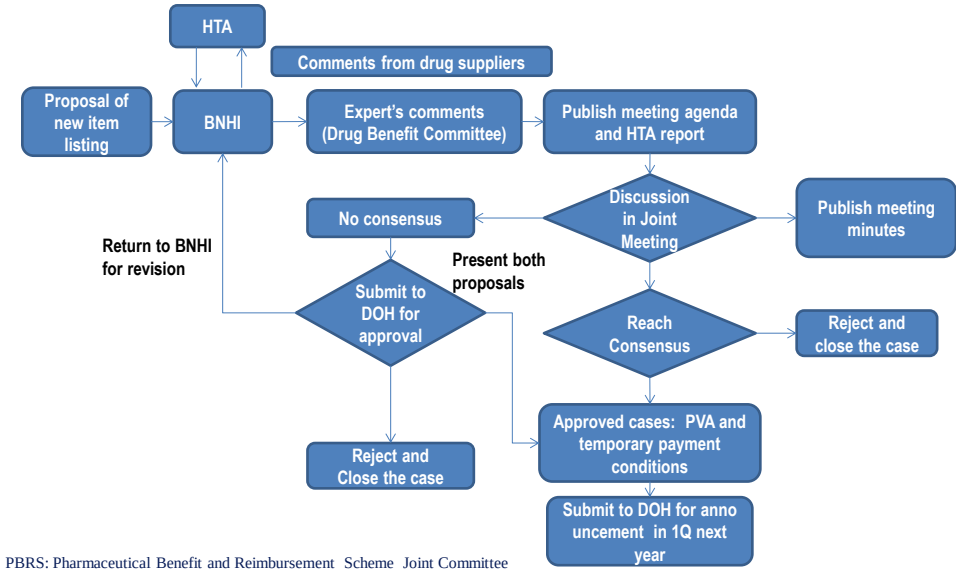
Taiwan

The Taiwanese government pays for all its citizens' health care needs. They were able to cover the needs of the population yet have managed to decrease health care costs. Much credit is given to the rise in the use of smart cards. These smart cards already contain the patient's medical history from birth, making it easy for doctors to diagnose any health issue. This also significantly cuts down time on paperwork, which could be a probable cause of additional costs from medical providers. This system is employment-based, therefore, the elderly and those who can't afford the system are given subsidies.

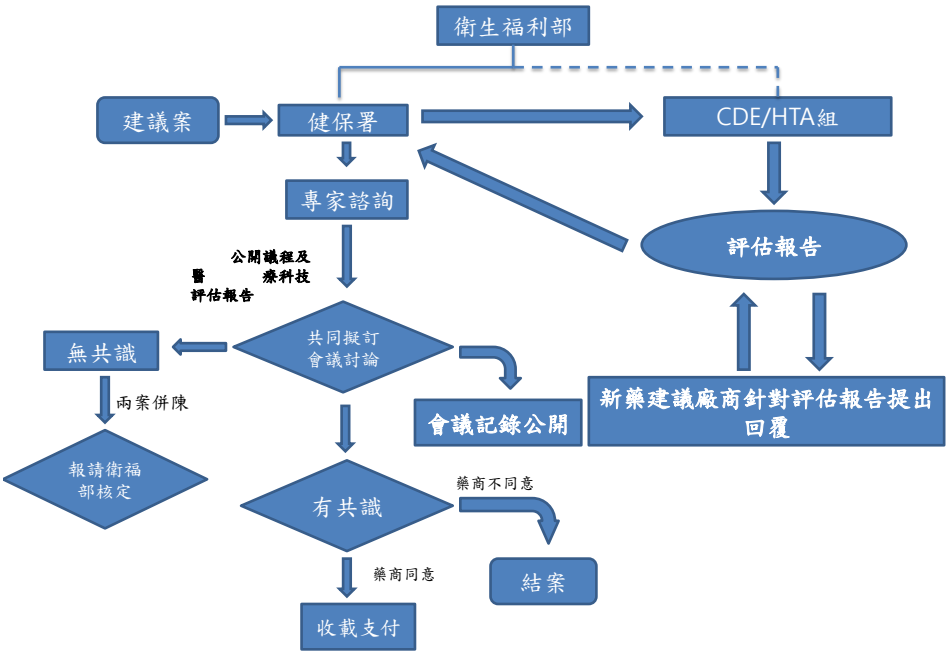
Health Reform (1st vs 2nd)
一代與二代之差異比較

	一代健保 (1st)	二代健保 (2nd)
已收載成分品項（學名藥）	保險人依藥價基準規定核定	先由保險人初核，提共同擬訂會議報告後生效
新藥 (New Drugs)	藥事小組討論 (DBC, HTA)	提共同擬訂會議討論 (PBRS)
醫療科技評估	96年10月開始委託辦理	101年1月成立國家醫療科技評估中心籌備辦公室

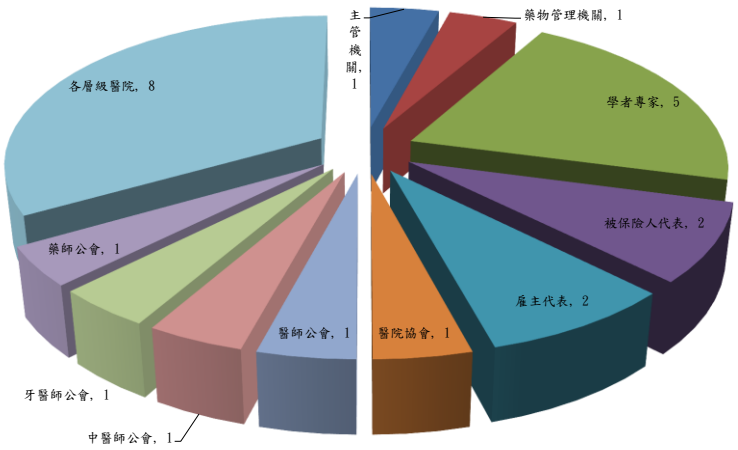
Procedure of Formulating PBRS



PBRS: Pharmaceutical Benefit and Reimbursement Scheme Joint Committee



PBRS Joint Committee
共同擬訂會議代表組成



Patient Empowerment and Educational Initiatives

- A new model of patient care involving self-monitoring and patient initiated follow-up
- An online learning resource to prepare patients and carers to actively engage in research, guideline development, advocacy and media activities
- A new patient decision aid to better inform and involve patients in treatment choices
- Video guides providing advice on living with a rheumatic diseases
- Patient Group support for patients wanting to become involved in guideline development and political committees

European League Against Rheumatism
Annual Congress, 2014

Patient's Organization

- Systemic Lupus Erythematosus (SLE)
- Rheumatoid Arthritis (RA)
- Ankylosing Spondylitis (AS)

  – Catastrophic Insurance Card
  – Voice in health care decision making
  – Health reimbursement policy (PBRS)

協助創立之病友團體

- 中華民國思樂醫之友協會

  http://www.sle.org.tw/front/bin/home.phtml

- 中華民國類風溼性關節炎之友協會

  http://www.raag.org.tw/knowra_list.php

- 中華民國僵直性脊椎炎關懷協會

  http://www.ascare.org.tw/

- 台北榮民總醫院硬皮病友俱樂部

Treat-to-target in systemic lupus erythematosus: recommendations from an international task force

Ronald F van Vollenhoven, Marta Mosca, George Bertsias, et al.

Ann Rheum Dis 2014 73: 958-967 originally published online April 16, 2014
doi: 10.1136/annrheumdis-2013-205139

Treat-to-Target in Systemic Lupus Erythematosus

van Vollenhoven RF, et al. Ann Rheum Dis 2014;73:958–967

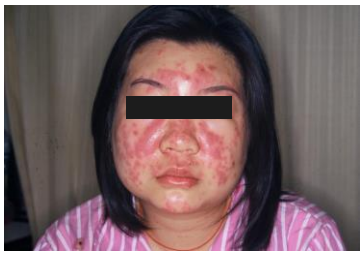
Box 1 Treat-to-target in systemic lupus erythematosus: overarching principles and bullet points

Overarching Principles 1.The management of systemic lupus erythematosus(SLE)should be based on shared decisions between the informed patient and her/his physician(s)

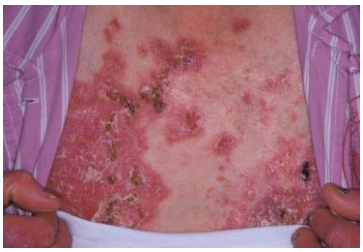
3. It is not recommended that the treatment in clinically asymptomatic patients be escalated based solely on stable or persistent serological activity.
4. Since damage predicts subsequent damage and death, prevention of damage accrual should be a major therapeutic goal in SLE.
5. Factors negatively influencing health-related quality of life (HRQOL), such as fatigue, pain and depression should be addressed, in addition to control of disease activity and prevention of damage.
6. Early recognition and treatment of renal involvement in lupus patients is strongly recommended.
7. For lupus nephritis, following induction therapy, at least 3 years of immunosuppressive maintenance treatment is recommended to optimise outcomes.
8. Lupus maintenance treatment should aim for the lowest glucocorticoid dosage needed to control disease, and if possible, glucocorticoids should be withdrawn completely.
9. Prevention and treatment of antiphospholipid syndrome (APS)-related morbidity should be a therapeutic goal in SLE; therapeutic recommendations do not differ from those in primary APS.
10. Irrespective of the use of other treatments, serious consideration should be given to the use of antimalarials.
11. Relevant therapies adjunctive to any immunomodulation should be considered to control comorbidity in SLE patients.

van Vollenhoven RF, et al. Ann Rheum Dis 2014;73:958–967

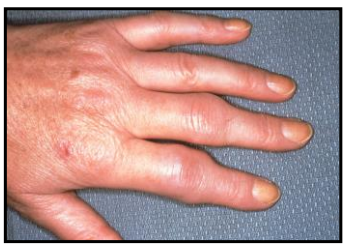
紅性斑狼瘡(SLE)



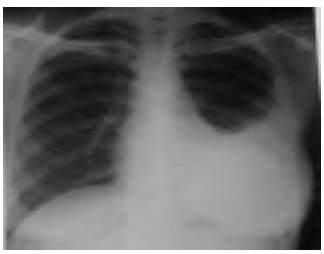
臉頰蝴蝶狀紅斑



盤狀狼瘡皮疹



關節炎



漿膜炎

思樂醫記者會(SLE Press)

思樂醫-旅遊聯誼

Recommendations

Treating rheumatoid arthritis to target: recommendations of an international task force

OPEN ACCESS Editor's choice

Josef S Smolen[1,2], Daniel Aletaha[1], Johannes W J Bijlsma[3], Ferdinand C Breedveld[4], Dimitrios Boumpas[5], Gerd Burmester[6], Bernard Combe[7], Maurizio Cutolo[8], Maarten de Wit[9], Maxime Dougados[10], Paul Emery[11], Alan Gibofsky[12], Juan Jesus Gomez-Reino[13], Boulos Haraoui[14], Joachim Kalden[15], Edward C Keystone[16], Tore K Kvien[17], Iain McInnes[18], Emilio Martin-Mola[19], Carlomaurizio Montecucco[20], Monika Schoels[2], Desirée van der Heijde[4] for the T2T Expert Committee

+ Author Affiliations

Correspondence to
Dr Josef S Smolen, Department of Internal Medicine 3, Division of Rheumatology, Medical University of Vienna,Waehringer Guertel 18-20, A-1090 Vienna, Austria; josef.smolen@wienkav.at

Accepted 12 January 2010
Published Online First 9 March 2010

Ann Rheum Dis 2010;**69**:631-637 doi:10.1136/ard.2009.123919

Box 1 Recommendations

Overarching principles

A. (A). The treatment of rheumatoid arthritis must be based on a shared decision between patient and rheumatologist.

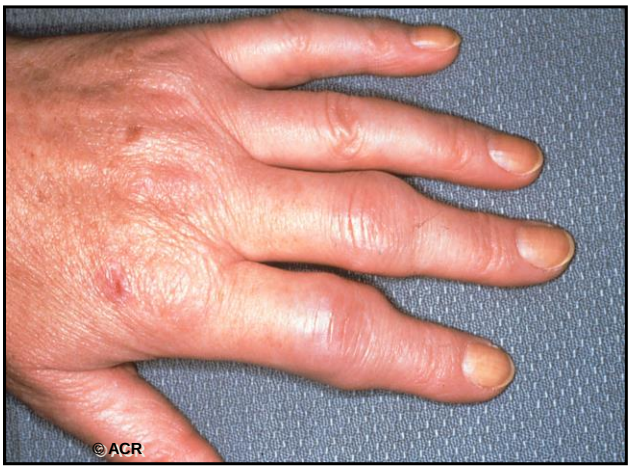
B. (B). The primary goal of treating the patient with rheumatoid arthritis is to maximise long-term health-related quality of life through control of symptoms, prevention of structural damage, normalisation of function and social participation.

C. (C). Abrogation of inflammation is the most important way to achieve these goals.

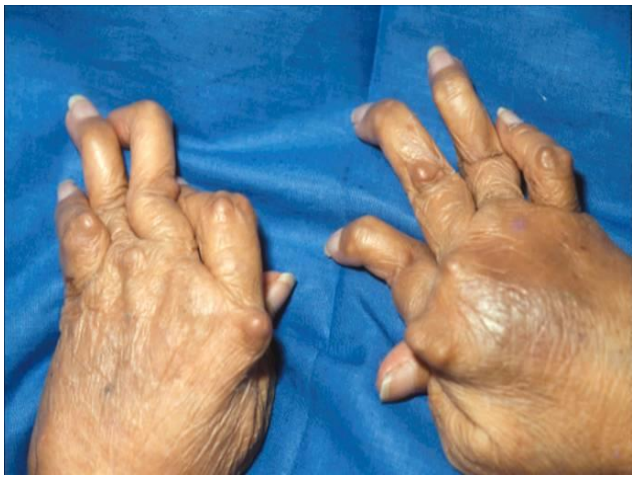
D. (D). Treatment to target by measuring disease activity and adjusting therapy accordingly optimises outcomes in rheumatoid arthritis.

RA of Hand

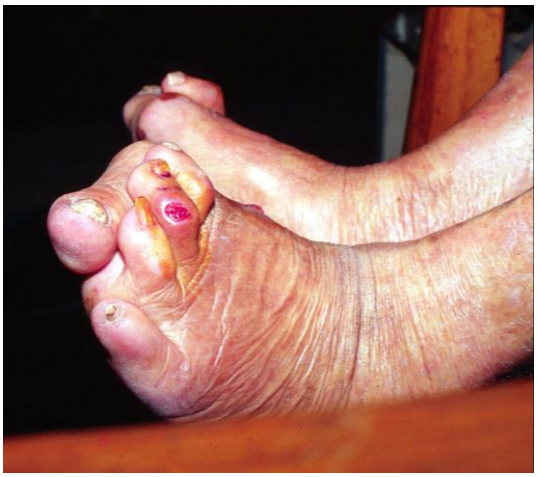
Fusiform Swelling



RA of Hand-Deformity



RA of Foot-Deformity



Praradigm: Anti-TNFs

- Biologics
  - Etanercept、Adalimumab 、Golimumab

中華民國類風濕性關節炎之友協會

RA之友協會簡介

各地區醫師、病友座談聯誼會

RA之友協會簡介

醫學講座舉辦遍及全國

RA之友協會簡介

歲末聯歡

Rheumatoid Arthritis Aid Group of R.O.C.

OUR MISSION

- To facilitate the support and to spirit up between patients and family to face diseases
- To maximize the impact of medical care with providing the communication channels between patients, health care providers, and social workers
- To regularly publish newsletter to increase disease awareness, hygiene knowledge and relationshiop.

WHO WE REPRESENT

For all rheumatoid arthritis patients (about 80,000) in Taiwan .

OTHERS WE WORK WITH

Our corporate partners provide us with the opportunity to reach people where they live, work and play. In addition to a financial contribution, we have found a unique way to involve in raising awareness and hope when facing rheumatoid diseases . We thank them for their commitment to the fight to rheumatoid diseases

WHAT WE DO

Target Audience: all rheumatoid arthritis patients and families

Cause Marketing

Cause marketing provides an easy way for consumers to engage in and support our mission, while generating awareness and funds.

Events

Leverage global arthritis day to have local arthritis day to increase disease awareness.

RECENT SUCCESS

Situation Overview

In order to control national health care budget, our reimbursement system, BNHI, published a Exit Criteria that RA patients have to be lowered down dosage after 2 years treatment, and have to stopped treatment after 3 years treatment.

Goals

Develop a campaign to raise disease awareness, the importance of long term treatment and disease severity monitoring

Action

We planned to coordinate with health care providers, medical societies, patient groups, law makers, and key stakeholders to reach our goals.

Result

Planning now

No.201, Sec. 2, Shipai Rd., Beitu District, Taipei City 112, Taiwan (R.O.C.)

Mission

- To facilitate the support and to create spirit between patients and family to face diseases
- To maximize the impact of medical care by pro viding communication channels between patie nts, health care providers and social workers
- To regularly publish a newsletter to increase disease awareness, hygiene knowledge and relationship

What We Do

- **Target Audience**: all RA patients and families
- **Cause Marketing**: provides an easy way for consumers to engage in and support our mission, while generating awareness and funds.
- **Events**: leverage global arthritis day to have local arthritis day events to increase disease awareness.

Goals

- Help increase the awareness of the importance and process of biologic treatment, relative infections control and prevention.
- Develop a campaign to raise disease awareness the importance of long term treatment and disease severity monitoring.

Action

- Coordinate with relative patient groups and societies to provide a series of educational lectures of relevant knowledge.
- Plan to coordinate with health care providers, medical societies, patient groups, law makers and key stakeholders to reach our goals.

Situation

- Endemic area for tuberculosis, B and C hepatitis
- Biologics may increase risks of tuberculosis, B or C hepatitis reactivation.
- Working with the Department of Health (DOH) Health care providers, Taiwan Rheumatology Association (TRA)
- BNHI publish the risk management plan **(RMP)** Guideline to control/ prevent the risks of relative infection risks using screening and educational processes.

Hurdles to Access Treatment
-Rheumatoid Arthritis in Taiwan-

- **Catastrophic Illness Card (CIC)**
- **NICE guideline**
- **Budget Impact**
  - **6 biologics + 1 JAK inhibitor**
  - **100% reimbursed for RA patients**
  - **Treat to Target (T2T)**
  - **Reduction/Withdrawal Policy**

Catastrophic Illness Card

Patients with catastrophic diseases represent **3.56%** of Population, who used **27.13%** of NHI medical expenditures. According to an estimate of the NHIA, an average CIC patient spends NT$3.3 million on treatment each year, which is 131 times the amount of an average person's yearly health insurance payments. The treatment for hemophilia costs the most among all the diseases, said the NHIA.

http://www.chinapost.com.tw/taiwan/national/national-news/2014/07/12/412217/Time-limit.htm

Management of RA in Original Version

Main Features	Criteria for initiating treatment
Criteria for initiating treatment **(NICE)**	1. Pre-review (pre authorization use) 2. File DAS28 score, previous DMARD usage and regimen data, photo of swelling joint, and x-ray report for pre-preview 3. **Monotherapy with methotrexate at least 15 mg weekly** 4. After 6 months treatment, update DAS28 score, outcome of treatment, side effects, and complications status every 3 months 5. Patients should qualify all (a) (b) (c) criteria listed below: a) The American Rheumatism Association 1987 revised criteria for the classification of rheumatoid arthritis b) Ongoing active RA defined as: (i) **DAS28>5.1**;(ii) Require two DAS score consecutively and **at least 1 month interval**; c) Failure on DMARDs treatment. **At least 2 DMARDs** and no significant outcome I. Definition of "adequate" treatment: (i) At least **6** months of DMARD treatment, and meet the standard target dose at least **2** months; (ii) intolerable toxicity occurs II. Definition of treatment efficacy: The DAS28 score drop **>1.2 points** or DAS28 total score **< 3.2**

Budget Impact

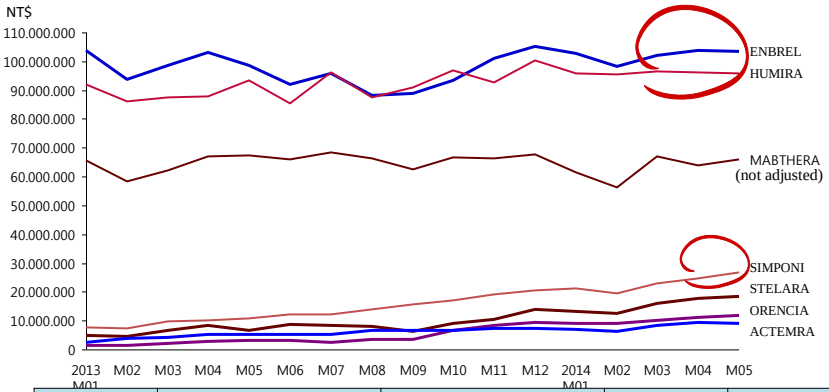
- **Very expensive biologics**
- **Very strict NICE guideline**
- **100% reimbursement**
- **Treat to target (T2T)**
- **Dose reduction or withdrawal policy**
- **Relapse and Re-entry**

Trend of RA Patients on Biologics

Year	2011	2012	2013
Biologics eligible patients	**4,954**	**5,858**	**6,969**
Medical Cost Claimed (Million NTD)	1,358	1605	1849
Growth Rate		**18.1%**	**15.2%**

Biologics Costs Claimed for RA in 2011-2013 in NHI databse, Taiwan

Taiwan Inflammation Market Trend



Brand(Million)	MAT2	MAT	GR%	Ratio
ENB	1,194	1,175	-2%	40%
ADA	1,064	1,130	6%	38%
ACT	27	85	216%	3%
ORE	13	88	564%	3%
SIM	70	225	221%	8%
STE	44	142	222%	5%
MAB	109	117	7%	4%
Total	2,521	2,960	17%	100%

Source: IMS data Value NT$, May 2014

Discontinuation of TNF-Inhibitor Therapy in Remission
退場機制

- Remission defined as DAS28 <2.6
- Withdrawal of TNF-inhibitor after 6 months of remission (n=21)
- Monthly reassessments thereafter

Conclusion

1. TNFi discontinuation in patients in remission of RA was followed by a relapse within 12 months in 75% cases
2. Relapsing patients responded well resumption of the same TNFi

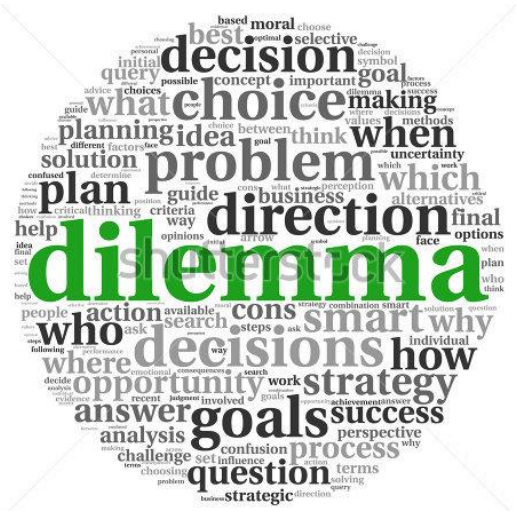
Broqc et al. Joint Bone Spine 2009.

Management of RA in Revised Version

退場機制

Main Features	Criteria for tapering treatment
Criteria for tapering treatment **(Never before)** **Taiwan NICE ??**	1. Reducing dosage after 2 years - DAS28≦ 3.2 -ESR≦ 25mm/h & CRP ≦ 1mg/dL 2. Reducing treatment way: - Propose appropriate treatment plan for pre-view stage after 2 years 3. **Receiving treatment as same as before during tapering period** - The DAS28 total score grow **>1.2 points** or ESR **>25mm/h** - ESR growth rate **>25%** 4. Failure on one biologic treatment, shifting to receive the other biologics based on different MOA 5. RA flare for temporary consecutive treatment , showing criteria as below: - Consecutively receive 2 DMARDs firstly - DAS28 **>1.2 points**

Source: BNHI treatment guideline updated in 2013



The dilemma in the real world

The Dilemma in Clinical Practice

- Lack of time
  - Insufficient communication → poor understanding → poor compliance → suboptimal disease control
- Cost concern
  - Not a issue to physician and patient under Taiwan reim bursement → suboptimal utilization of medical record
- Treatment target
  - Slightly different with current reimbursement criteria
  - Criteria for dose tapering and discontinuation

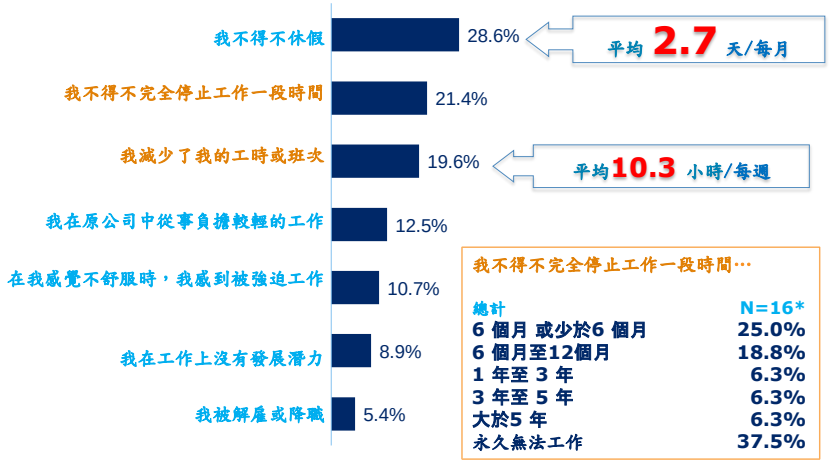
imshealth™
INTELLIGENCE APPLIED.

類風濕性關節炎病患生活品質調查 (Quality of Life questionnaire)

生物製劑藥品調查報告

類風濕性關節炎透過哪些方式影響工作/職涯或工作 (Influence on Job/career or Ability to Work)

類風溼性關節炎對工作的影響

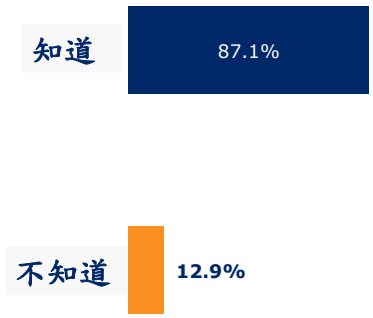


Base: Job/Career Or Ability To Work Negatively Affected By RA (n=56)
Source: Q41
*: Small sample size, for reference only

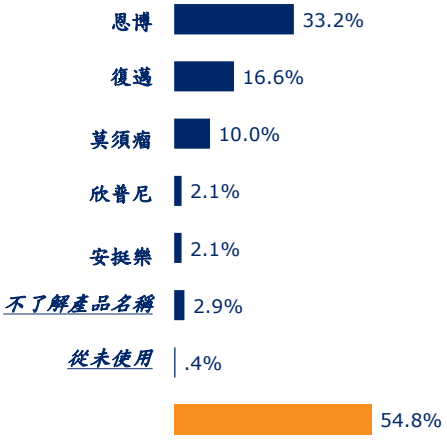
imshealth

大部分類風濕性關節炎病友知道生物製劑；然而，只有一半的病患曾經使用過生物製劑 (% RA patients prescribed with biologics)

知道生物製劑嗎



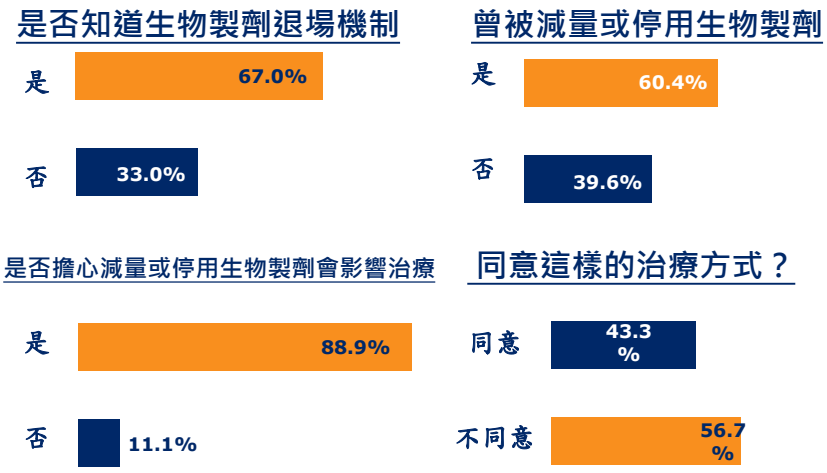
曾經使用過哪些生物製劑



Base: All respondents but excluding Refused (n=248)
Source: Q46,Q47(MA)

imshealth

大多數的病友擔心減量或停用生物製劑的使用，將會影響治療; 有許多病友並不同意這樣的治療方式 (Reduction/Withdrwal)



Base: Those who have ever used biological products but excluding Refused (n=106)
Source: Q49

imshealth

Evidence of Medicine:

Recent publication of trials investigating drug-free remission

imshealth

Recent publication of trials investigating drug-free remission

RRR (Remission induction by Remicade in RA)	**Tanaka et al**
CIMESTRA	**Hetlant et al**
Finland early RA cohort	**Tiippana-Kinnunen et al**
BeSt	**Klarenbeek et al**
OPTIMA	**Emery et al**
PRESERVE	**Smolen et al**

Tanaka Y, et al. Ann Rheum Dis. 2010;69:1286–1291
.Hetland ML, et al. Ann Rheum Dis. 2010;69:1789–1795
Tiippana-Kinnunen T, et al. Scand J Rheumatol. 2010;39:12–18
Klarenbeek NB, et al. Ann Rheum Dis. 2011;70:315–319
Emery P, et al. EULAR 2011
Smolen JS, et al. Arthritis Rheum. 2011;63–4041

imshealth

Recent systemic review/review of RA biologic discontinuation studies

Tanaka et al	**Literature overview**	• **Discontinuation of TNF-i in MTX-IR patients** • **Dose reduction of TNF-i in MTX-IR patients** • **Discontinuation of Abatacept in MTX-IR patients** • **Discontinuation of Tocilizamab in MTX-IR patients** • **Discontinuation of TNF-i in MTX-naïve patients** • **Discontinuation of TNF-i in MTX-naïve patients very early RA patients**
Yoshida et al	**Systemic Review**	• **9 published articles** • **5 ACR/EULAR meeting abstracts**

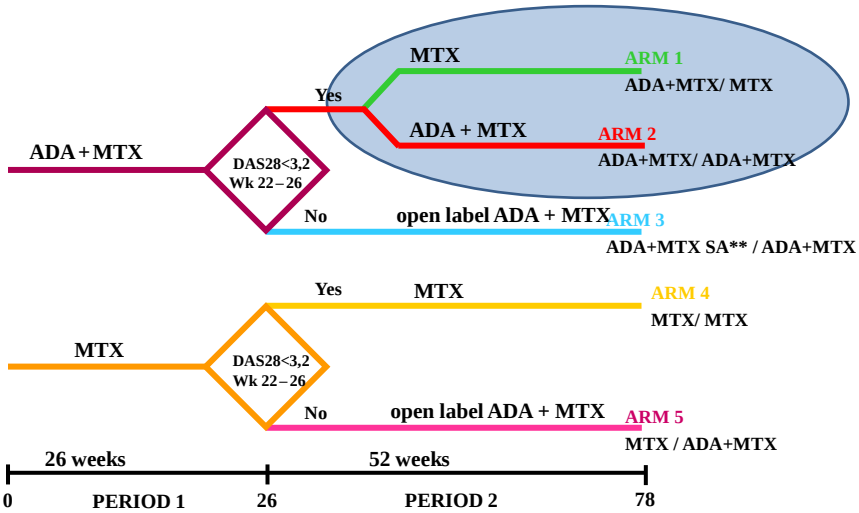
Yoshida K, et al. Ann Rheum Dis 2014;73:43
Tanaka Y, et al. Clin Exp Rheumatol 2013;31(4 Suppl 78):S22-27. 2.

imshealth

Benchmarking Studies

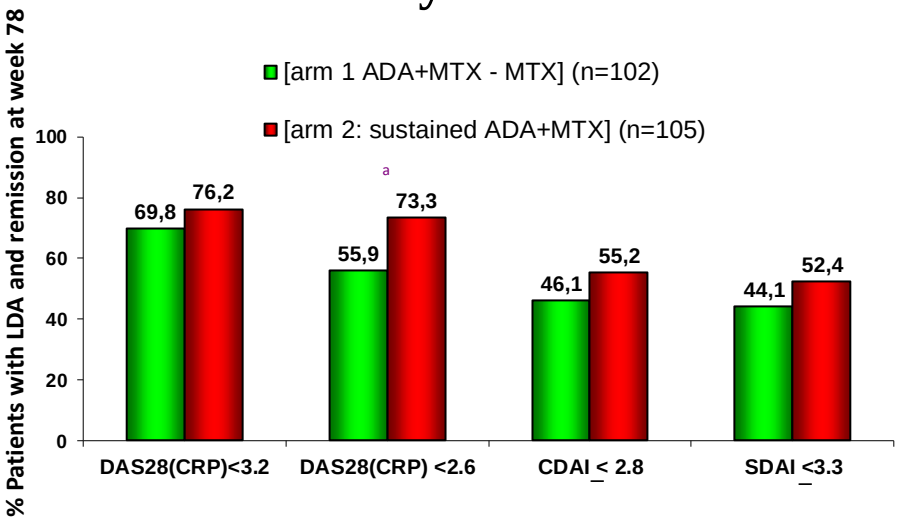
- **OPTIMA Study**
- **The PRESERVE Study**

Tapering Biologicals: OPTIMA Study: arm 1 vs arm 2



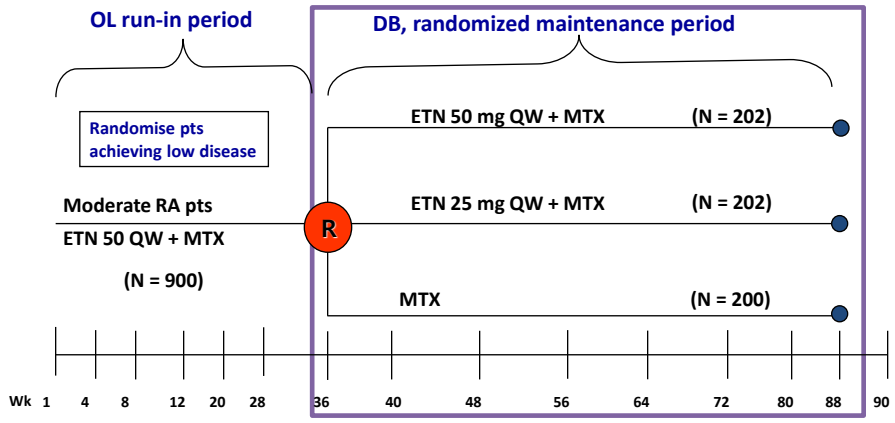
Smolen et al. Lancet 2013.

Tapering Biologicals: OPTIMA Study: arm 1 vs arm 2



Smolen et al. Lancet 2013. Online P<0.05 (a = vs. 1); (b = vs. 2); (c = vs. 3); (d = vs. 4); (e = vs. 5)

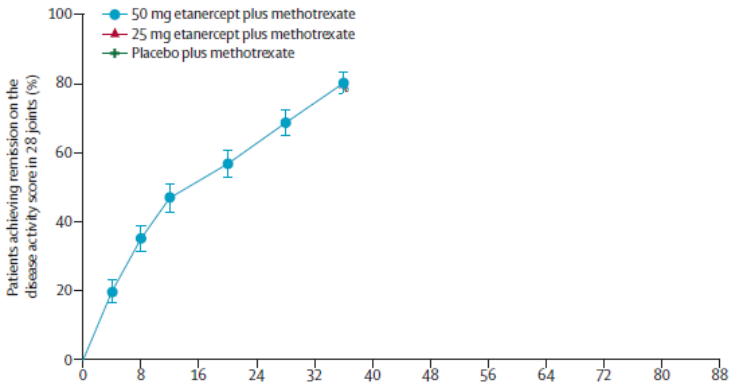
The PRESERVE Study



R = **Completers** of phase I with DAS28 ≤ 3.2 at week 36 ***and*** average of ≤ 3.2 from week 12 to week 36

Smolen et al. Lancet 2013.

The PRESERVE Study: Results Phase II: Patients in Remission



- Both ETN groups had similar distribution of loss to response
- Both were superior to the MTX group

Smolen et al. Lancet 2013.

Treatment Reduction According to the EULAR Recommendations

Duration of full remission

Sequence of treatment reduction:

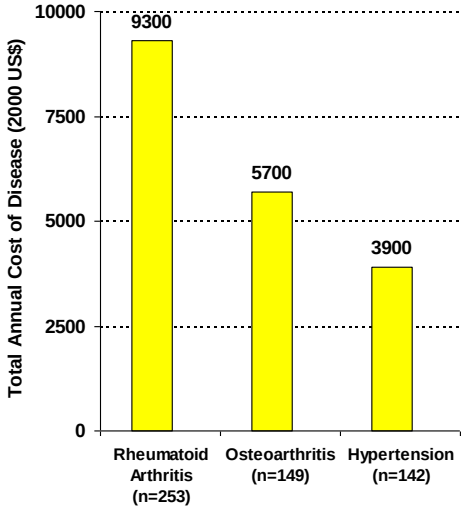
1. (Stopping Glucocorticoids)
2. Tapering biological DMARDs (#12)
   especially if this treatment is combined with a DMARD
3. Cautious reduction of the DMARDs dose (#13)

→ As always: shared decision between patient and physician

Smolen JS, et al. Ann Rheum Dis 2014;73:492–509.

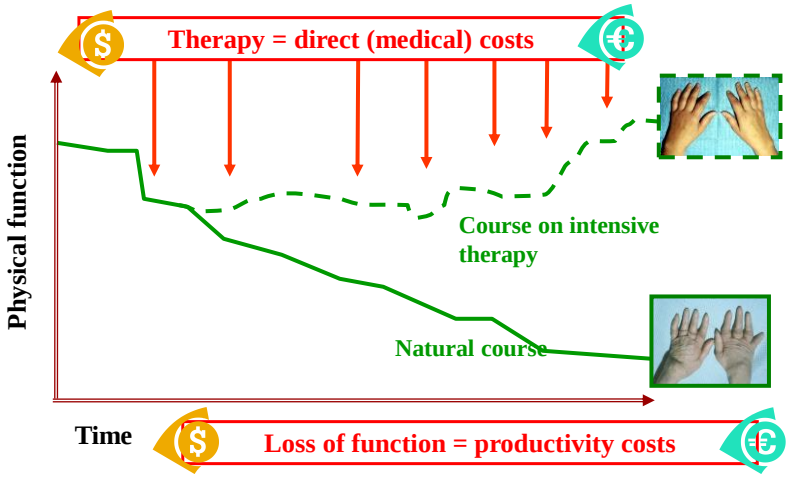
Value of treatment for long term outcomes

Costs of RA Higher than in Other Diseases



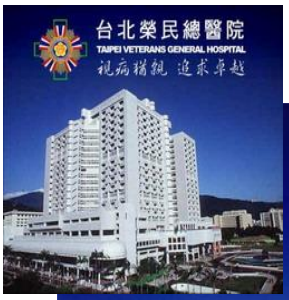
Meatzel A et al. Ann Rheum Dis 2004.

The Balance of Direct and Indirect Costs



Conclusion

- **Better treatment options might be available to patients timely in spite of strict BNHI treatment guideline**
- **The social activities encourage RA patient group to get involved in decision making**
- **Budget impact on healthcare reform is never ending**
- **Physicians are playing the crucial role in effectively communicating with patients**


台北榮民總醫院
TAIPEI VETERANS GENERAL HOSPITAL
視病猶親 追求卓越

歡迎蒞臨寶島台灣