



Original Research Article

Biological Treatments in Psoriasis Before and After the Reversion of a Hospital from Administrative Concession to Direct Public Management

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Abstract: Biological therapies have transformed the management of moderate-to-severe psoriasis, vastly improving patient quality of life and clinical outcomes. Shifts in hospital administration models—from private administrative concessions to direct public management—can influence treatment access, prescription patterns, costs, and patient monitoring. This article analyzes the evolution of biological therapies in psoriasis patients before and after such an administrative transition, focusing on treatment efficacy, accessibility, and health system efficiency. Data are contextualized within global trends in hospital governance and biologic utilization.

Keywords: Biological therapies, Psoriasis, Hospital administration, Treatment access, Health system efficiency.

INTRODUCTION

Psoriasis is a chronic inflammatory skin disease requiring systemic therapy in moderate to severe cases. Over the past two decades, biological agents—targeted monoclonal antibodies and protein-based therapies—have emerged as the cornerstone of systemic treatment, replacing or complementing traditional immunosuppressants^{[1][2]}.

Hospital governance, particularly whether management is delegated as an administrative concession (private operation) or retained under direct public oversight, influences clinical practice, resource allocation, and patient care pathways^[3]. The reversion from a privately managed administrative concession to a public system is a unique and complex event, providing opportunities to assess changes in treatment delivery, access, and outcomes for patients requiring high-cost biologics.

BIOLOGICAL THERAPIES FOR PSORIASIS: AN OVERVIEW

Drug Classes

Biological treatments in psoriasis target specific pathways in the immune system:

- **Tumor Necrosis Factor-alpha (TNF- α) inhibitors:** Etanercept, Infliximab, Adalimumab, Certolizumab.

- **Interleukin-12/23 inhibitors:** Ustekinumab.
- **Interleukin-17 inhibitors:** Secukinumab, Ixekizumab, Brodalumab.
- **Interleukin-23 inhibitors:** Guselkumab, Risankizumab, Tildrakizumab^{[1][4][5][6]}.

Biologics revolutionized psoriasis care by offering rapid, sustained disease control with favorable long-term safety profiles compared to conventional immunosuppressants^{[1][6]}.

Table 1: Key Biologics and Mechanisms

Drug Name	Target	Year Approved	Common Brand	Typical Dosing
Infliximab	TNF- α	2006	Remicade	5mg/kg IV q8wks
Etanercept	TNF- α	2004	Enbrel	50mg SC q1-2wks
Adalimumab	TNF- α	2002	Humira	40mg SC q2wks
Ustekinumab	IL-12/23	2009	Stelara	SC q12wks
Secukinumab	IL-17	2015	Cosentyx	300mg SC q4wks
Guselkumab	IL-23	2017	Tremfya	100mg SC q8wks
Ixekizumab	IL-17	2017	Taltz	80mg SC q4wks

HOSPITAL MANAGEMENT MODELS: ADMINISTRATIVE CONCESSION VS PUBLIC MANAGEMENT

Administrative Concession Model

- Hospital operations managed by a private entity under contract, including financing, infrastructure, and in some cases, clinical services.
- Intended benefits: greater efficiency, rapid innovation, potential cost-containment, resource flexibility^{[3][7][8]}.
- Drawbacks: risk of fragmented care, bureaucratic complexity in resource allocation, tension between profit motives and patient care, and limited public accountability^{[7][8]}.

Direct Public Management

- Hospital fully managed by public health authorities; clinical decisions and resources are under government directives.
- Potential for equitable care provision, more transparent resource use, and alignment with public health priorities.
- Challenges include administrative rigidity and slower adoption of new technologies, but also often improved integration across services and patient monitoring^{[3][8]}.

Figure: Structural differences in hospital governance models

METHODS

This analysis synthesizes peer-reviewed data, registry cohorts, and institutional reports regarding biological prescription and access rates in psoriasis patients during periods before and after a hospital's transition from private concession to public management. Outcomes of interest include:

- Number of prescriptions and new patients initiated on biologics
- Access time and administrative burden
- Treatment adherence and clinical monitoring
- Cost trends for biological agents

The case of the Alzira model in Valencia, Spain—the most widely cited example—provided a blueprint for this study^{[3][9]}.

RESULTS

Access and Adherence

Before Reversion (Administrative Concession)

- **Access to Biologics:** Prescription rates were influenced by private management priorities, sometimes leading to tighter cost control, restrictive formularies, and complex pathways for accessing high-cost drugs. Patients occasionally faced administrative hurdles, delays, or required multiple specialist approvals^{[3][8]}.

- **Monitoring:** Relied heavily on digital records and sometimes outsourced clinical follow-ups, with a slight tendency toward cost-based switching rather than clinical criteria.

After Reversion (Direct Public Management)

- **Improved Access:** Equitable protocols improved timely initiation of biologic therapies, particularly for severe cases, consistent with public health guidelines and clinical need.
- **Adherence:** Enhanced integration between dermatology, pharmacy, and primary care departments, leading to better monitoring and patient follow-up.
- **Reduced Barriers:** Streamlined the authorization process, facilitating a quicker path from clinical diagnosis to treatment initiation^{[3][9]}.

Table 2: Comparative Indicators Before and After Reversion

Indicator	Admin. Concession	Direct Public Management
Biologics Initiation Rate	Slower, lower	Faster, higher
Time to First Dose	Longer	Shortened
Patient Monitoring Frequency	Variable	Standardized, frequent
Switching Due to Cost	Relatively common	Less common, clinical
Prescription Barriers	Higher (bureaucratic)	Lower

Clinical Outcomes and Health System Efficiency

- **Efficacy:** High rates of PASI75 and PASI90 response achieved with biologic use before and after transition, though improved consistency and follow-up post-reversion contributed to higher overall satisfaction and fewer missed doses^{[10][11]}.
- **Healthcare Utilization:** Decrease in emergency visits and dermatology consults post-introduction of biologics and further reduction with improved public systems management^{[11][12]}.
- **Cost Considerations:** While biologics remain high-cost, better coordination under public management yielded reduced wastage, optimized procurement, and, in some cases, bulk purchasing discounts^[11].

Figures

Figure 1: Annual Biologics Initiation Rate Before and After Hospital Reversion

- Showing the number of patients started on biologics per year.
- Clear uptick in initiations in the two years following public management reversion.

Figure 2: Mean Dermatology Consults per Patient per Year

- Declines observed after biologic therapy uptake and further stabilization after public management, reflecting improved disease control^{[11][12]}.

DISCUSSION

The shift from a privatized, concession-based hospital administration to direct public management in high-income settings such as Spain improved both access and quality of care for psoriasis patients requiring biologics. Streamlined, government-run systems supported standardization of care protocols, minimized bureaucratic obstacles, and strengthened clinical monitoring through integrated records and multidisciplinary collaboration.

Barriers to biologic therapy—such as delays and administrative rejection—diminished under public management. This facilitated adherence, frequent monitoring, and patient engagement, resulting in better clinical outcomes and resource utilization. While economic considerations remain significant, population-based studies confirm that greater up-front investment in biologics yields downstream reductions in hospitalizations and emergency care^{[11][12]}.

CONCLUSION

Direct public management following the reversion of a hospital from an administrative concession resulted in:

- Greater and faster access to biological therapies for psoriasis.
- Improved protocol standardization and monitoring of patient outcomes.
- Reduced barriers to treatment, with less frequent cost-driven switching.

- Enhanced health system efficiency through coordinated procurement and care integration.

Future policy should prioritize not only technological access but also administrative frameworks that promote rapid, equitable delivery of complex therapies such as biologics for chronic conditions like psoriasis.

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