There is a deepening crisis in the provision of care for Canadians with rheumatic disease. Inadequate numbers of trainees are coming through Canada’s rheumatology training programs. The workforce is increasingly aging. And there is a projected increase in the number of patients who will develop arthritis over the next 15 years.

Rheumatologists are the experts in caring for patients with arthritis; specialized postgraduate studies enable them to provide accurate diagnoses for the more than 100 distinct types of arthritis and connective-tissue diseases. Rheumatologists are also well versed in the variety of treatments available and their associated side effects. Finally, they are the major proponents of coordinating arthritis care with other members of a health-care team—a step proven to benefit arthritis sufferers.

A FOREMOST CAUSE OF DISABILITY
A recent study commissioned by the Canadian Rheumatology Association confirms that arthritis/rheumatism is one of the most prevalent chronic conditions in the Canadian population today—and the foremost cause of physical disability.

In 1996, there were 3.2 million Canadians, ages 15 years and older, who reported “arthritis or rheumatism” as a “long-term health condition”.\(^1\) This study forecasted that, by the year 2016, with the aging of the population, the number of people in Canada with arthritis will increase from 3.2 million to five million people. The study also found that 19% of adult women in Canada have some form of arthritis, and that more than half of these individuals are under 65 years of age. Eleven percent of adult men in Canada, it was noted, have some form of arthritis.

One of the conditions that represents a significant proportion of the workload for rheumatologists is rheumatoid arthritis (RA). Workplace disability occurs in 25% of those patients with a more persistent, aggressive form of this disease after six years of disease duration; the figure increases to 50% after 20 years.\(^2\) Several international studies of patients with the more severe forms of RA consistently show increased mortality rates compared to persons of the same age and sex in the general population.\(^3-5\) (This comparison is in direct association with the increase in the number of joints involved, the presence of heart disease, older age and poorer functional status at the onset of disease.)

In patients with the most severe form of RA (greater than thirty joints active, with poor functional status) a five-year survival expectancy is 40% to 50%—which is directly comparable to individuals with three-vessel coronary-artery disease or Stage-IV lymphoma.\(^6\)

A recent study revealed that the total cost of musculoskeletal disorders in Canada was $25.6 billion, with direct costs at $7.5 billion and indirect costs at $18.1 billion.\(^7\) Arthritis and rheumatism were in the third-highest category in this study, after injuries and back/spine disorders. The cost of arthritis and rheumatism was $5.9 billion. (Direct costs comprised resources—including the labour of health professionals, equipment, buildings and supplies—while indirect costs included lost productivity due to disability and premature mortality.) Long-term and short-term disability attributed to musculoskeletal diseases in Canada accounted for 31.9% and 11.7% of all lost income due to disability, respectively.
Several studies have examined the provision of care to patients RA. In one recent study, outcome measures were compared for patients with RA who were managed by rheumatologists versus those managed by non-rheumatologists. It was found that the patients treated by rheumatologists reported significantly better functional status, fewer painful joints, a lower overall pain rating and general improvement in all outcome measures.

In another study, the management of patients with osteoarthritis of the knee by general internists, family physicians and rheumatologists were all compared. The rheumatologists showed a greater sensitivity of the risks of gastroenteropathy, and were more likely to have a thorough discussion of non-pharmacological interventions (e.g., exercise, joint protection).

Yet another study examined the frequency of visits by RA patients to rheumatologists and correlate them with outcomes in functional disability and pain. More frequent visits to rheumatologists were associated with greater improvements in pain and functional disability over six- and twelve-month periods. Outcomes seemed improved, in fact, in patients having more than seven visits per year.

Criswell et al looked at the differences in the use of second-line agents and prednisone for the treatment of RA by rheumatologists versus non-rheumatologists. It was found that the patients managed by rheumatologists experienced a better response to treatment—a finding that seemed to be based on the predilection of rheumatologists to treat early in the disease course with remittive drugs.

In a 1994 U.S. article by Carias and Panush, rheumatologists were again compared to nonrheumatologists in the provision of care—this time in patients with acute arthritis. The rheumatologists established a definite diagnosis by ACR criteria significantly more often than did the non-rheumatologists. The trend outcomes also strongly favored rheumatologists’ patients, who improved significantly and more rapidly, and had shorter hospital stays at considerably less cost.

Primary-care physicians may have some difficulties in diagnosing common rheumatic disorders, according to several studies that examined the management of rheumatological problems by primary-care physicians. In one review, as many as 50% of referred diagnoses were modified at rheumatology outpatient clinics. Furthermore, in some situations, there was a significant delay in the referral of patients with RA to rheumatologists. This finding obviously has a significant implication in a disease where it is now recognized that early assessment, diagnosis and treatment are essential in preventing patients from developing joint damage, as well as in reducing their morbidity, maintaining their function, prolonging their lives and reducing overall health-care costs.

Time and again, studies show that rheumatologists have the greatest expertise for performing a thorough history and physical examination, and, ultimately, to confirm the appropriate diagnosis. If it is necessary, rheumatologists are the ones best suited to select and initiate disease-modifying antirheumatic drug (DMARD) treatment, and to adjust or combine the use of these agents in the aggressive management of arthritis.

It is well recognized that the health-care costs of rheumatic diseases are directly proportional to an individual’s functional capabilities and, thus, interventions that have been shown to reduce functional disability (i.e., rheumatological intervention) should be pursued.

A recent survey by the Economics and Manpower Committee of the CRA has revealed that members in most areas of the country feel there is a shortage of rheumatologists in both the community and academic institutions. A recent report by the Canadian Council of Academic Rheumatology revealed 21 vacant positions in nine centres across the country. This survey also revealed that the current programs are generating 10 to 12 trainees per year, with a percentage of these individuals planning to return to their country of origin, leaving approximately seven trainees per year available to address the present shortfall of rheumatologists.

Upon examining the demographics of the Canadian rheumatology community, it is found that over 50% of practicing rheumatologists are currently over the age of 45, with approximately 15% of those surveyed indicating they intend to retire within the next 10 years.
Recent examination of rheumatology numbers in Canada have led to the belief there is an immediate need for 50 rheumatologists. The goal is one rheumatologist per 50,000–70,000 people, depending on the population.

RECOMMENDATIONS

How can these concerns—increasing prevalence of rheumatological disease, the need for specialist disease management and a lack of rheumatology manpower—be addressed?

It is imperative for the rheumatology community in Canada to make all stakeholders aware of the existing situation, and to encourage certain steps to ensure that this problem is alleviated:

1) There is a need to increase reimbursement schedules for rheumatologists. Studies have consistently shown rheumatologists to be at the bottom end of earnings scales when compared to other sub-specialties in internal medicine. Standardized equitable fees for rheumatologists must be advocated with the Canadian Medical Association and provincial governments.

2) It must also be recognized that rheumatologists, to have the desired impact on patient outcomes, spend longer meeting times with patients, and often spend time each day monitoring laboratory data to prevent the side effects associated with treatments. Equitable reimbursement for these time-consuming, non-procedure-oriented services should be advocated.

3) The profession itself must take steps to encourage medical students to choose rheumatology as an option. The recent decision by the CRA to establish a summer “studentship” in rheumatology for Canadian medical students is certainly a step in the right direction.

4) Rheumatologists must have a more direct role in the teaching of history-taking and musculoskeletal examination, to improve the diagnostic capabilities of medical students and family practitioners.

5) The profession must advocate, with the academic centres, to increase the number of places available for rheumatology trainees, and to appropriately fund these trainees.

References