Enhancing the effectiveness of health care for Ontarians through research

ICES Institute for Clinical Evaluative Sciences

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A Summary of ICES Research Findings for Decision Makers

Arthritis and Related Conditions in Ontario: ICES Research Atlas

Arthritis, a leading cause of pain, physical disability and health care utilization in Ontario, is part of a family of musculoskeletal (MSK) disorders creating a notable burden on population health. It is not confined to the elderly population—many people are affected in the prime of life. By 2031, it is estimated that 738,000 Canadians in the 45–54 age group along with 1.4 million in the 55–64 age group will be diagnosed with arthritis. Though there is no cure, arthritis management is most effective when therapies are started early.

Arthritis and related (A&R) conditions stimulate a host of related costs ranging from reduced quality of life to significant expenditures for physician visits, specialist care, prescription medication, surgery and rehabilitation. With more than four million Canadians living with A&R conditions, the attached annual cost is $17.8 billion, second only to costs associated with cardiovascular disease and more costly than cancer.

Following the 1998 ICES research atlas on A&R conditions, this 2nd edition paints a comprehensive picture of the impact of A&R conditions in Ontario from the 1990s to 2002 and proposes strategies to meet growing demand for care and treatment. Produced in partnership with the Arthritis Community Research and Evaluation Unit (ACREU) and The Arthritis Society (Ontario Division), this research atlas contains the following chapters:

Atlas Content

Key Findings and Policy Options

Key findings	Policy options
Prevalence In 2000/01, arthritis and rheumatism affected over 1.6 million Ontarians aged 15 and older. By 2026, it is estimated that 2.8 million Ontarians aged 15 years and older will have arthritis or rheumatism. In 2000/01, two-thirds of people with arthritis were women and nearly 3 out of every 5 people with arthritis were younger than age 65. The prevalence of arthritis tends to be higher in northern Ontario, though there are also areas of high prevalence in southern Ontario. Arthritis was more frequently reported in people with a lower level of education and in the Aboriginal population.	• Target an intensive public education program to specific populations about prevention and management of osteoarthritis (OA) by decreasing risk factors such as obesity and injury. • Develop, implement and evaluate a chronic disease model of care that includes disease prevention, health promotion, self-management, and is grounded in best practices. The model should incorporate a collaborative network of health professionals, key principles of client-centredness and timely and relevant interventions in a variety of settings.
Access to care Access to arthritis-related services, specialist care, surgical services and use of post-acute rehabilitation varied across the province. The level of health professional services for people with A&R conditions has remained relatively static since 1997. As the number of people with arthritis rises, this will translate into declining levels of service per individual.	• Step up recruitment and training in specialist care to address the shortage of orthopaedic surgeons, rheumatologists and other health care providers and ensure access and equity in care throughout the province. • Provide targeted training and education to allied health professionals (physiotherapists, occupational therapists, and chiropractors) to facilitate specialization and increase their role in arthritis treatment.
Primary care The majority of 2.8 million physician visits for A&R conditions in 2000/01 were to primary care physicians, highlighting their key role in the management of these disorders.	• Improve the education and training of primary care physicians with respect to MSK conditions to increase appropriate referrals and encourage effective relationships with rheumatologists.

Key Findings and Policy Options

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Total joint replacement The rate of total hip replacements (THRs) and total knee replacements (TKRs) increased during the 1990s. There is unmet need for total joint replacement (TJR). With an aging population and the associated increase of arthritis, demand for surgery will grow. Between 1993/94 and 2001/02, wait times increased for primary THR (from 16 to 20 weeks) and primary TKR (from 20 to 29 weeks). Ontario orthopaedic surgeons spent only 35% of their time dedicated to surgery, while in the US, the recommended dedication of time is 62%. Arthroscopy comprises almost half of orthopaedic surgery for A&R conditions, though its efficacy in arthritis management remains unclear. Between 1995/96 and 2001/02, inpatient rehabilitation following primary and revision THR and TKR increased from about 30% to 40%.	• In the short-term, strategies to reduce wait times for surgery, including methods to prioritize patients waiting for TJR, are key. In the long-term, the shortage of orthopaedic surgeons should be addressed through more recruitment and training. • Further research into the efficacy of arthroscopic surgery in the management of OA is key to determine appropriate indications for this surgery. • As well, additional research into the outcomes of different rehabilitation processes for TJR is necessary to determine the best approach and to ascertain its contribution to improving capacity for TJR surgery.
Use of medication The total cost of arthritis-related prescriptions increased by 224% between 1998 and 2001 due mainly to the increased use and higher cost of COX-2 inhibitors, a type of nonsteroidal anti-inflammatory drug (NSAID), introduced in 1999. Treatment with disease-modifying antirheumatic drugs (DMARDs) is recommended as soon as rheumatoid arthritis (RA) is diagnosed. In contrast, the proportion of people receiving DMARDs is much less than the estimated number of Ontarians with RA.	• Ensure that people with inflammatory arthritis have access to drugs such as DMARDs and biologics (to help prevent joint damage) through specialist care, particularly rheumatologists and internal medicine physicians. • Ensure that people have access to necessary drugs on the Ontario Drug Benefit Formulary and that drugs are appropriately prescribed.
Data collection Lack of data in some areas creates an incomplete picture of the impact of A&R conditions on the population of Ontario. For example, information is scarce for rehabilitation services (publicly and privately funded), use of community services, and children with arthritis.	• Continue rigorous surveillance of A&R conditions to monitor trends in disease prevalence, health status, health care utilization and wait times. • Collect reliable data for rehabilitation services (publicly and privately funded), use of community services, and children with arthritis to accurately describe the impact of arthritis in Ontario.

For more information, contact:
Carolynne Varney, Senior Communications Coordinator, ICES
416-480-4055, ext. 3797; carolynne.varney@ices.on.ca