Editorial

Access to Care for Rheumatology Patients May Be Compromised: Results of a Survey to Members of the Canadian Rheumatology Association



Access to care in the medical profession plays an important role in disease outcomes, the patient-doctor relationship, and the patient's perceived value of the provided care. The timely availability of treatments and services partially determines what is considered "good" care. The relationship between appropriate access to care and improved patient outcome and satisfaction has been described in the literature[1-3]. It is concerning that recent evidence has suggested that access to care in Canada, especially in the field of rheumatology, might be inadequate.

Disease outcome is affected by adequate referral to rheumatologists. Ward, *et al*[3] demonstrated that 42% of patients in their study who were not referred to a rheumatologist had progressively increasing functional disability as measured by the Health Assessment Questionnaire Disability Index[4]. Further, patients who had continuing care from rheumatologists experienced lower rates of progression of functional disability than those who had only intermittent care[3]. A study from Ireland reported that 5% of all general practitioners (GP) in the community performed the majority of joint and soft tissue injections; as well, there was poor availability of these treatments for most patients with rheumatic disease[5].

It appears that rheumatology patients are content with the physician interaction they receive in their care; however, one may argue that many patients may not be qualified to answer the question of whether or not they receive adequate care if they have no other benchmark with which to compare their treatment. For example, although standardized patients have reported satisfaction with their care, citing "being treated respectfully" and "being given enough room to mention all complaints" as contributing factors[6], patient satisfaction may be influenced by factors that affect the pleasantness of their experience without truly addressing the underlying problem of whether the majority of patients receive the highest possible standard of care available. Rheumatologists are in a better position to determine whether their patients have been receiving the best possible standard of care, as they may be more apt to be knowledgeable about the availability of treatments/interventions, as well as the barriers that may exist to obtaining optimal medical services and agents.

There appears to be a growing perception that accessibility to timely rheumatological care has become inadequate. An initiative by the Canadian Rheumatology Association (CRA) Therapeutics Committee was undertaken to determine attitudes toward the care of Canadians with arthritis and other musculoskeletal (MSK) diseases. The objective was to determine if rheumatologists felt access to care for their patients was being limited by a lack of timeliness in obtaining treatments and services or lack of access to specific therapies.

A survey to determine the attitudes of Canadian rheumatologists toward the care of their patients with arthritis was made available to 306 members of the CRA (online at the CRA website and by mail to nonrespondents). The 33-question survey began with a short demographics section (age, sex, province, practice type, year of completion of rheumatology, and number of years in practice) and questions to assess: (1) if rheumatologists felt able to provide care as they would like to patients with rheumatic diseases; (2) whether unnecessary time was used in obtaining services and treatments for patients; (3) whether newer approved treatments in arthritis had more favorable profiles compared with older treatments; (4) if access to other services occurred in a timely fashion; (5) if government restrictions impeded their ability to deliver good proven care to rheumatology patients; and (6) whether accessibility to rheumatological care was similar to that of other chronic diseases. The survey used a Likert 5-point rating scale (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree).

Eighty CRA members responded to the survey (26%); thus, the results should be interpreted with caution. The mean age was 49 years (range 31–70), and 63% were male (n = 50). The majority of respondents were from Ontario (n = 53), followed by Alberta (9), British Columbia (6), Quebec (6), Saskatchewan (3), New Brunswick, (2) and Nova Scotia (1). A similar number of rheumatologists in private (n = 36) and academic (n = 38) practice responded.

Forty had practiced for less than 20 years. Responses were similar across demographically distinct factions.

When asked if he/she felt unable to give care as he/she would like to patients, 73% of respondents agreed. Similar proportions of rheumatologists who worked in private (81%) versus academic practice (68%), and those who had been in practice for more than 20 years (76%) versus less (73%), felt unable to provide care the way they would like for their patients. Attitudes were similar across Canada, with 73% of respondents from Ontario and 74% of the others agreeing. Patient characteristics (such as diagnosis and disease severity), the involvement of other healthcare providers, and government restrictions all appeared to influence the attitudes of respondents. Respondents felt better able to treat patients with rheumatoid arthritis (RA) that was well controlled as compared to patients with progressive RA or patients intolerant to methotrexate (MTX) therapy. In well controlled RA, 27% felt they could not treat their patients as well as they would have liked. However, 84% treating patients with progressive RA and 76% of those treating patients intolerant to MTX agreed that they were unable to provide care that they would have liked. Table 1 describes the survey responses.

When considering other diseases, 51% of respondents felt unable to give care as they would like for patients with osteoporosis. In more severe osteoporosis, 52% felt unable to give the most optimal care for patients with osteoporotic fractures.

Respondents were asked if their time was unnecessarily used in obtaining services for patients, and 85% agreed. Only 27% felt able to access inpatient services, and only 14% believed they could access outpatient services in a timely fashion for patients with RA and other MSK diseases. Access to orthopedic consultations and procedures for patients with arthritis was thought to occur in a timely fashion by only 11% of respondents in academic practice and 23% in private practice. Twenty-three percent of Ontario rheumatologists and 7% of the others agreed that access to the orthopedic specialty service occurred in a timely fashion, and 16% felt that access to the allied health profession occurred in a timely fashion.

Rheumatologists believed that newer treatment options were more efficacious in helping their patients. Eighty-six percent agreed that newer treatments had more favorable profiles compared with older therapies. This feeling was strongest when considering approved treatments for patients with RA. Ninety-seven percent agreed that new treatments for RA had more favorable profiles than older therapies. Eighty-nine percent agreed that there was a lack of timeliness in obtaining medications and treatments approved for patients with arthritis. This did not hold true for nonsteroidal antiinflammatory drugs (28% felt unnecessary time was used in obtaining them). However, rheumatologists felt unable to access outpatient infusions, like infliximab, in a timely fashion. Some regional differences did exist, where 38% from Ontario compared to 70% from other respondents felt unable to access these expensive newer therapies in a timely fashion.

Table 1. Respondents' assessment of various statements in the sruvey on perceptions/attitudes toward access to care for patients. Reported as number of respondents (%).

Statement with which Respondents Were Asked to Rate Their Agreement/Disagreement	Agree	Neutral	Disagree
I feel unable to give care as I would like to my patients with arthritis/MSK problems	57 (73)	4 (5)	17 (22)
I feel unable to give care as I would like for my patients with RA that is well controlled	19 (25)	17 (22)	40 (53)
I feel unable to give care as I would like for my patients with progressing RA	66 (85)	2 (3)	10 (12)
I feel unable to give care as I would like for my patients not tolerating methotrexate	58 (74)	7 (9)	13 (17)
I feel unable to give care as I would like for my patients with osteoporosis	39 (51)	15 (19)	23 (30)
I feel unable to give care as I would like for my patients with osteoporotic fractures	40 (52)	8 (10)	29 (38)
I feel my time is used unnecessarily trying to obtain services for my patients instead of treating my patients	65 (85)	6 (8)	5 (7)
I feel I am able to access inpatient services for my patients with arthritis or MSK problems in a timely fashion	21 (27)	14 (18)	42 (55)
I feel my patients have access to other required outpatient services in a timely fashion	11 (14)	20 (26)	45 (59)
I feel there is a lack of timeliness in getting medications and treatment that has been approved for my patients with arthritis and MSK problems	68 (89)	6 (8)	2 (3)
I feel able to access outpatient infusions in a timely fashion	40 (51)	16 (21)	22 (28)
I think the newer approved treatments in arthritis have more favorable profiles compared to older treatments for RA	68 (97)	0	2 (3)
I think government restrictions impede my ability to deliver good proven care for my patients with arthritis and MSK problems	64 (84)	6 (8)	6 (8)
I think government restrictions impede my ability to deliver good proven care for my patients with RA	68 (88)	3 (4)	6 (8)
I think my patients with arthritis are treated the same with respect to access to good care as patients with other chronic diseases	10 (13)	15 (19)	52 (68)

Eighty-four percent agreed with the statement: "The government plays a role in delaying access to care for patients." These restrictions did not appear to affect their ability to treat patients with osteoarthritis (OA) or osteoporosis. However, 88% agreed that government restrictions impeded their ability to deliver good care to patients with RA.

This survey showed that respondents held unfavorable opinions toward the care that patients with RA and other MSK diseases receive; 73% agreed to being unable to provide care as they would like to these patients. We wonder about a connection between being unable to deliver care and this perceived barrier to access. Other reasons for lack of good standards of care, such as hospital policies, patient adherence, lack of effective therapy, and misdistribution of arthritis care professionals, cannot be ruled out. There is also a possibility that there may be a sense of frustration among rheumatologists, which may or may not be present in other subspecialties.

Diagnosis and disease severity appear to have contributed to physicians' attitudes. Most rheumatologists (two-thirds) expressed no discontent with respect to treatment of mild disease. However, three-quarters of rheumatologists felt unable to treat patients with progressive RA or those intolerant to MTX. This attitude was held by half the rheumatologists for treating osteoporosis and its complications. Differences might have been due to the fact that patients with severe RA require more expensive medical services and take more time to be reassessed, and they may be recalcitrant to standard treatment.

A study has shown that less than 60% of GP in Ontario made referrals to rheumatologists for patients with early RA[7]. This trend among Ontario GP goes against findings in the literature, which suggest that patients with polyarthritis should be referred to a rheumatologist as soon as possible to avoid delay of proper treatment[8]. Thus, it may be that the GP are reluctant to refer to rheumatology if they anticipate long waits. This could be detrimental for the longterm outcome for patients with RA[3].

Shipton, *et al*, when surveying Ontario rheumatologists, reported that 83% stated the most common barrier to providing adequate care was cost of drugs[7]. Other policies that have created physician shortages, such as the fee schedule for rheumatologists' reimbursement or shrinking medical school enrolments, were not assessed in the CRA survey and may be important factors in the physicians' attitudes.

Rheumatologists felt that inadequate access to care for patients is a much greater problem for arthritis than for some other chronic diseases. Attitudes seemed to be consistent across respondents, indicating that access to care for patients is a national phenomenon and not an issue concerning certain isolated provinces.

The survey described here had important limitations. The response rate was low (26%), with a sample size that may or may not have been reflective of all Canadian rheumatologists. Perhaps only rheumatologists with strong feelings (in either direction) or only the discontented responded. The questions may have been biased or "loaded." Although study respondents had a similar demographic composition to that described in a previous CRA survey[9], the response rate was much lower in our survey (26% vs 64%). Thus, the survey results may or may not be representative of the majority of CRA members. An additional limitation is that rheumatologists were not asked their opinions on possible solutions and what they consider to be good care.

We conclude that there is a perception that our patients are being denied timely and appropriate access to treatments, including restrictive access to expensive treatments, such as biologics, and to the orthopedic and allied professional services. Part of the solution appears to be a need for better availability of effective drugs (in RA). Other important issues, including a lack of qualified personnel to care for the expanding arthritis population (rheumatologists, orthopedic surgeons, skilled family practitioners, and allied health professionals) and timely access to surgical interventions were not addressed in this survey and will continue to influence Canadian arthritis care.

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