Bone and Joint Diseases Around the World. The UK Perspective

TOM G. PALFERMAN

ABSTRACT. Rheumatology is a discipline that has evolved through the influence of physical medicine, with the aid of advances in immunology and epidemiology. An ageing population has seen osteoarthritis and osteoporosis, among other rheumatic diseases, flourish. Health provision relies on the National Health Service (NHS), funded largely, but no longer exclusively, through direct taxation. Access to specialist rheumatology services (secondary care) is achieved by referral through a general practitioner (primary care). Increasingly, primary care is charged with planning clinical services supported by budgets devolved from central government. Rheumatology is a popular discipline for trainee specialists, but consultant numbers are inadequate. One rheumatologist per 85,000 population is deemed desirable, whereas in practice the number is less than one per 120,000. These figures belie the uneven distribution of services. The National Institute for Clinical Effectiveness assesses all new therapies according to their clinical- and cost-effectiveness. Those approved should, in theory, be funded, but this system remains imperfect. A unique initiative in the UK is the central register for those taking biologic agents. Regrettably, the NHS has been underfunded and steps are under way to reverse this in order to match the proportion of gross domestic product spent on health care by other major European economies. The delivery of medical services will have to change to accommodate increasing numbers of women graduates, now exceeding 50%, by increasing job sharing and part-time posts. UK rheumatology has close links with Europe and the US, while increasingly its horizons are broadening, to great advantage. (J Rheumatol 2003;30 Suppl 67:33–35)

Key Indexing Terms:
RHEUMATOID ARTHRITIS BIOLOGIC AGENTS MORTALITY
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS MORBIDITY

BACKGROUND

Hippocrates, the Greek philosopher of 2500 years ago, is the father of medicine. As were all great clinicians, he was a rheumatologist. His descriptions of gout and rheumatic fever are examples of clarity of thought at their best. The father of rheumatology in the UK is considered to be William Heberden, who gave the classic definition of angina pectoris but also was a prominent rheumatologist, to which the osteoarthritic nodes in the distal phalangeal joints bearing his name will testify.

Since Roman times there has been a tradition of "taking the waters." Natural springs with perceived health-giving properties brought about a number of famous spa towns where the affluent with rheumatism would holiday or to which they would retire. Alongside this informal hydrotherapy developed a number of physical and exercise therapies to relieve pain, improve joint movement, and maintain joint integrity.

Gradually, rheumatology became recognized as a specialty in its own right. The first UK chair in rheumatology was in Manchester in 1953, held by Professor Kellgren, whose death sadly was reported last year.

The past 30 years have seen the practice of rheumatology proceed by leaps and bounds. This owes much to developments in immunology and epidemiology. As many of the population live longer, so musculoskeletal disorders become more prevalent; it is now the case that some 15–20% of consultations in general practice have a locomotor basis. Rheumatology as a major specialty sits somewhat uncomfortably with general internal medicine. While most trainees in rheumatology have experience in acute general medicine, 80% of specialist rheumatologists practice independent of it.

Current Service Provision

The present system of health care provision relies on the National Health Service (NHS), which remains exclusively funded by taxation. An individual's first access to medical services is through their general practitioner (GP) in primary care. The GP acts as a "gate-keeper," deciding who will be referred on to specialist practice. The GP, therefore, has a pivotal role in UK health services. This has traditionally been considered a great strength and promoted by successive governments, which have increasingly transferred decisions about provision and purchasing of health care, from secondary, hospital based, care to general practitioner, community based, primary care. Primary care trusts have

From the Department of Rheumatology, Yeovil District Hospital, Yeovil, Somerset, United Kingdom.

T.G. Palferman, MD, Consultant Rheumatologist, Yeovil District Hospital; Chairman, Clinical Affairs Committee and Council Member, British Society for Rheumatology.

Address reprint requests to Dr. T.G. Palferman, Department of Rheumatology, Yeovil District Hospital, Yeovil, Somerset BA21 4AT, UK. E-mail: pluch@est.nhs.uk

been formed, from April 2002, by the amalgamation of individual general practices for the purposes of deciding health care priorities and funding.

While acknowledging the strength of primary care, its gate-keeper role should not be accepted uncritically when applied to rheumatology services. Table 1 lists the potential advantages and disadvantages of that role.

Current Position of Rheumatology Services in the UK

Rheumatology remains a popular specialty, attracting high caliber trainees, despite the relative lack of undergraduate exposure. Nonetheless, there has been recent concern about recruitment to the consultant, specialist grade as several recent posts in the UK have received no applicants. Specialist rheumatology services are unevenly distributed throughout the UK. There are areas with little or none, whereas some parts of the UK, most notably London, are richly endowed. It has been estimated that one full-time rheumatologist per 85,000 population is a reasonable aim, whereas currently the average is one per 120,000, and this figure conceals the patchy distribution of services in the UK.

Research is widespread and generally of a high standard. There is an impression that this is being discouraged as an active part of training in rheumatology, which possibly reflects the need to produce a greater number of fully-fledged specialists as quickly as possible.

There are systems of audit and clinical governance that serve to set standards and scrutinize an individual's practice, which can be measured against accepted norms. External peer review is in place, which is popular within the profession and is an essential precondition to maintaining a degree of self-regulation.

In the UK there is a National Institute for Clinical Excellence (NICE) charged with producing clinical guidelines and with appraising new technologies, particularly drug therapies. Recently NICE approved cyclooxygenase-2 inhibitors and anti-tumor necrosis factor-α drugs, to the great benefit of selected groups of patients. Notwithstanding these achievements, NICE has not been widely embraced by the medical profession owing to its somewhat inconsistent conclusions. There has been fierce opposition from some influential quarters[1,2].

There is a central register in place for those taking biologic agents; this is a unique initiative within Europe that will aid in ensuring that the appropriate criteria are met for prescribing these drugs, monitoring progress, and withdrawing treatment when ineffective.

Changing Work Pattern/Workload[3]

Rheumatoid arthritis (RA) remains the commonest condition managed by rheumatologists[4]. Increased quality of care is being demanded both by professionals and those with RA. Patient expectations have not always realistically been raised, as targets set by central government have not been matched by increased resources in order for these to be achieved.

With an ageing population comes more osteoarthritis, while the diagnosis and management of osteoporosis, of which there is far greater awareness, has largely been assimilated into the rheumatologist's workload. Fibromyalgia has reached almost epidemic proportions and this condition, not recognized by an earlier generation of rheumatologists, and its diagnosis and management are extremely labor intensive.

Conversely, certain conditions now appear less frequently, either because they are effectively managed in primary care, or because of a genuine decrease in prevalence. For example, how often nowadays is the rheumatologist faced with severe rheumatoid vasculitis or its other severe multisystem, extraarticular manifestations?

Funding Problems

The NHS has been chronically starved of funds. This has only recently been acknowledged by government, such that now a greater proportion of gross domestic product is being devoted to health care expenditure, to match that of other major European economies. The UK has too few doctors, nurses, and all allied health professionals. There is a drive to increase recruitment to all these posts. The number of

Table 1. Gatekeeper role of the general practitioner.

Advantages	Disadvantages
• Role ensures appropriate referrals, protects specialist services • GP knows patient better and is involved in continuing care • Simpler disorders more cheaply managed by GP	• Access might be denied owing to lack of knowledge or financial considerations • Rheumatologist has longterm continuing involvement with patient, family, and carers • Continuity of care undermined in large practice, detrimental to patient • Appropriate referral depends on diagnosis/ experience • Patient assumes 'doctor knows best' • Role contravenes regulations on monopolies • Role contravenes human rights

medical schools is to be increased by 2, with an increase in student numbers in some existing faculties. However, there has also been a fall in the number of applicants to medicine. Following qualification, general practice, particularly, is facing problems with recruitment and a small, but significant, minority of doctors are turning to careers outside medicine. It is clear that the delivery of medical services will need to change to accommodate a higher percentage of women graduates, which now is well in excess of 50%. As such, there is likely to be a drive towards more job sharing, which many male specialists might find similarly attractive.

Access to rheumatology services is not uniform throughout the UK. Moreover, the availability of treatments for an individual can depend on geographical location rather than clinical need. This has led to charges of so-called "post-code prescribing."

Musculoskeletal disorders have a low profile with central government; they lack the emotive appeal of oncology, coronary artery disease, and disorders of children. In recent years a number of initiatives known as National Service Frameworks (NSF) have been introduced for particular disorders. These include the setting of explicit targets by government and have meant that, for example, cardiology and oncology services have been able to obtain increased resources in order to comply with the requirements of the NSF. Regrettably, none such exists, or is likely to exist, for musculoskeletal diseases.

Prospects

There are certainly causes for cautious optimism. Funding for health services, as outlined above, is increasing above the rate of inflation. The profession is introducing a number of defined clinical standards of care. Inroads are slowly being made with regard to increasing awareness of the importance of musculoskeletal disorders and patients' organizations are proving to be enormously successful in this regard. There has never been a wider choice of better and safer treatments. Although some of these, most notably the biologic agents, are hugely expensive (approximately £8000 per patient per annum in the UK), this has to some degree focused attention on rheumatology, since expensive treatments indicate, to the hitherto uninformed, that some of the disorders we manage can be extremely serious.

Opportunities for International Cooperation

The UK is part of the European League Against Rheumatism (EULAR) and the *Annals of Rheumatic Diseases*, one of the two main UK rheumatology journals, is the official EULAR publication. The British Society of Rheumatology (BSR) has enjoyed a number of successful combined national meetings in conjunction with French, Dutch, and Scandinavian rheumatology societies. Many UK rheumatologists now attend American meetings and the number of UK delegates to the American College of Rheumatology annual meeting is second only to the number at the BSR annual scientific meeting. Increasing opportunities exist for research and for clinical fellowships in other European countries, the US, and Australia.

There is a strong need for the World Health Organization (WHO) to shout louder for the cause of musculoskeletal diseases. There have been notable successes and the WHO, with the United Nations, has given full support to the International Bone and Joint Decade. The Japan Rheumatism Foundation, by virtue of this meeting, is setting an example for other nations to follow and has provided an invaluable opportunity to learn about the provision of rheumatology services in many countries throughout the world. The sharing of such ideas can only benefit, ultimately, those people who suffer bone and joint diseases whom we are trained and so privileged to serve.

REFERENCES

1. Smith R. The failings of NICE. BMJ 2000;321:1363-4.
2. Dent HS, Sadler M. From guidance to practice: why NICE is not enough. BMJ 2002;324:842-5.
3. Turner G, Symmons A, Bamji A, Palferman T. Consultant rheumatology workforce in the UK: Changing patterns of provision 1997-2001. Rheumatology 2002;41:680-4.
4. Kirwan JR. Rheumatology out-patient workload increases inexorably. Br J Rheumatol 1997;36:481-6.