

Rheumatology Workforce in Canada

By Claire Barber, MD, PhD, FRCPC

The Arthritis Alliance of Canada's System Level Performance Measures were designed to evaluate models of care to ensure patients with inflammatory arthritis receive timely diagnosis and treatment. Central to ensuring timely care is making sure there are adequate numbers of rheumatologists for making an early diagnosis and starting appropriate treatment.

In 2015, the Canadian Rheumatology Association launched "Stand Up and Be Counted," a national workforce survey of rheumatologists across Canada. The results highlighted that there is a current shortage of rheumatologists across the country that may worsen over the next 10 years because a third of the workforce reported plans to retire in the near future.

Further analysis of the results of the survey will be published imminently in *The Journal of Clinical Rheumatology* and will describe factors associated with rheumatologists' clinical work hours and patient volumes.

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Reference:
Barber CEH, et al. Stand Up and Be Counted: Measuring and Mapping the Rheumatology Workforce in Canada. *J Rheumatol* 2017; 44(2):248-57.

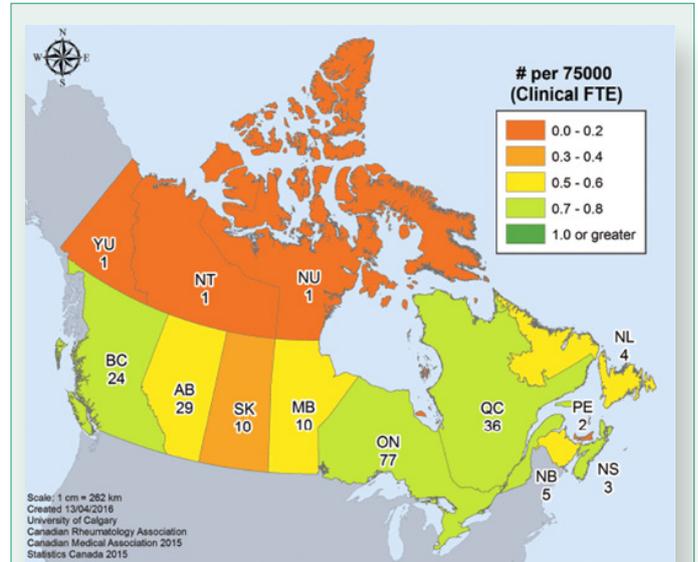


Figure 1. Distribution of Rheumatologists Across Canada

Map of Canada showing the number of FTE-practicing rheumatologists per 75,000 population and the number of FTE rheumatologists required to meet the target of 1:75,000 benchmark (superimposed provincial count). FTE were estimated based on the national median reported time allocated to clinics from all respondents of the 2015 Stand Up and Be Counted survey and used to adjust the 2015 Canadian Medical Association numbers of rheumatologists in each province.

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Economic Perspectives

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The devastating consequences of inflammatory arthritis (IA) to individual patients and the healthcare system burden associated with the treatment of IA and productivity losses^{1,2} highlight the need to provide the right care to the right patient at the right time.³

Given the scarcity of healthcare resources and financial constraints,⁴ the efficiency of care (*i.e.*, optimal use of resources in achieving desired outcomes⁵) is an important aspect to consider.⁵⁻⁷ Models of care (MOCs) are one approach that is expected to improve accessibility, appropriateness, effectiveness, and safety of care for IA patients⁸ and, consequently, to improve patient outcomes and increase likelihood of remission⁹ and reduce the associated medical costs.¹⁰⁻¹⁵

From an economic perspective, there may be costs associated with the implementation and operation of MOCs (*e.g.*, education and training of staff, ongoing funding for staff salaries), but this must be balanced against the benefits to patients in terms of improved outcomes and reduced health care costs associated with the management of patients with IA with lower disease activity. MOCs for IA patients thus have the potential to be cost-effective and possibly cost-saving.

The current evidence regarding the efficiency of MOCs for IA patients is limited, especially in local Canadian settings. To draw decision-makers' attention to and improve uptake of MOCs for arthritis patients, evidence on their efficiency is required. The Arthritis Alliance of Canada (AAC) is currently undertaking a cost consequences analysis of MOCs