

'Rheumatologist go home!' Coming up next?

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High use of healthcare services is characteristic for rheumatoid arthritis (RA). Health spas have provided care for patients with RA in many countries, and many patients with early RA used to be kept in hospitals for several weeks.¹ In the 1970s, Swedish researchers reported that over a 13-year follow-up period, patients with RA were admitted to hospital more than twice as often, and spent three times as many days in hospital, as control subjects,² primarily because of high inflammatory activity. Over the past two decades, however, many rheumatology wards have been closed and rheumatology beds in departments were given away, especially in the Nordic countries.³

Today, rheumatology is characterised by active medication strategies using a combination of early treatment with traditional disease-modifying antirheumatic drugs and other effective drugs, with adjustment during close follow-up. In many countries a multidisciplinary approach to RA means support in a wide array of areas, from devices⁴ to coping with the disease.⁵ The patient is taught to take an active role.

Of concern to many are the high medication costs. Early remission has unambiguously been defined as a treatment target. In addition to methotrexate and combinations of conventional antirheumatic drugs, a subset of patients with RA needs more powerful though expensive drugs. In the search for remission in a subset of patients with RA, with the prospect of reduced symptoms and reduced or halted future joint damage, use of biological agents with their high costs is unavoidable. These costs are not affordable in all countries.⁶ The use of biological agents is associated with reduced suffering and improved health.

Therefore, these high direct costs may be partly offset by reduced rates of work disability.

Once the symptoms of patients with RA are alleviated and their quality of life improves, will rheumatologists be needed less? Do we actually see a decline in healthcare use as a reward for effective patient treatment? Obviously, if patients with rheumatic diseases were cured, they would no longer need doctors, health professionals, or hospitals, at least for their rheumatic disease. But we know that our patients with RA have chronic disease. And even if we have seen milder disease in recent years in Western societies,^{7, 8}—although not in all countries⁶—we have become more aware of the importance of frequent monitoring of patients to ensure that the disease is kept in a state of remission or low activity. This principle of tight control is also recommended⁹ and today we aim for numerical targets of disease activity as do cardiologists and diabetologists.¹⁰ Active RA disease entails costs and use of healthcare during the following years,¹¹ and it is plausible that improved disease status might result in a smaller requirement for healthcare.

As indicated earlier, the structure and delivery of rheumatology care has changed over the past decade. There are few reports of changes in healthcare use in actively treated patients with RA in the 2000s. After initiation of biological treatment a decrease in the number of visits to the doctor has been described.¹² Furthermore, one study showed that the need for hospital inpatient time and telephone contacts measured per year was lower in patients with RA receiving biological treatment than in patients not receiving anti-tumour necrosis factor treatment.¹³

In this issue of the *Annals of the Rheumatic Diseases* Hagel *et al*¹⁴ report a decrease in healthcare use in patients with RA in the Swedish region of Skåne during the 2000s compared with a reference population. The decline was considerable—in the range of 20–30%—for hospitalisations, outpatient visits and visits with nurses and physiotherapists. To compare the findings in patients with RA with those in a reference population,

authors calculated the ratio of the mean number of visits for the RA cohort and reference cohort for each calendar year, and then applied a test for trend across ordered groups. The authors report reduced healthcare use by patients with RA in comparison with the reference population, and not necessarily reductions in absolute numbers. They were careful not to attribute this altered pattern of healthcare use to the application of biological therapies, which were used in about one in five of their patients with RA. Nevertheless, it is obvious that active approaches to treatments have replaced frequent visits and hospital stays in rheumatology care.

Some caveats about this study deserve mentioning. Interpretation of changes given in percentages can be difficult, and absolute values for the use of healthcare are needed to assess true trends. It is difficult to grasp the implication of the message that between patients with RA and reference population the ratio for visits to a physician declined by 29% during the decade. We can more easily understand the statement that patients with RA consult their GPs for about one less appointment during the last years of the examined decade than at the beginning—when the pattern of the reference population has not changed. Some bias in the study¹⁴ might also have been introduced since during follow-up more patients than referents (36% vs 23%) died, probably those who would have required more care during the course of the observation period. This case of right censoring might have resulted in overestimation of the magnitude of findings.

If findings of lower healthcare use were obtained in a country other than Sweden, one might suspect that the patients with RA had been given less care because they were not a priority compared with other patient groups in the healthcare system. This can happen when rheumatology has to compete with other disciplines within internal medicine or others for available resources. General constraints on expenditure—such as during the recent financial crisis—or hospital budgets under stress may easily affect the way patients are treated. Such major changes are unlikely to have been the case in this study in Sweden, where care for patients with RA is in many ways outstanding, and access to medication and care most often is at home. In the Nordic countries, there are some indications of saturation in the prescription

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of tumour necrosis factor inhibitors among biological drugs during recent years and with lower disease activity at their initiation.^{15–17}

While we need to take into account increased healthcare use with increasing age, this was only seen in the reference population, but not in patients with RA in the study by Hagel *et al.*¹⁴ In general, musculoskeletal health has improved over the past decades, as indicated in population studies.¹⁸

Another factor which may determine healthcare use during follow-up of patients with RA is the way in which we monitor patients for disease activity, extra-articular manifestations and adverse events of disease-modifying antirheumatic drug treatment. A possibility of self-assessment for disease activity, especially by patients in remission or with low disease activity is promising.¹⁹ Monitoring of these patients also requires considerable resources in rheumatology outpatient departments. Patients could in part be followed up by means of electronic devices for monitoring disease course,^{20–21} and retain access to rheumatology care through 'on-demand' visits to a rheumatologist or a nurse.²² Such measures might make the follow-up of patients more effective and could alleviate the sometimes meaningless routine control of happy patients. This may especially be the case for patients with established disease where initial and aggressive *lege artis* treatment has led to remission and low disease activity.

If the successful treatment and management of RA and other inflammatory rheumatic diseases like ankylosing spondylitis and psoriatic arthritis continues, we will pay more attention to other more neglected diseases—for example, osteoarthritis and gout. The ongoing EUMUSC.NET project (<http://www.eumusc.net>), supported by the European Union and EULAR highlights the need for more attention towards osteoarthritis within the field of rheumatology, but also by others not familiar with rheumatic diseases. This needs to be a focus and rheumatologists and other

therapists will need to increase their awareness of treatment needs. Thus, rheumatologists will be required and need not be sent home or sit jobless, and will remain valuable therapists with tasks to take on in the future.

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REFERENCES

1. Short CL, Bauer W. The course of rheumatoid arthritis in patients receiving simple medical and orthopedic measures. *N Engl J Med* 1948;**238**:142–8.
2. Hansagi H, Allebeck P, Allander E. Utilization of hospital care among persons with rheumatoid arthritis compared with controls. A 13-year follow-up of an epidemiological survey. *Scand J Rheumatol* 1985;**14**:403–10.
3. Kvalvik AG, Larsen S, Aadland HA, *et al.* Changing structure and resources in a rheumatology combined unit during 1977–1999. *Scand J Rheumatol* 2007;**36**:125–35.
4. Hagen KB. Canes for knee osteoarthritis: is a randomised trial necessary? *Ann Rheum Dis* 2012;**71**:159–60.
5. Zangi HA, Mowinckel P, Finset A, *et al.* A mindfulness-based group intervention to reduce psychological distress and fatigue in patients with inflammatory rheumatic joint diseases: a randomised controlled trial. *Ann Rheum Dis* 2012;**71**:911–17.
6. Sokka T, Kautiainen H, Pincus T, *et al.* Disparities in rheumatoid arthritis disease activity according to gross domestic product in 25 countries in the QUEST-RA database. *Ann Rheum Dis* 2009;**68**:1666–72.
7. Uhlig T, Heiberg T, Mowinckel P, *et al.* Rheumatoid arthritis is milder in the new millennium: Health status in RA patients 1994–2004. *Ann Rheum Dis* 2008;**67**:1710–5.
8. Pincus T, Sokka T, Kautiainen H. Patients seen for standard rheumatoid arthritis care have significantly better articular, radiographic, laboratory, and

- functional status in 2000 than in 1985. *Arthritis Rheum* 2005;**52**:1009–19.
9. Smolen JS, Aletaha D, Bijlsma JW, *et al.* Treating rheumatoid arthritis to target: recommendations of an international task force. *Ann Rheum Dis* 2010;**69**:631–7.
 10. Atar D, Birkeland KI, Uhlig T. 'Treat to target': moving targets from hypertension, hyperlipidaemia and diabetes to rheumatoid arthritis. *Ann Rheum Dis* 2010;**69**:629–30.
 11. Hallert E, Husberg M, Skogh T. 28-Joint count disease activity score at 3 months after diagnosis of early rheumatoid arthritis is strongly associated with direct and indirect costs over the following 4 years: the Swedish TIRA project. *Rheumatology (Oxford)* 2011;**50**:1259–67.
 12. Joyce GF, Goldman DP, Karaca-Mandic P, *et al.* Impact of specialty drugs on the use of other medical services. *Am J Manag Care* 2008;**14**:821–8.
 13. Sandhu RS, Trehan GJ, Douglas KM, *et al.* The impact of anti-tumour necrosis factor therapy for rheumatoid arthritis on the use of other drugs and hospital resources in a pragmatic setting. *Musculoskeletal Care* 2006;**4**:204–22.
 14. Hagel S, Petersson I, Bremander A, *et al.* Trends in the first decade of 21st century healthcare utilisation in a rheumatoid arthritis cohort compared with the general population. *Ann Rheum Dis* 2013;**72**:1212–16.
 15. Aga A-B, Lie E, Fagerli K, *et al.* Trends in disease activity, response and remission rates in rheumatoid arthritis during the last decade: results from the NOR-DMARD register. *Arthritis Rheum* 2012;**63** (suppl):S172.
 16. Hetland ML, Lindegaard HM, Hansen A, *et al.* Do changes in prescription practice in patients with rheumatoid arthritis treated with biological agents affect treatment response and adherence to therapy? Results from the nationwide Danish DANBIO Registry. *Ann Rheum Dis* 2008;**67**:1023–6.
 17. Simard JF, Arkema EV, Sundstrom A, *et al.* Ten years with biologics: to whom do data on effectiveness and safety apply? *Rheumatology (Oxford)* 2011;**50**:204–13.
 18. Arokoski J, Heistaro S, Heliövaara M, *et al.* Musculoskeletal disorders and diseases in Finland. Results of the Health 2000 Survey. National Public Health Institute; 2007, Report No.: KTL B25-2007.
 19. Radner H, Grisar J, Smolen JS, *et al.* Value of self-performed joint counts in rheumatoid arthritis patients near remission. *Arthritis Res Ther* 2012;**14**:R61.
 20. Heiberg T, Kvien TK, Dale O, *et al.* Daily health status registration (patient diary) in patients with rheumatoid arthritis: a comparison between personal digital assistant and paper-pencil format. *Arthritis Rheum* 2007;**57**:454–60.
 21. Puolakka K, Sokka T, Kautiainen H. Cell phone based automated monitoring of patients with early rheumatoid arthritis. *Arthritis Rheum* 2012;**64**(10 Suppl):163–4.
 22. Pope D, Tipler S, Kirwan J, *et al.* Implementing a patient-led service for chronic conditions. *Nurs Times* 2005;**101**:28–31.