

As the peak body for arthritis, Arthritis Australia is responsible for promoting awareness, early diagnosis and early intervention to improve and preserve sufferers' quality of life. In collaboration with its state and territory affiliates it provides a range of awareness, education and support services, as well as manages a national arthritis research program. Gaps in service delivery have been identified and action is being sought to build capacity and reduce incidence and associated costs. For example, the need to reach people from non-English speaking backgrounds has been identified as has the need to inform and educate GPs, pharmacists and other health professionals so that accurate and appropriate care and advice is provided.

Other Arthritis Australia's priorities include:

### Improving knowledge about arthritis

*"As the individual's appreciation of their condition expands and their understanding of the impact of their everyday decision grows, they are able to actively engage in the self-management, with the potential for reduced reliance on formal health care...." Painful Realities Report 2007*

The prevalence of arthritis (nearly 1 in 5 Australians) and lack of understanding of the disease within the community requires a significant investment to improve knowledge about arthritis. With this knowledge consumers will understand the need to see their doctor, get a proper diagnosis and follow a management strategy to improve their health and wellbeing.

There is evidence that mass media campaigns can change attitudes and alter behaviour. This is why Arthritis Australia has introduced an annual community service announcement TV and radio campaign with the support of Federal Government funding.

Better health outcomes would also be achieved by targeting rural/remote and multicultural communities.

Recently Arthritis Australia received a one-off grant of \$150,000 from the Federal Government to increase its awareness and education programs in rural/remote Australia. Programs will be held in Western Australia (Karratha, Broome, Esperance, Kalgoorlie); Northern Territory (Gove and Katherine); Queensland (Rockhampton, Mackay and Gladstone); and South Australia (Broken Hill and Port Lincoln).

However, this issue is so important that one-off funding is insufficient. Arthritis Australia will be urging the Government to invest ongoing funding to increase knowledge and understanding of the disease that will lead to early diagnosis and management.

Arthritis Australia is receiving Federal funding for a pilot program to determine the most effective ways of reaching and educating members of the Chinese and Greek communities about arthritis. At the end of the 2007-08 financial year the project will have established guidelines for the most appropriate programs to be delivered to these communities and which will inform a national strategy.

Also, by making arthritis a key budget area for the Australian General Practice Network further investment can be made in developing best practice through the provision of additional resources and education for GPs.

### Case Study

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*Hannah is a 68 year old widow living in the far northwest wheat belt. She has arthritis in her hip and knee and, although diagnosed some years ago, had visited her GP only occasionally for medication to relieve the pain. Recently, Hannah travelled 250kms to attend an arthritis awareness seminar. With the knowledge she gained Hannah has taken simple but effective steps in managing her arthritis, particularly in the understanding and correct use of her medications. Hannah changed her lifestyle by exercising daily and changing her dietary habits. She has lost weight and is experiencing less pain. Because her local community has limited access to healthcare Hannah has asked that an arthritis seminar be held closer to her home so that her isolated community can also benefit from increased knowledge about their disease.*

**Recommendation: Ongoing investment in increasing consumer and health professional knowledge about arthritis by supporting rural/remote programs and building on resources and education for GPs.**

## **Increasing consumer knowledge of treatments available and improving access to allied health services**

More widespread access to appropriate cost effective interventions such as weight loss, exercise, self-management programs, total hip replacement and medicines, will reduce the costs to the healthcare system and the burden of disease.

But many sufferers are unaware there is a range of non-medicine treatment options available which will help their joints function better and significantly improve their quality of life. These include but are not limited to physical activity programs (e.g. warm water exercise and tai chi); mobility aids (e.g. walking sticks and orthotics); and allied health services (e.g. occupational therapists, physiotherapists and podiatrists).

Apart from lack of knowledge, another obstacle to accessing these products and services is the associated costs. According to the Australian Health Care Alliance (July 2007), 45 percent of Australians reported cost barriers to healthcare. Another 15 percent said they experienced financial hardship as a result of continuing to pay for expensive care.

Some private health funds provide rebates for some allied health services but not all Australians living with arthritis can afford these services, let alone the private health cover. A Medicare Chronic Disease Management (MCDM) item allows eligible patients to claim a maximum of five allied health services per annum. However, for many patients with more serious forms of arthritis, five visits are not enough.

To offer a more realistic and equitable scheme it is suggested that the number of services be further subsidised under MCDM for those patients matching criteria that might, for example, include being treated by a specialist, i.e. rheumatologist or orthopaedic surgeon.

***Recommendation: To offer a more realistic and equitable scheme it is suggested that the Medicare Chronic Disease Management item for allied health services be reviewed.***

## Case Study

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*Brian, aged 44, lives in a regional city and has recently been diagnosed with rheumatoid arthritis. He is unable to see the visiting rheumatologist for 12 months due to a 30 patient waiting list. Brian has to travel to the nearest capital city (800km). The cost of his travel is not covered by the Patient Assisted Transport Scheme because a limited rheumatology service is provided in his home town – despite the long waiting list. Brian has private hospital cover but no ancillary cover. Therefore it is very expensive to access allied health services, i.e. physiotherapy and occupational therapy, both of which he needs in the long term. Because he cannot get an appointment to see the visiting rheumatologist at the local district hospital he cannot access the allied health services offered by that hospital. Although he is working full time to support his wife and four children, Brian is very concerned about his future working ability. Not only would he benefit from regular allied health therapy he would also benefit from an arthritis self-management program to help him come to terms with his condition and gain knowledge about its management. Due to limited financial and human resources self-management programs are not offered in his area.*

## **Ensuring quality use of medicines as well as access to appropriate medications to arrest joint damage**

*“There is increasing evidence that early, aggressive treatment of rheumatoid disease can significantly slow the progression of joint damage.” Painful Realities Report 2007*

There should be a review of the PBS criteria for certain medications so that some special-needs arthritis sufferers have the opportunity to benefit at a time when treatment is most critical.

A number of newer, so-called biological medications (etanercept, adalimumab, infliximab – the anti-TNF agents) are available in Australia for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. Rituximab is another recently listed agent for rheumatoid arthritis. These agents are expensive (around \$20,000 per annum) and their subsidisation by the PBS is limited to those with severe and late-stage disease, in whom major joint damage has already occurred. No patients can afford these medications on private prescription due to the ongoing nature of treatment.

However, the guidelines for their use in Australia do not reflect the evidence base. The anti-TNF agents have been shown to be very effective in early rheumatoid arthritis especially when taken with methotrexate. Therefore, in those with bad outlook rheumatoid arthritis (e.g. high level rheumatoid factor and/or cyclic citrullinated peptide (CCP)), it would be reasonable to use them in those who fail to respond quickly to methotrexate.

To access treatment with biological agents for psoriatic arthritis, patients are required to have 20 or more affected joints, but rarely do. Indeed, this is reflected in the scientific trials where the mean joint score is 6-8. It seems more equitable to decrease the joint count to 8-10 in psoriatic arthritis rather than restrict it to the most severe margins of disease.

In ankylosing spondylitis severe X-ray changes are necessary to qualify. This means that only longstanding disease gets the new treatments because X-rays may take 5-10 years to change. It would seem much fairer to require objective evidence of sacroiliitis on MRI or other imaging as proof of significant disease rather than wait until the illness is irreversible.

## Case Study

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*Claire is 38 years old and an experienced paralegal. She developed psoriasis at age 21 and struggled over many years to control her skin disease with creams and light therapy. Ten years ago she developed severe arthritis affecting multiple joints including her hands, knees and ankles. The pain and swelling were so severe that she eventually had to give up her job. She was barely able to look after herself, and struggled to care for her two toddlers then aged three and two. Claire and her family had to move in with her mother in order to try to cope. The disease was relentless. None of the then available therapies were successful for her and she became angry and depressed. Finally, through the benevolence of a teaching hospital drug committee, she was able to access etanercept, one of the newer biological drugs. This enabled excellent control of her arthritis and allowed Claire to do many everyday tasks that we take for granted. “I brushed my daughter’s hair for the first time in her life today,” Claire told her rheumatologist. Claire is now fully functional and considering a return to work.*

**Recommendation: That Arthritis Australia work with the Federal Government and the Australian Rheumatology Association to review the criteria for biological medications to ensure they reflect the scientific evidence and allow reasonable access for those patients expected to benefit.**

## **Strengthen capacity to improve consumer needs and service delivery**

*"A full cost effectiveness analysis of the Osteoarthritis of the Knee (OAK) Program would appear a worthwhile exercise on which to base decision-making regarding the future of the program."*

Through its state and territory affiliates Arthritis Australia delivers a range of consumer services, including self-management programs, warm water exercises, support groups and a national toll-free telephone information line. Reviewing services is part of our ongoing business strategy to ensure quality improvement and to meet consumer demand.

Arthritis Western Australia has developed a six weeks program for people with osteoarthritis of the knee. It is conducted by health professional practitioners, is free of charge to patients, runs for 2.5 hours a week and includes pain management strategies, exercise instruction, joint protection, medication/analgesia, balance and falls prevention, coping with negative emotions and self-management skills (e.g. goal setting, problem solving and cognitive techniques).

The specific aims of the program are to improve participants' quality of life by reducing pain and increasing physical function.

Using internationally accepted measurement standards a randomised control trial of 145 participants has shown significant, long-term clinical improvements in pain, function and quality of life, while there are signs that the OAK program may lead to cost savings in the formal health care sector.

More than 400 people have undertaken the program over the past few years and, in order to further validate outcomes and cost effectiveness, funding is sought to engage an independent health economist to undertake this task.

***Recommendation: The Federal Government invest in a full cost effective analysis of the Osteoarthritis of the Knee Program so that its potential for national implementation can be properly assessed.***

## Case Study

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*Sally, aged 39, enrolled in the OAK program because her painful knees limited daily living activities. She was on a disability pension and had been prescribed antidepressants by her general practitioner. As a central part of OAK, Sally commenced a weekly regimen of increased physical activity that included aerobic, strengthening, flexibility and balance in conjunction with pain management strategies and other self-management activities. She reported improved pain and increased tolerance to physical activity over the course duration. At the six months follow-up assessment Sally had continued her exercise and was feeling positive about her progress. At the 12 months follow-up Sally was in full time employment, remained positive about her situation and was still physically active.*