Executive Summary

A survey of all rheumatologists in Ontario was carried out in 2007 by the Arthritis Community Research and Evaluation Unit (ACREU) to examine the current supply of rheumatology human resources, geographic location of delivery of services to patients by Local Health Integration Network (LHIN), amount of service delivered, reported waiting times for rheumatology services, characteristics and practice patterns of rheumatologists, care for patients with inflammatory arthritis, and availability of and referrals by rheumatologists to other services and programs. This survey updates a similar survey carried out by ACREU in 2000.

A total of 164 practicing rheumatologists were identified in Ontario in 2007: 152 responded to a two part questionnaire (response rate 93%). All of these answered Part 1 of the questionnaire on location of practice, clinic hours and waiting times. Seventy-four percent (n=111) also answered questions in Part 2 on practice patterns, rheumatology characteristics, care for patients with inflammatory arthritis, and availability of and referrals to other services, representing an overall response rate of 68% to Part 2.

The overall provincial per capita provision was 1.20 rheumatologists per 100,000 population equivalent to 1.00 full-time equivalent (FTE) per 100,000 population. Apart from the South East LHIN, the absolute number of rheumatologists tended to be higher in the LHINs with teaching hospitals (LHINs that have a university that offers medical training).

Twelve percent practiced in more than one LHIN with most cross-boundary flow between urban LHINs, primarily the Greater Toronto Area. The main exception was the North East, where traveling rheumatologists more than doubled the care for that LHIN.

The overall amount of direct clinical care provided by rheumatologists was 38.3 hours (9.6 half days) per week per 100,000 population. On average, rheumatologists in Ontario each provided 32 hours of direct clinical care per week with wide variation across LHINs. There was very little change in the amount of rheumatology provision across Ontario per 100,000 population between the 2007 and 2000 surveys of rheumatologists.

As expected, the mean waiting time reported by rheumatologists for likely inflammatory patients was lower than that for non-urgent referrals, 3.6 weeks versus 13.4 weeks respectively with the longest waiting times reported for northern Ontario.

The following summary points refer to the 63% of rheumatologists responding to Part 2 of the questionnaire:

Slightly more than one-third of respondents were female (37%). The mean age was 43 years and mean years in practice was 18. Almost one-third of rheumatologists planned to retire within ten years.

Adults comprised the majority of the patient population. Two fifths of rheumatologists reported a subspecialty, most frequently rheumatoid arthritis. Most rheumatologists had a hospital appointment, and over half had a faculty appointment. Clinical practice comprised the largest proportion of a rheumatologist's time. Rheumatologists in teaching LHINs spent significantly less time in clinical activities and significantly more time in research, teaching and administration compared with rheumatologists in non-teaching LHINs.

The proportion of rheumatologists reporting difficulties scheduling follow-up appointments was similar to 2000, with 57% in 2007 reporting such difficulties. The proportion of rheumatologists able to see urgent referrals within a week “all the time” decreased from 2000 (43%) to 2007 (33%). Two thirds of rheumatologists indicated that their practice volume was increasing, compared with three years ago, a continuing trend from the 2000 survey.

Rheumatologists were asked about barriers to practicing as they would like. The most frequently mentioned barrier was “financial barriers, such as affordability of drugs to patients”: this was also the case for the 2000 survey. “Billing policies and regulations for consultation and follow-up visits” were not as highly ranked as a barrier as in 2000, when it was the second highest reported barrier. In line with this a higher proportion of rheumatologists in 2007 (20%) than 2000 (7%) reported they could easily make ends meet from rheumatology practice alone.

Most rheumatologists saw patients with inflammatory arthritis. The majority of rheumatologists reported their inflammatory caseload had either remained the same or had increased. Approximately half of patients seen in the last month had inflammatory arthritis. The mean reported proportion of inflammatory arthritis patients referred within three months of symptom onset was 44%.

Combination disease modifying anti-rheumatic drugs continued to be the treatment of choice, with over two thirds of rheumatologists reporting that more than 50% of their patients received this therapy. Overall the use of biologics appeared to be increasing with 42% of rheumatologists in LHINs with teaching hospitals and 81% in LHINS without teaching hospitals reporting that biologic prescription had increased in the past year ($p=0.05$). One-quarter of rheumatologists in Ontario supervised an infusion clinic.

Forty-five percent reported that they were involved in new emerging models of care, most commonly early arthritis clinics and comprehensive team care/coordinated care programs.

Overall, reported availability of services (i.e., orthopaedic surgery, The Arthritis Society, non-pharmacological therapy) for patients to manage their arthritis was quite high. While most rheumatologists who reported services available made referrals to a range of services, the average percentage of patients being referred to specific services varied by service. Physiotherapy was the service with the highest reported percentage (35%) of patients referred. Perceived appropriateness of waiting times varied across services.

When compared to the 2000 data the lack of an increase in the amount of rheumatology service in 2007 as well as continued geographic maldistribution is problematic given the number of people with arthritis is increasing. However, changes in billing policies have had a positive effect on rheumatology practice and may influence potential trainees regarding rheumatology as a profitable specialty. A comprehensive solution that is rooted in evidence-based research is need to better understand how to increase the number of rheumatologists and how best to utilize available health human resources and to ensure timely and appropriate care for individuals with arthritis in Ontario wherever they may live.