Summary (1 of 4)

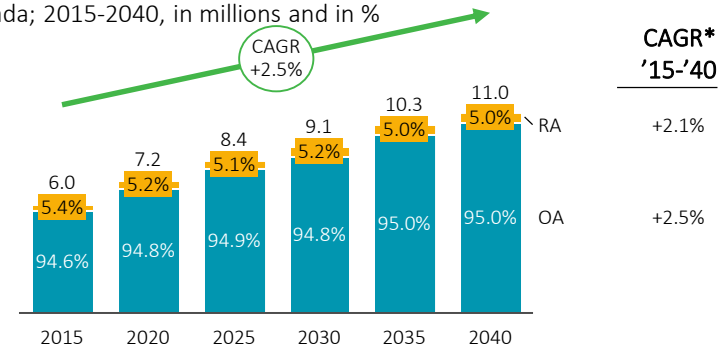
Indirect and intangible costs of OA and RA are over $19 billion and $4 billion in Canada and in Quebec respectively

The objective of the study is twofold:

- To aggregate the main resources on indirect costs associated with the disease.
- To provide a roadmap with measures to help improve the delivery of care and support for people living with inflammatory arthritis.

Current and future prevalence (# of people with arthritis) of osteoarthritis (OA) and rheumatoid arthritis (RA) in Canada

Canada; 2015-2040, in millions and in %

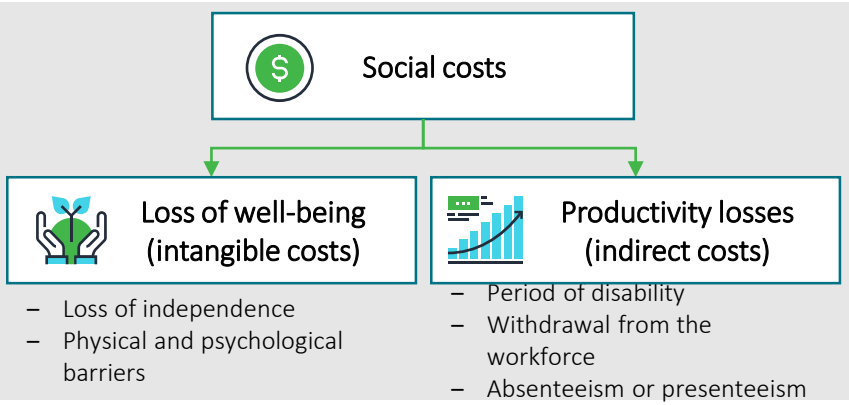


	CAGR* '15-'40
RA	+2.1%
OA	+2.5%

- OA and RA are the two most common types of arthritis and make up for most of the costs associated with arthritis
- RA is the most common form of inflammatory arthritis.

Estimate of aggregate annual indirect and intangible costs of OA and RA – In Canada and Quebec

2016; in $CAD billions



Sources: Birnbaum et al. *(5); Oxford Economics (67); Sharif (80); Li and Gignac (46); Arthritis Alliance of Canada (2); Statistics Canada (83, 85, 87, 88); Aviseo Analysis*

*CAGR: compound annual growth rate

Summary (2 of 4)

To improve health outcomes and minimize indirect costs, complementary care must be the priority

1 Primary and complementary care

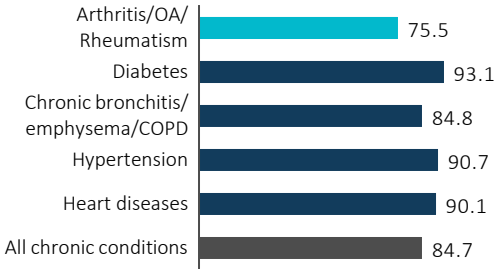
- Access to insured complementary care is limited
  - Over 18,000 people are on waiting lists for hospital centers out-patient physical therapy clinics
  - On average, the median waiting time was 7.6 months
- Expert practitioners and central triage are a success in Ontario
- Because of personal budgetary constraints, many needs are not met
- Unmet needs add to indirect costs

2 Case management and self-management

- Self-management support needs are greater for arthritis than for other diseases.
- The offer is more limited than in Ontario

Perception of being well-informed on one's disease – By disease type

Quebec, 2010-2011, in %



3 Employment supports

- Job retention and return-to-work help reduce indirect costs for all stakeholders in society, and improve the patients' quality of life
- It would therefore be preferable to decrease hours worked than to exit the workforce
- Employment support is suited to those who can get back to full-time work. But the majority of people living with the disease are neither unemployable nor able to work full-time
- 84% of chronically ill people face episodic disability, and are able to work during remission periods

4 Income supports

- The disease leads to additional expenditure and temporary income losses
  - Constraints on availability of liquid assets in the short-term, coupled with the rigidity of the support system can lead some people to leave the workforce
- Lack of coordination between the various levels of governments.
  - Lack of consistency in the definition of disability
- Eligibility criteria are sometimes too restrictive and miss their target, having a perverse effect or adding to indirect costs

Sources: Birnbaum et al. *(17, 18); Perreault* et al. *(69); ISQ (23); Public Policy Forum (72); Aviseo Analysis*

Summary (3 of 4)

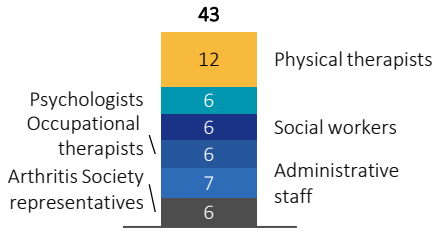
Lack of complementary care and creation of Service Request Dispatch Centers (CRDS) make implementation of multidisciplinary teams a top priority

Team (stand alone program)

43 FTE

Distribution of staff dedicated to pilot project

2018; FTE resources



Services

- Care and guidance
- Case management and follow-up
- Self-management
- Home care

Clientele

- Main clientele: People with inflammatory arthritis
- Residual clientele: People with osteoarthritis

Eligibility criteria

- New diagnosis
- People at risk of:
  - Developing functional limitations
  - Relapsing or seeing their disease status negatively impact their determinants of health

Implementation in 1st line

Option 1: Implementation in FMG or CLSC

1st line + Multi. teams

Option 2: Stand alone program with its own budget

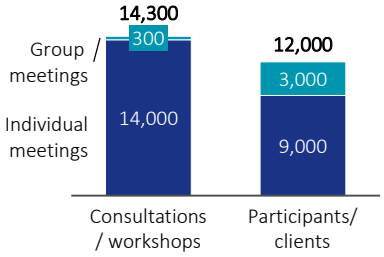
1st line + Multi. teams

Projected results

9,000 clients

Pilot project projected results

2018; # of consultations and participants

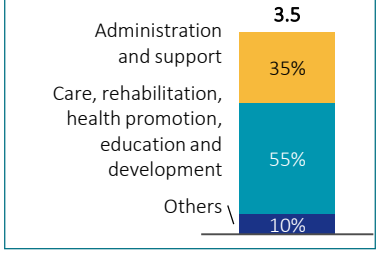


Costs (stand alone program)

$3.5M

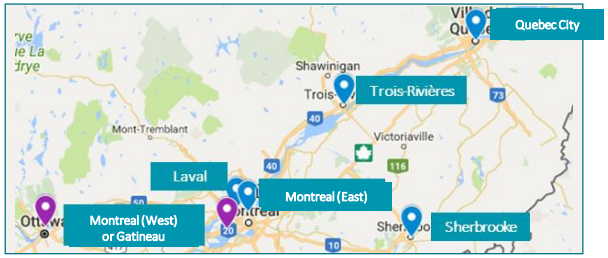
Pilot project total budget breakdown

2018; In %, Budget in $M



Implementation areas

6 teams



Sources: Quebec Ministry of Health and Social Services (60); Arthritis Society (25, 35, 57); Arthritis Alliance of Canada (2); Aviseo Analysis

Summary (4 of 4)

Authorities should also consider implementing the following measures

	Observations	Recommendations	Suggested measures
Triage	– It has been proven that central triage made by expert practitioners can decrease waiting times	1 **Make use of expert practitioners to optimize central triage**	– Add a person specialized in the treatment of arthritis to the CRDS team to review rheumatology requests
Training	– For an efficient triage, specialized professionals must be trained in the treatment of arthritis	2 **Make sure there are enough** specialized professionals **to meet the needs (triage, case management, multidisciplinary teams)**	– Promote the specialized training program and provide sufficient incentives to complete it or develop specialized training on-site
Organization of health care	– Expert practitioners can optimize care, but its development is limited by the regulatory environment – In Ontario, expert practitioners are increasingly integrated, but their services are still sub-optimally used	3 **Make sure expert practitioners can accomplish 100% of their task in a specialized practice**	– Extend practice to expert practitioners in order for them to work with or without supervision, if applicable – Ensure some funding or independent billing is in place for expert practitioners
Case management and self-management	– Self-management online courses are not part of primary care	4 **Incorporate self-management online programs into the health care system**	– Appoint a contact person who is already part of the system
Employment supports	– Job retention and reinstatement help reduce indirect costs, and improve patients' quality of life	5 **Improve the flexibility of financial supports** 6 **Improve the flexibility of work**	– Paid sick and flexible leave credit for caregivers – Make large organizations to develop a disabilities management plan
	– The current social-fiscal system does not reflect the needs of the majority of people living with chronic conditions	7 **Adapt employment supports to fit episodic disabilities in order to promote productivity and retention**	– Improve short-term sick leaves or broaden the definition of disability – E.g.: Disability insurance could be more flexible, instead of maintaining the 15 consecutive weeks or 75 complete days criteria
Income supports	– Access to income supports is sometimes conflicting with job retention – The Canadian social-fiscal system is characterized by a lack of coordination between its different stakeholders	8 **Update and standardize definitions and eligibility criteria to:** – **Remove any work disincentive** – **Increase the available income for people living with a disease**	– Different levels of government to standardize the definition of disability