groups to answer specific questions. This could have the benefit of reducing the statistical variation in outcomes recorded, increasing statistical power, and hence reduce the number of patients required for a particular study. Laurent et al. [3] highlight the importance of sampling size given that some of the trials they reviewed were too small.

In summary the messages therefore are (1) a clear statement about the purposes of the study, (2) better training and standardization of observers, and (3) recruitment of homogeneous patient populations to answer specific questions.

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HEALTH SERVICE REFORMS AND ACCESS TO SPECIALIST SERVICES

During the past few months we have witnessed a high profile political debate about the organization and funding of the health service. The debate seems to be ideologically led, with the government trying to introduce quasi-market forces into the service to make it more 'efficient', while the opposition has highlighted the anomalies and what it sees as injustices in terms of unequal access to some, particularly non-urgent, medical services. Amidst this supercharged atmosphere, in which the BMA and others are taking positions, and amidst the plethora of statistics and counter-statistics, there is the distinct danger that we forget the truth about the current provision of health care in some sectors. An examination of the existing response to the needs of those with musculoskeletal disorders offers a timely reminder of the baseline for this debate.

The recent OPCS survey [1] estimated that there are some 3 million people in the UK with disability associated with musculoskeletal disorders. These are by far the most common cause of disability and in the UK [2] and elsewhere [3,4] have been shown to produce substantial costs to the community in terms of both lost productivity, and demands upon the health service.

One recent community survey [5] funded by the Arthritis and Rheumatism Council (ARC) found that almost one-quarter of the adult population reported that they were currently suffering from pain, swelling or stiffness in their joints, neck or back. Yet the survey found that less than half of those who were experiencing some level of restriction in everyday activities in association with rheumatic diseases had actually been referred to a specialist [6]. If this held true for the country as a whole, then as a background to the current debate, over one million adults experiencing disability in association with rheumatic diseases are living through this experience without the benefit of specialist advice.

The reasons for this are likely to be complex. Current provision of rheumatological services is variable [7], and in the area covered by the ARC survey, achieved only 39% of the recommended cover. The level of priority given by successive governments to the development of rheumatological services is perhaps best reflected by the fact that the majority of chairs in rheumatology at our major teaching hospitals are funded by charity. Also, waiting lists, for example for hip operations, one of the most successful areas of
intervention in the rheumatic diseases, are known to vary considerably from area to area [8].

Even if rheumatological consultants or orthopaedic surgeons are on hand, how do the gatekeepers to these scarce resources, the general practitioners (GPs), manage the enormous demand placed upon them [9]? Little is known about the decision making processes of GPs, and what we know about their propensity to refer suggests that there is considerable variation in both referral rates [10] and also possibly on the pressure brought to bear on the GP by the patient [11]. We also know little about the GP’s knowledge of their local rheumatological facilities and service, or what they know about services outside their area.

What we know about the lay referral process suggests that the variability at the professional level is repeated at the lay level. What, for example, are the factors that mediate between a person experiencing problems with their joints, and the decision to seek help from their GP? Evidence from the public’s response to hypothetical medical problems suggests that many factors, including social class, will affect the decision making process [12].

These layers of decision making, by lay and professional people alike, make the question of access to specialist services very complex. Yet it is clear, as indicated in the article in this journal by Foster and colleagues from Newcastle [13], that those who are referred tend to receive better packages of care from the health and welfare services than those not referred, despite apparently equal levels of disability. We need to ask, are the current reforms of the health service likely to make any impact upon access to specialist services, and will they reduce the substantial pool of unmet need that exists in the community?

To be able to answer this question we must have answers to questions dealing with (1) the process of referral; (2) the provision of services; and (3) the efficacy of those services. By-and-large we know most about the provision of services, although the advent of audit [14] should help us learn more about their efficacy. If, as evidence from surveys of disability suggest [15], there are likely to be many times the number of people disabled by osteoarthrosis as by rheumatoid arthritis, why do the former miss out on referral to the specialist? As Foster shows it is not simply a matter of the difference in degree of disability. Do GPs think that consultants have little or nothing to offer for these patients? If so, then reforms which give GPs more power to refer their patients are going to make little impact on this substantial block of unmet need. More likely a system of shared management between hospital and primary care, working under locally agreed guidelines, would offer a better model of care [15].

Suppose that reforms do provide better access for those in need. As the provision of specialist services is still well below accepted norms, how will existing facilities cope with such an increase in demand? What provision has been made in terms of national funding, and in the development of local contracts [16], for responding to this improvement in access to specialist services? Such matters are further complicated by an ageing population [17] and the associated increase in prevalence of joint troubles. Basic guidelines for rheumatological provision may have to be reconsidered as prevalence rises.

There is, unfortunately, little sign that any of these questions has been considered. Given the effect of rheumatic diseases on disablement this does not bode well for the future. The fact that much still needs to be done to provide even a basic rheumatological service seems unacknowledged in the current debate. The absence of a proper evaluation of the impact of the reforms, coupled with the lack of appraisal of the effect of the internal market on undergraduate and postgraduate medical and therapist education, gives little confidence that health service reforms will bring the benefits which the population wishes and anxiously awaits.

It is also unlikely that the funding of the health service will increase at the pace required by the ageing population, or by advances in medical technology. Given that for the foreseeable future additional monies are likely to be targeted at information technology largely devoted to increasingly sophisticated contracting arrangements, often preoccupied by the surgical model, it behoves rheumatologists and associated researchers to monitor carefully how the remaining resources are deployed. Audit makes a welcome contribution to this objective. There should also be no apologies that in rheumatology primary outcome is concerned with quality of life, rather than mortality. Much of the medicine is now about such matters [18].

Incisive thinking is needed to tease out the benefits produced by treatment, and as much investment into measuring outcome and quality of life is needed as is currently being devoted to contracting arrangements. We need to demonstrate that a proposed intervention works, that it produces worthwhile gains which justify the loss of other opportunities, and that it really does improve quality of life in the patient’s terms.

The next task is to appraise the purchaser, both districts and GPs, of the significant gains that patients experience as a result of the rheumatologist’s intervention. It will be necessary to convince them that these gains are as important as others which are more obvious (e.g. surgical), and also that in general, disabled people do not receive a fair share of the resources available [19]. Only then will purchasers be able to make rational decisions about referral to specialist services. Addressing such questions with energy, precision and tenacity should bring benefits to the millions of ‘customers’, actual and potential, whose life is currently impoverished because of the lack of appropriate intervention. It must, however, be made very clear that the current reforms are unlikely to make much impact on unmet need when so much remains to be done to provide a uniformly adequate basic service.

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The thought of more meetings, and in particular, more journals, is a depressing one. What possible justification can there be for yet another special society in the field of rheumatology? None I suspect, but 'regenerative joint disease' is a subject that involves many disciplines, and cannot be regarded as the property of the rheumatologist alone.

At the beginning of this century pathology and radiology facilitated the division of chronic arthritis into two main categories: atrophic and hypertrophic [1]. The atrophic form is now known as inflammatory arthritis, and the hypertrophic as osteoarthritis (OA). The term 'degenerative joint disease' was then used to describe OA because of its association with ageing, and the presence of articular cartilage destruction. However, hypertrophy of the bone and soft tissues were the features that first distinguished OA from rheumatoid arthritis, so perhaps it is time to relabel OA as 'regenerative joint disease'—a term that would fit with much of the current thinking about the condition [2].

During the last decade there has been a large, multidisciplinary increase in interest and research into osteoarthritis. The recognition that OA represents 'joint failure'—analagous to cardiac or renal failure—has helped stimulate the interest of a variety of disciplines. Research into OA has become the investigation of the integrity and control of the whole musculoskeletal system. An understanding of the pathogenesis of OA implies an understanding of the pathophysiology and biomechanics of joints. Clinically, OA is no less than the final manifestation of all forms of joint disease.

Osteoarthritis research sits uncomfortably at the periphery of many societies and meetings. Rheumatologists remain primarily interested in the inflammatory arthropathies, orthopaedic surgeons are concerned largely with the reconstruction of damaged joints, and interested biologists, physiologists, pathologists, biochemists and engineers are always in a small minority within their own societies. Over the last few years many special meetings have been arranged to help exchange information between different investigators interested in OA. Some have reflected the multidisciplinary nature of relevant research better than others. However, most have been solely dependent on the current interest in their respective fields, and dissemination of pressure from patients for referral. The OARS will have together researchers from a variety of fields and to encourage cross-fertilization of their results and projects. In addition to meetings and a society journal (Osteoarthritis and Cartilage), the OARS will have three standing committees, one on basic research, one on clinical research, and one on the treatment of OA. These standing committees will address issues of current interest in their respective fields, and dissemi-

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REGENERATIVE JOINT DISEASE