ARTHRITIS NEW ZEALAND
KAIPONAPONA AOTEAROA
Our Vision: Improving the life of every person affected by arthritis
Ko tō mātou aronga: Kia whakapiki i te oranga o te hunga kua pāngia e te mate kaiponapona

Submission to the Health Select Committee in support of the petition from Arthritis New Zealand

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This submission comes from a petition circulated at the launch of the Deloitte Access Economics Report on the Economic Cost of Arthritis in New Zealand 2018. This petition asked:

That the House pass legislation to establish a national model of care for people with arthritis with particular emphasis on gout arthritis as a form of arthritis that disproportionately impacts Māori and Pacific communities.

Recommendations made by this submission:

- The Ministry of Health be asked to formulate a national strategy for the management and treatment of arthritis and report back to the Health Select Committee in 2021
- That the development of a Model of Care for arthritis be commissioned and resourced by the Ministry of Health by 2021
- The Ministry of Health be asked to facilitate research into the actual numbers of children and young people under 15 who have arthritis
- Each DHB be asked to include specific provision for management of gout arthritis, particularly for Māori and Pacific populations in their area in their 2020 and future Annual Plans including progress being made on increasing the percentage of people on a best practice treatment programme
- DHBs in areas with significant gout arthritis prevalence be asked to plan an awareness and education health workforce programme on treatment and management of gout arthritis in their regions
- Each DHB be asked to include an update on progress in managing gout arthritis in their reporting to the Ministry of Health

Introduction

This is Tristan-Perry Moananu, TP. He does not fit the popular stereotype of someone with arthritis. He is a young Pasifika man showing that arthritis affects anyone and at any age.

He was diagnosed with lupus – a form of arthritis, when he was 13 years old. He says his first winter after diagnosis was a struggle and overwhelming at times.

TP is a Pasifika leader at Wellington College, a Halberg Council member, a Parafed member, plays rugby and spends his time fundraising for organisations, including Arthritis New Zealand. He is also a youth leader at the annual camp run by Arthritis New Zealand for children with arthritis.

TP says, "I'm lucky I haven't been left alone in what I'm going through – sharing feelings and having good support is so important."

This submission provides many statistics, though each is a person like TP living with arthritis every day.

About Arthritis New Zealand

Arthritis New Zealand is a charitable trust registered with the Charities Commission and we have been in operation for over 50 years. We are a national organisation and are the main charity for people with arthritis.

Arthritis New Zealand's mission is "**Improving the life of every person affected by arthritis"** and is the "go to" organisation for information, advice and advocacy on all aspects of living with and managing arthritis.

We provide

- Comprehensive information, advice and support for people affected by arthritis
- Advice and support for Primary and Secondary healthcare organisations
- Advocacy on issues of concern to people with arthritis
- Research and research funding
- Volunteer programmes and peer support

Over 80% of our funding comes from grants and generous donations and community fundraising from throughout New Zealand. Only 19% of our funding comes from health contracts with DHBs and PHOs.

Audited annual accounts and our annual report are available here:
https://www.arthritis.org.nz/wp-content/uploads/2019/01/ArthritisNZ-2018-Audited-Financial-Statements-Final-1.pdf

https://www.arthritis.org.nz/wp-content/uploads/2018/12/Arth-NZ-Dec-2018-Final-AGM-paths-website.pdf

In the preparation of the submission we worked with a number of other groups and individuals who are listed on page 18 as well as canvassing a body of literature and research from both New Zealand and other countries.

Background

This submission is born of a petition circulated at the launch of the Deloitte Access Economics Report on the Economic Cost of Arthritis in New Zealand 2018. This petition asked:

That the House pass legislation to establish a national model of care for people with arthritis, with particular emphasis on gout arthritis as a form of arthritis disproportionately impacting Māori and Pacific communities.

It is a cry for help from people who have watched officials meet for decades with elevated ideals promoted, though no material change has been seen at flax roots level in the way arthritis is managed and treated.

Arthritis as a condition is rarely cited by policy makers when compared to conditions such as diabetes, cardiovascular disease and asthma. Arthritis could be named the Cinderella of long-term conditions.

The petition wording reflects the frustration of our consumers. Therefore we are asking for the support of the Health Select Committee for the recommendations made in this submission.

In essence, we seek a change of practice.

One senior clinician expressed the feelings of many people with arthritis when he noted that :..***these discussions have been going on for 20 years and little has changed***."

There is currently no nationally consistent model of care for people with arthritis in New Zealand. NZ currently lags well behind other Western and developed countries in this regard.

In Australia an Australian National Strategic Action Plan for Arthritis has been developed to provide guidance on key priorities and actions to improve arthritis prevention and care. Arthritis Australia has led the development of the action plan on behalf of the Australian Government Department of Health. The draft action plan is in the feedback stage.

We note that as we write this submission the Minister of Health is committing to rolling out a national cancer plan to improve access to fair and consistent cancer treatment regardless of

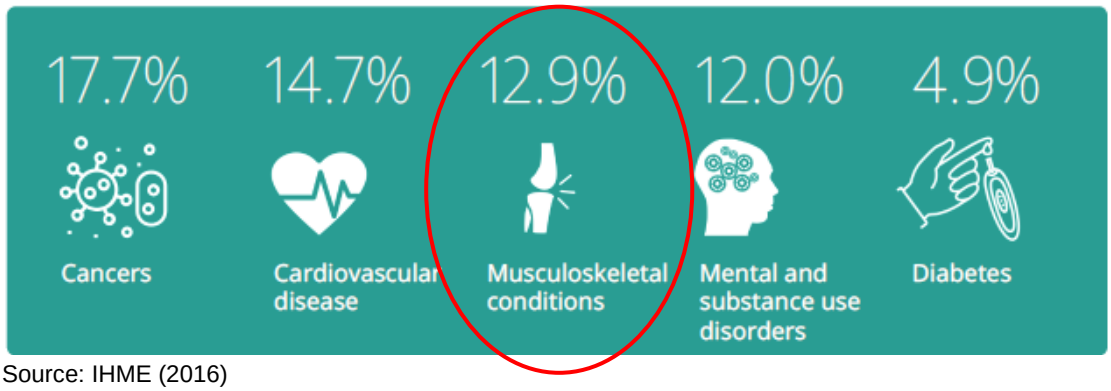
where people live. He was quoted on Radio New Zealand's morning report on February 1st saying that "no-one would expect to wait 13 hours for a decision when they are in excruciating pain". He was talking about cancer treatment but our consumers ask why their pain doesn't count?

We need the same fair and consistent treatment for people with arthritis.

This submission with its recommendations will shine a light on the shortcomings of planning to date and the need for significant change.

The graphic below shows comparative percentage of costs for selected conditions[1]. It shows the comparative importance of the cost of musculoskeletal conditions (including arthritis) in New Zealand.

This illustrates that musculoskeletal conditions (of which arthritis is the major condition) have a similar level of cost as mental health and substance use disorders.



Source: IHME (2016)

Section 1

1.1 Arthritis in New Zealand

***Milly was told to stop working.**

Milly is a single woman, living alone. She was diagnosed with osteoarthritis at age 52 while working part time as a teacher aide. She loved her work with special needs children. Four years later her arthritis has deteriorated to such an extent, she has very reluctantly given up work as her mobility has failed.

"I would really have appreciated some assistance to help me stay in the workforce," she told Arthritis New Zealand. "Now I am not working I feel as though I have been tossed on the scrapheap. I was told that I would be better off giving up work and going on a benefit. Surely there is a better way of helping people like me".

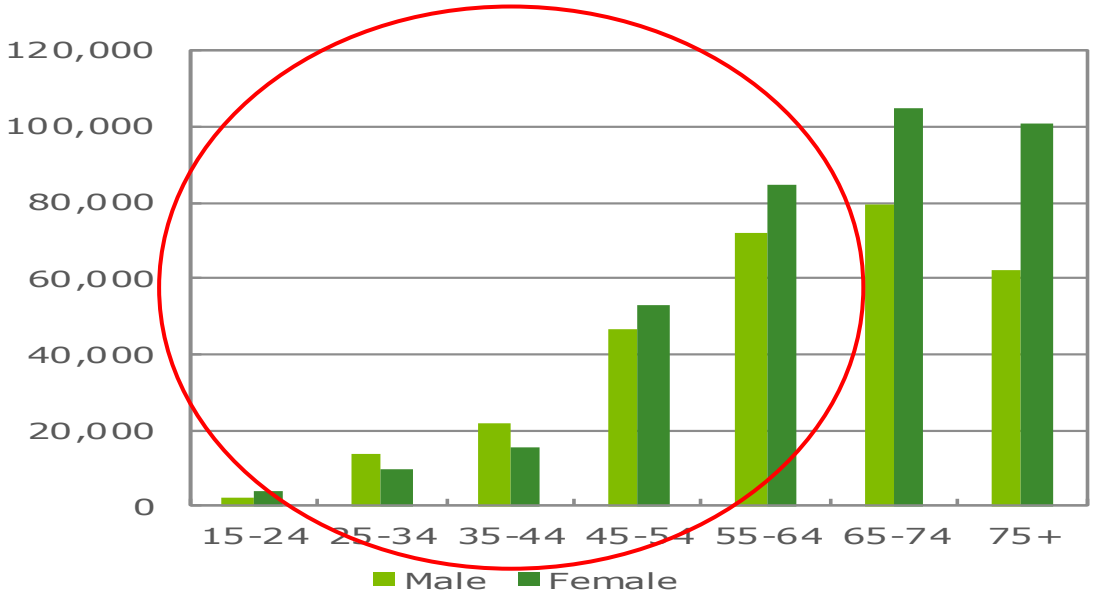
*Name has been changed to protect identity at request of client.

Currently there are 1:6 (670,000) people in New Zealand affected by arthritis. This number is projected to reach **one million** by 2040.

As previously noted, there is NO national strategy and model of care to manage the escalating numbers. While there is some planning in place, it is limited and slow moving. This submission and its recommendations can strengthen this planning.

One of the most pernicious myths about arthritis is that it affects only the elderly. In fact, 49% of people who have arthritis are of working age and this number is expected to increase.

Prevalence of arthritis by age and gender 2018 - *49% of people who have arthritis are of working age*

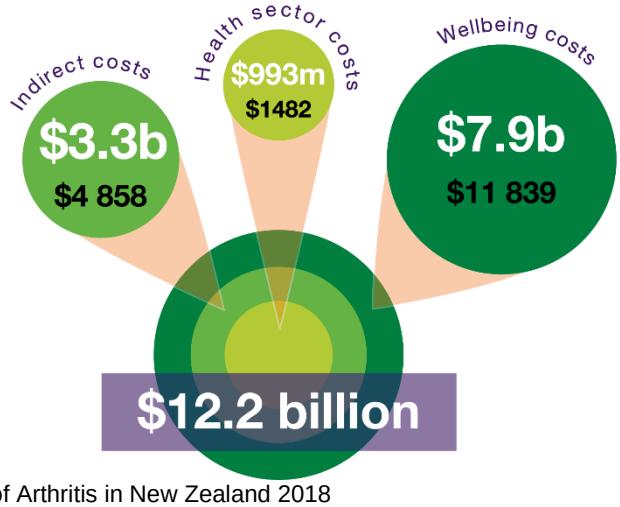


Source: Economic Cost of Arthritis in New Zealand 2018

1.2 The cost of arthritis

Every year arthritis costs New Zealand an estimated $12 b [2].

The breakdown of these costs per annum in the graphic below shows the total national cost p.a. The numbers in white reflect the total cost, while the numbers in black show the cost per person.



Source: Economic Cost of Arthritis in New Zealand 2018

This $12 b p.a. includes:

Wellbeing ($7.9 b)

- Arthritis significantly reduces healthy years lived. The loss of wellbeing for people with arthritis is estimated to cost an additional 44,930 disability adjusted life years (DALYS)
- Loss of wellbeing incudes the impact of pain, suffering disability and premature death

Indirect costs ($3.3 b)

- Informal and formal carer costs ($1.5 b)
- Loss of productivity ($1.2 b)
- Efficiency losses associated with lost tax revenue and government payments ($390 m)

Health sector costs ($993 m)

- Hospital inpatient and outpatient costs ($321 m)
- Cost of GP visits, specialists and allied health services ($210 m)
- Pharmaceuticals ($69.5 m)

Behind these bold figures are the experiences of hundreds of thousands of people who are often living in excruciating pain, having a devastating impact on their mental health and wellbeing.

It is worth noting that the greatest cost of arthritis is the loss of wellbeing.

Arthritis New Zealand made a submission to the Mental Health and Addiction Inquiry stating the strong link between chronic conditions such as arthritis and mental health.

A cross-sectional study in the rheumatology outpatient clinic at Waikato Hospital showed that depression and anxiety disorders were reported in approximately one third of patients affected. This finding is reinforced by research by He et al (2009), Dickens et al (2003), finding that people with arthritis are more likely to suffer from depressive illnesses [3,4].

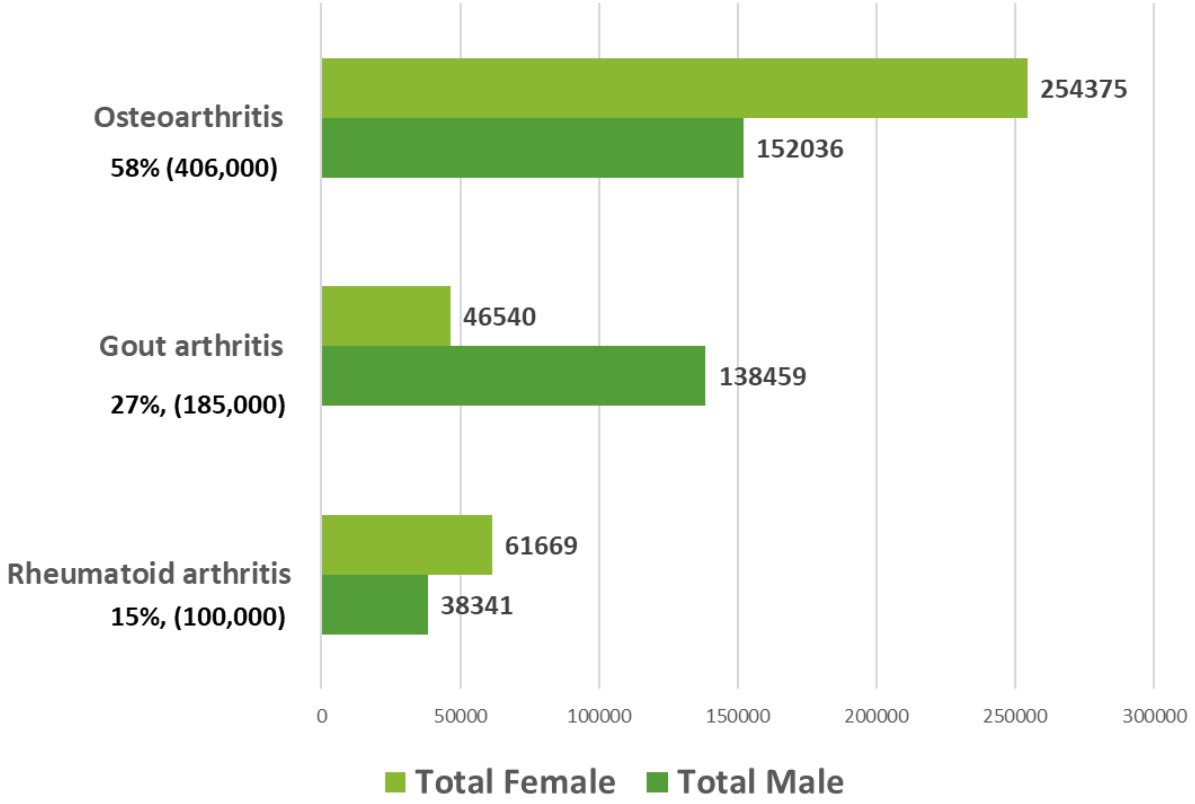
Meaning the projected increase of the number of people with arthritis to one million by 2040 will also have significant implications for mental health services.

By improving the preventative and proactive management of arthritis at an early stage the mental health of people with arthritis would be significantly enhanced. In turn, this would contribute to improved wellbeing and increased productivity, with an additional benefit of lowering long term costs to the health system. It would particularly benefit young adults with arthritis, lending weight to the need to identify the numbers of children and teenagers living with arthritis.

Feedback from consumers has emphasised that mental health support is largely provided at crisis point. Pain management is vitally important – if pain is not well-managed the repercussions for mental health can be significant. Good and early intervention would greatly benefit younger people with arthritis.

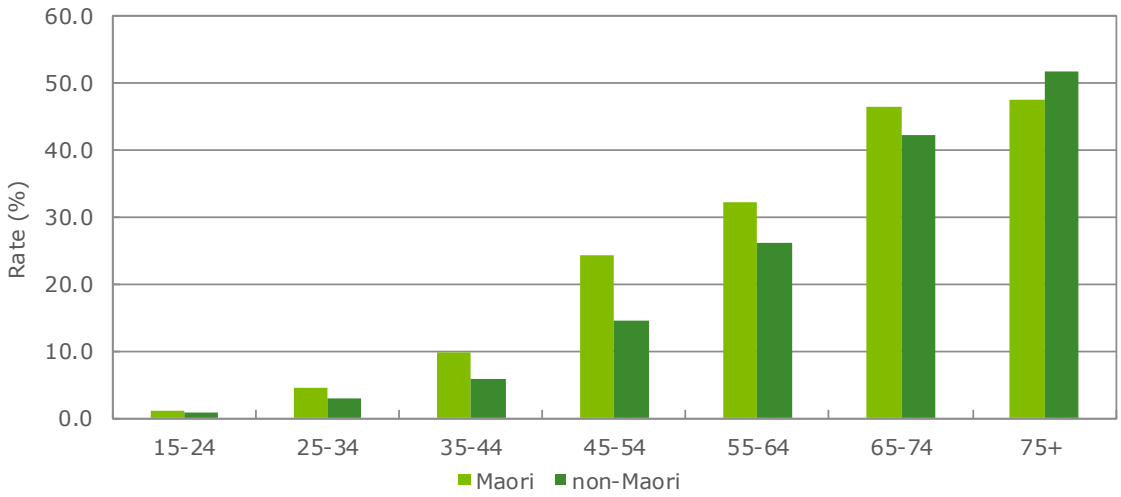
1.3 Prevalence of arthritis

There are over 140 different forms of arthritis, with the most common in New Zealand being:



Source: Economic Cost of Arthritis in New Zealand 2018

Arthritis is more prevalent in the young Māori population compared to the non-Māori population



Source: Economic Cost of Arthritis in New Zealand 2018

Arthritis also affects children and teenagers but there is no current information available to provide accurate data on the numbers of children and teens who have arthritis.

Management of arthritis differs from area to area. Arthritis New Zealand has identified a pressing need for nationally consistent guidelines to be used in the management of arthritis across the country. We call such guidelines a model of care.

1.4 Consideration of a model of care

A model of care is a principle-based guide describing evidence-informed best practice care for particular health conditions or populations. The focus is on person-centred care with consideration of applicability in local settings and at a regional or national level. A model of care is not an operational plan for a health service or a clinical practice guideline. A model of care is usually presented as a document describing this best practice care for particular health conditions (in this case, musculoskeletal conditions) [5].

A clinical framework, based on evidence, which guides the delivery of consistent care for those with arthritis would include education for the consumer about the condition and self-management options and workforce upskilling[6], and;

- Arthritis prevention - early intervention, healthy lifestyles
- Early diagnosis - trained and resourced health professionals
- Early treatment - primary care or access to specialist services
- Ongoing treatment - coordinated care, information and advice to adopt healthy lifestyles and remain in the workforce
- Advanced care and surgery - multidisciplinary management and timely referral, clear information

The lack of a model of care for arthritis is reflected in a number of issues in both the primary and secondary health sector:

- The shortage of rheumatologists and special interest GP's
- Lack of a training pathway for rheumatology nurse specialists and practitioners
- General practice nurses and doctors untrained in managing musculoskeletal disorders
- Poor adherence to guidelines for care of people with osteoarthritis and gout arthritis
- Joint replacement is unavailable, except to those most disabled or those who can pay
- Postcode health care – some areas better off than others

1.5 Examples of models of care

There are no specific "models of care" for conditions in New Zealand, however the term is used to describe ways of working in the health sector.

One example is the development of "Health Care Homes" in primary care. This model describes an approach that is patient-centred and has four domains

- to manage urgent and unplanned care effectively
- to be proactive rather than reactive for those with more complex health or social needs
- ensuring routine and preventative care are delivered conveniently, systematically and aimed at keeping people as well as they can be
- making sure this is all done with greater business efficiency for long term sustainability

The development of a model of care for arthritis would fit well with these principles.

- The NSW Model of Care for the Osteoarthritis Chronic Care Program, developed by the NSW Agency for Clinical Innovation, offers a pathway to improved care for people with osteoarthritis based on an interdisciplinary coordinated approach to management. https://www.aci.health.nsw.gov.au/resources/musculoskeletal/osteoarthritis_chronic_care_program/osteoarthritis-chronic-care-program
- Victorian Model of Care for Osteoarthritis of the Hip and Knee, developed by the Victorian Musculoskeletal Clinical Leadership Group supported by multiple health agencies, again describes a model that begins with patient education and non-pharmacological and non-surgical interventions that should be available to all patients. http://www.acsep.org.au/content/Document/MOVE_MoC_WebVersion_WithHyperlinks.pdf
- Model of Care for Rheumatology in Ireland, developed by an interdisciplinary group, the National Clinical Programme for Rheumatology describes a service design with a hub and spoke model of service delivery ensuring that the chronic disease approach of "right person, right place, first time" is taken in the management of rheumatological

diseases.
https://www.hse.ie/eng/about/who/cspd/ncps/rheumatology/achievements/model-of-care-for-rheumatology-in-ireland.pdf

Developing a model of care for arthritis is included in our recommendations. This would be a trail blazing initiative, placing arthritis management as a leader in health rather than the tortoise slowly crawling behind everyone else in New Zealand.

Several steps will be necessary in order to develop and implement a national model of care for arthritis with a primary focus on gout arthritis but not excluding osteoarthritis and other forms of arthritis. These will include evaluation of existing programmes, examination of models of care in other countries, cultural needs of communities in New Zealand, consideration of vulnerable communities, and planning for different regions and population groups.

1.6 Recommendations

A system-wide approach incorporating policy, prevention, early intervention and appropriate treatment is required, thus integrating arthritis care into existing public health and primary care activity. We recommend:

- The Ministry of Health be asked to formulate a national strategy for the management and treatment of arthritis, to report back to the Health Select Committee in 2021
- That the development of a Model of Care for arthritis be commissioned and resourced by the Ministry of Health by 2021
- The Ministry of Health be asked to facilitate research into the actual numbers of children and young people under 15 who have arthritis

Section 2

2.1 Gout arthritis

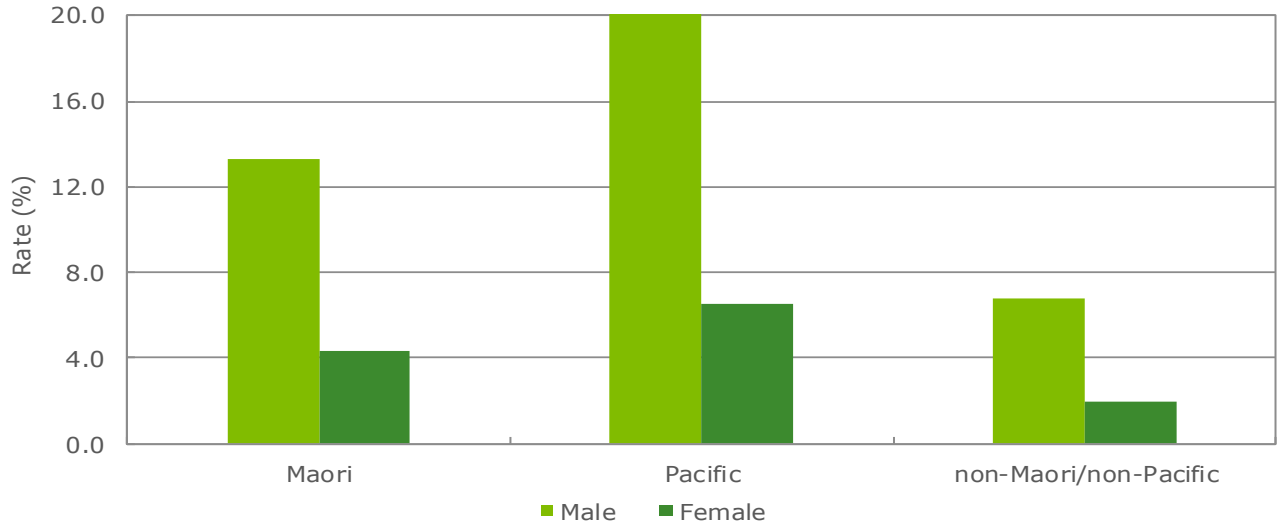
We wish to pay attention to gout arthritis as a form of arthritis with longstanding inadequacy and inequity of treatment and management plus grave consequences for non-treatment.

Many people, including those with gout arthritis, do not even realise that gout arthritis, often more commonly known as gout, is a form of arthritis.

Gout arthritis is also more prevalent in Māori and Pacific populations, particularly males, and is more prevalent in the young Māori population compared to the non-Māori population, these are significant factors for consideration when planning and delivering services.

In addition to a higher prevalence and earlier development of gout in Māori and Pacific people, the genetic component of the disease leads to greater severity of gout arthritis. There is also a greater use of non-steroidal anti-inflammatory drugs (NSAID's) in these groups indicating less well-controlled disease.

Gender-specific raw prevalence rate, gout arthritis, by ethnicity



Source: Economic Cost of Arthritis in New Zealand 2018

The urgency of addressing the management of gout arthritis is well summarised in an impassioned editorial in the NZMJ (New Zealand Medical Journal) in November 2018.

"Gout in Aotearoa was growing and being mismanaged with different prevalence and treatment by ethnicity [7].

We asked the question in Gout in Aoteoroa New Zealand - are we going to ignore this for another three years? New data for 2018 and the answer is YES." [8]

The gout arthritis domain of the Atlas of Healthcare publishes data by DHB on six indicators of gout arthritis prevalence and treatment. Data just published shows an escalating crisis in inequity – "…there is more gout arthritis nationwide and less treatment for Māori…" continued the editorial.

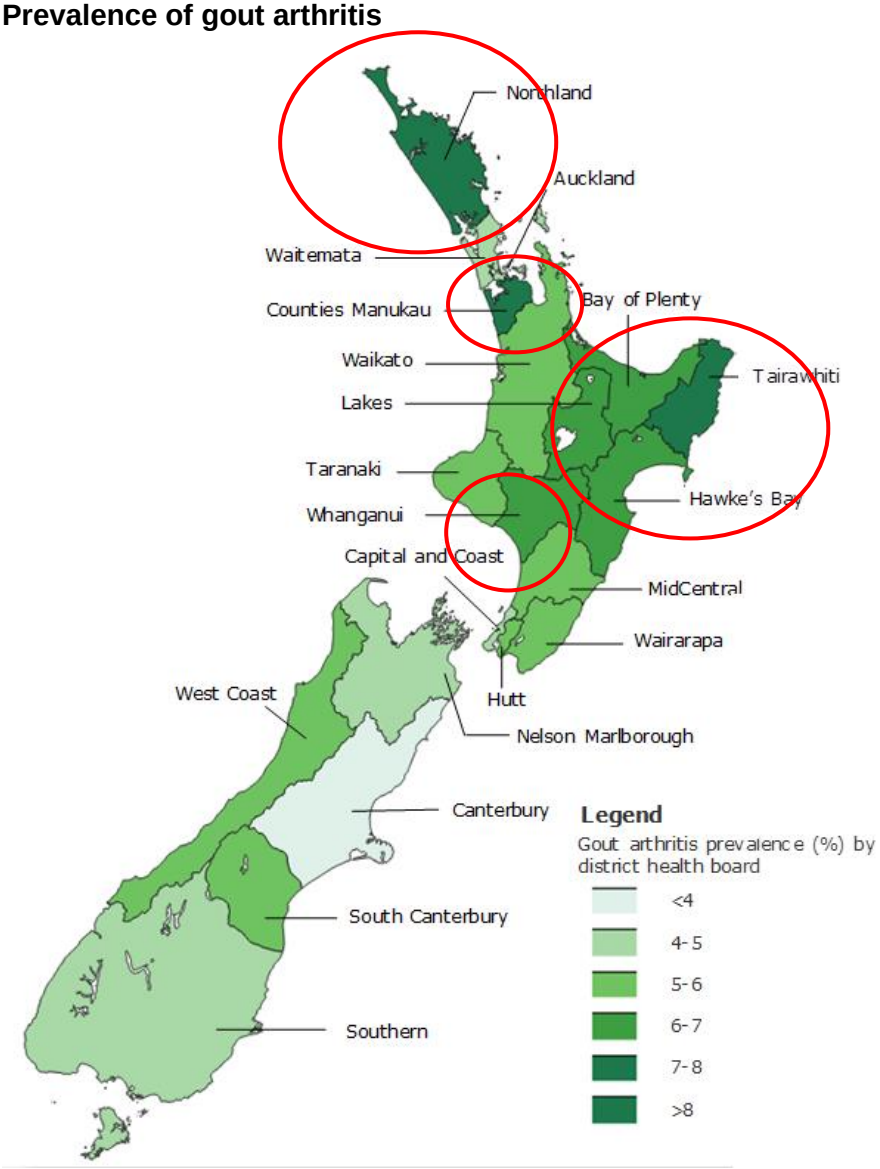
To look at the Gout Atlas figures is extremely sobering:

- The number and prevalence of people identified as having gout is increasing. Men, Māori and Pacific peoples and people aged 65 and over are most affected

- Māori and Pacific have two to three times the gout arthritis prevalence of non-Māori and non-Pacific BUT they are less likely to receive the required treatment to manage their gout arthritis

https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/gout

Prevalence of gout arthritis



Source: Economic Cost of Arthritis in New Zealand 2018

The prevalence of gout arthritis is highest in Northland, Counties Manukau, Tairawhiti, Whanganui and Hawkes Bay. We suggest the most progress needs to be made with initiatives in these areas with an emphasis upon programmes for Māori populations.

2.2 Cause of gout arthritis - genetic not environmental

There are longstanding beliefs that gout arthritis is caused by behaviour such as drinking too much beer or wine or eating too much kai moana. In fact, it is caused by a build-up of uric acid, forming uric acid crystals in the joint, most commonly the big toe. Gout arthritis is the second most common form of arthritis in New Zealand and it the only form of arthritis which can be controlled by easily accessible uric acid lowering medicines.

The major factor in causing uric acid to build up is genetic, meaning uric acid is less well excreted. Non-genetic factors such as some foods and drinks can play a minor role. However, this is linked more to triggering gout arthritis attacks or flares. Māori and Pacific have a genetic predisposition to gout arthritis, therefore beneficial treatment for these communities is a major priority.

A misconception that gout arthritis is self-inflicted carries a significant degree of social stigma as shown by the reluctance of people with gout arthritis to tell their stories in public.

Arthritis is not a “stand alone” issue. Many of the self-management and treatment pathways for arthritis show benefits for health overall, e.g. regular exercise and maintaining a healthy weight.

Gout arthritis is influenced by obesity. It has strong links to cardiovascular disease and renal impairment. Gout arthritis treatment and monitoring should be integrated into other primary care programmes such as those for diabetes and cardiovascular disease. While widespread screening is not advocated, it is important to consider serum urate testing in conjunction with cardiovascular and renal testing.

Comorbidities such as type 2 diabetes, hypertension and chronic kidney disease that are associated with raised uric acid levels also contribute to an increasing prevalence of gout arthritis.

2.3 Management of gout arthritis

A success story - Joseph has been taking medication for 15 years and his gout arthritis is well-managed.

Joseph is a Samoan-born man in his 60s who has gout arthritis. He has been a bus driver for 33 years and has had gout arthritis for many of those years. He remembers running out of sick leave at work and the reduced pay causing real financial pressures for his family.

Joseph has now learned how to manage his gout arthritis. His daughters remind him regularly to take his medication and he says*: “I never worry about my gout because I really believe in allopurinol (gout medication).* ***I can eat anything… like seafood and pig head with joy and laughter.”***

“A family alofa overcomes any whakamā you feel living with gout.”

Joseph refers to whakamā and this is a recurring theme when discussing gout arthritis – people with gout arthritis feel shame. Arthritis New Zealand sees the need for significant

education programmes to highlight both the real causes of gout arthritis and the treatment pathway to good outcomes. Such a programme would begin to destigmatise gout arthritis and provide secondary messages about lifestyle factors and the significance of family support.

2.4 The way forward

National standards are now in place for determining a desirable uric acid level (0.36mmol/l) and we are keen to see an emphasis upon monitoring uric acid levels for people who have gout arthritis.

Good treatment of gout arthritis can be a low-cost, low-tech intervention. In monetary terms the cost to a patient with gout arthritis alone could be as little as $220 in the first year, factoring in four average priced appointments and three-monthly prescriptions. This can reduce when stabilised to one appointment and three-monthly scripts averaging around $70 p.a.

Medicine management sometimes requires further appointments and this cost can be prohibitive to some. However, publicly funded gout treatment would save the cost of acute treatment and the potential cost of treatment in secondary care for severe gout arthritis, kidney disease and dialysis, not to mention the costs of work time and wellbeing lost by both patients and their families.

A well implemented treatment regime must to be complemented by extensive education and support for both the consumer and the family/whanau.

2.5 A successful gout arthritis initiative - Manaia PHO

There are pockets of good treatment in regions throughout New Zealand, showing significant improvements in the rate of people with well-managed gout arthritis. These programmes need to be evaluated to inform recommendations for other DHB's.

One project is the Gout Stop Programme run by Manaia PHO, Te Tai Tokerau PHO and Northland DHB (Arthritis NZ was involved in the early stages).

- A collaborative project with GPs, pharmacists and Kaiawhina working to improve gout arthritis management in Northland
- Challenges the whakamā around gout arthritis through education (e.g. video summarises the misconceptions about gout arthritis. https://youtu.be/svyrFaUHPx8
- Provides easy medication management - blister pack medication, prescription protocols and point-of-care testing
- Encourages re-admission into the programme if required
- Engages community and provides ongoing education throughout Northland

The results from the Gout Stop Programme from June 2015 - October 2018 were:

- 63% of total patient numbers completed the treatment programme
- Of those, 41% successfully achieved the treatment target and 25% required further medication changes
- 65% of the total completed number of patients continue to take preventative medication following the programme

A successful gout arthritis initiative currently underway:

- Owning My Gout project run in Counties Manukau Papakura marae diabetes whanau ora initiative which includes patients with gout arthritis

The key issue here is the lack of systematic implementation. These initiatives are run by committed individuals without broader support to develop ongoing coordination and evaluation of these programmes to inform a model of care.

We note that the Director General of Health referred to a “permissive policy environment” or “primary health” in his submission to the Waitangi Tribunal Inquiry into Māori Health. He concedes that such a permissive environment does not always respond well to the full range of consequences… meaning that “outcomes might not be distributed equally” [9].

He was speaking about Māori health outcomes, but his comments apply equally well to today’s gout arthritis management.

2.6 A solution

There are currently 182,000 New Zealanders with gout arthritis,76,969 (43%) are on urate lowering programmes.

Arthritis New Zealand has proposed a target be set, to increase this percentage of people on a managed gout arthritis programme from 43% to 55% by 2024. This would mean a further 23,123 people would be on a urate lowering programme. As the prevalence and severity of gout arthritis is higher in Māori and Pacific and people are younger when they are affected, a stronger focus is required for these groups to achieve equity of outcomes. This will require more resources and effort in gout arthritis management programmes. It is suggested that integration into existing health targets and programmes would be beneficial, e.g. diabetes and cardiovascular disease programmes.

The focus on Māori and Pacific would be the priority.

	Current # with gout arthritis	On programme (2016)	% on programme		Target on Programme 2024 (55%)	Increase numbers by 2024
Other	121575	53932	44.4%		66866	**12934**
Māori	38445	15291	39.8%		21145	**5854**
Pacific	21965	7746	35.3%		12081	**4335**
Total	**182013**	**76969**	**42.3%**		**100,092**	**23,123**

A breakdown of the target numbers by 2024 for each DHB is shown below.

	Total by DHB (2016)				Targeted Numbers by 2024							
					Other		Maori		Pacific Island			Total
	Numbers with Gout	# on a program	% on a program		Target 55%	# increase	Target 55%	# increase	Target 55%	# increase		# Increase by 2024
Northland	**9856**	**4378**	**44.4%**		3129	**518**	2179	**496**	113	**29**		**1043**
Counties Manukau	**27737**	**10350**	**37.3%**		6678	**1819**	2627	**746**	5950	**2340**		**4905**
BOP	**10424**	**4241**	**40.7%**		3926	**902**	1686	**545**	121	**45**		**1492**
Lakes	**4707**	**2014**	**42.8%**		1393	**234**	1096	**326**	101	**16**		**575**
Auckland	**17042**	**6315**	**37.1%**		5606	**1695**	2801	**1042**	966	**321**		**3058**
Canterbury	**14063**	**6746**	**48.0%**		6653	**728**	699	**124**	383	**137**		**989**
Capital Coast	**9322**	**4108**	**44.1%**		3462	**599**	692	**172**	972	**247**		**1019**
Tairawhiti	**2805**	**1196**	**42.6%**		572	**118**	937	**215**	34	**14**		**347**
Hawkes Bay	**7712**	**3493**	**45.3%**		2742	**401**	1288	**281**	201	**56**		**738**
Hutt Valley	**5536**	**2623**	**47.4%**		1986	**214**	596	**79**	463	**129**		**422**
Mid Central	**6745**	**3020**	**44.8%**		2821	**428**	739	**211**	150	**51**		**690**
Nelson Marlborough	**4807**	**2384**	**49.6%**		2341	**220**	258	**42**	45	**-2**		**260**
South Canterbury	**2599**	**1221**	**47.0%**		1337	**158**	74	**32**	19	**19**		**208**
Southern	**11317**	**5205**	**46.0%**		5507	**839**	524	**117**	193	**63**		**1019**
Taranaki	**4490**	**1921**	**42.8%**		1920	**404**	513	**135**	36	**9**		**549**
Waikato	**16313**	**7191**	**44.1%**		6042	**948**	2497	**671**	433	**162**		**1781**
Wairarapa	**1927**	**905**	**47.0%**		840	**107**	193	**43**	27	**5**		**155**
Waitemata	**20428**	**7886**	**38.6%**		8188	**2273**	1220	**401**	1827	**675**		**3349**
West Coast	**1391**	**552**	**39.7%**		692	**181**	68	**28**	1	**0**		**209**
Whanganui	**2792**	**1220**	**43.7%**		1030	**147**	460	**150**	45	**18**		**316**
Total	**182013**	**76969**	**42.3%**		**66866**	**12934**	**21145**	**5854**	**12081**	**4335**		**23123**

Achievement of these targets by each DHB would:

- Start to address the equity issue around the treatment of Māori and Pacific with gout arthritis
- Provide measurable outcomes
- Develop best practice leading to a consistent approach by DHBs to gout arthritis management.

2.7 Potential economic benefit

We know that the cost of arthritis on the health system is $12.2b p.a. The potential savings shown are based on an additional 23,123 people on urate lowering programmes.

	Overall Cost (p.a.)	Cost per person with arthritis[2]	Potential savings (based on 23,123)
Direct health costs	$993m	$1,482	$34.25m
Indirect health costs	$3.3b	$4,858	$112.3m
Wellbeing costs	$7.9b	$11,839	$273.75m
Total Cost	**$12.2b**	**$18,179**	**$420.3m**

The figure is an estimate, requiring economic modelling to ascertain more accurate savings, as there could be ongoing health costs related to those on this programme. For example; the Counties Manukau “Owning My Gout” project quotes an average of 360 admissions for gout arthritis a year to Middlemore Hospital at an estimated cost of $1,152,000 [10].

However, if we took a conservative approach and estimated that 50% of the above cost savings would be achieved this would be $210 million p.a.

Arthritis New Zealand sees the need for more detailed economic modelling on the cost benefits of increasing the numbers of people on managed gout arthritis programmes.

2.8 Strategy to achieve this outcome

Arthritis New Zealand is advocating a targeted approach - looking at regions where gout arthritis is most prevalent and working with key community agencies, health providers and other stakeholders (employers etc.) to develop a whanau-based approach.

Several steps will be necessary in order to develop and implement a national model of care for arthritis with a primary focus on gout arthritis but not excluding osteoarthritis and other arthritis.

- Evaluation of existing gout arthritis programmes
- Examination of existing models of care
- Consideration of vulnerable populations and cultural needs
- A public health campaign that reflects regional diversity and needs
- A workforce education package for health professionals
- Examination of the barriers to best practice
- Gout arthritis action planning by all DHB’s as set out in the table above together with a primary care workforce education plan with appropriate monitoring, auditing and reporting
- Integration with Health Care homes model
- Funding for a lead agency to develop a national arthritis strategy
- Model of care development teams developed from relevant disciplines and interest groups with central funding

Using this target as a measure of development, we could show progress and finally have a positive response to the question: “Will we in three years’ time see an improvement in the prevalence and management of gout arthritis or has it been ignored again?”

2.9 Other factors for consideration

- In addition to improving better outcomes for people with gout arthritis, such an approach can also be significant in improving outcomes for common comorbidities such as diabetes and cardiovascular disease. The initial sore toe leading to a GP visit can open the door to identifying other conditions requiring treatment
- A workforce education package and examination of barriers to best practice treatment would be required in addition to community education programmes

2.10 Recommendations

- Each DHB be asked to include specific provision for management of gout arthritis, particularly for Māori and Pacific populations in their area in their 2020 and future Annual Plans, including progress being made on increasing the percentage of people on a managed programme
- DHBs in areas with significant gout arthritis prevalence be asked to plan an awareness and education programme on management of gout in their regions
- Each DHB be asked to include an update on progress in managing gout arthritis in their reporting to the Ministry of Health

Section 3

3.1 Groups and individuals who have association with Arthritis New Zealand and are active in improving the management and treatment of arthritis and gout arthritis are:

Health Quality and Safety Commission – produced the Gout Atlas quoted in this submission "work with clinicians, providers and consumers to improve health and disability support services."

Gout Action Aotearoa – a group of health professionals and researchers providing leadership in gout management and education.

Pharmac – The New Zealand government agency who decides which pharmaceuticals to publicly fund.

New Zealand Rheumatology Association (NZRA) – the professional body of rheumatologists in New Zealand.

Manaia PHO – a PHO leading a model of gout arthritis management.

Owning My Gout – Counties Manukau DHB project led by Diana Phone, Rebecca Lawn and Trevor Lloyd.

Papakura Marae

Central Pacific Collective Wellington

Susan Reid – Health Literacy New Zealand.

Research Professor **Tony Merriman** –, Department of Chemistry, University of Otago.

Associate Professor **Peter Gow,** – Counties Manukau DHB.

Professor **Nicola Dalbeth,** – School of Medicine, University of Auckland.

Leanne Te Karu - Consultant Prescribing Pharmacist, Associate Dean Māori, School of Pharmacy, University of Otago.

Section 4 Recommendations of this Submission

Recommendations made by this submission:

- The Ministry of Health be asked to formulate a national strategy for the management and treatment of arthritis and report back to the Health Select Committee in 2021
- That the development of a Model of Care for arthritis be commissioned and resourced by the Ministry of Health by 2021
- The Ministry of Health be asked to facilitate research into the actual numbers of children and young people under 15 who have arthritis
- Each DHB be asked to include specific provision for management of gout arthritis, particularly for Māori and Pacific populations in their area in their 2020 and future Annual Plans including progress being made on increasing the percentage of people on a best practice treatment programme
- DHBs in areas with significant gout arthritis prevalence be asked to plan an awareness and education health workforce programme on treatment and management of gout in their regions
- Each DHB be asked to include an update on progress in managing gout arthritis in their reporting to the Ministry of Health

Arthritis New Zealand wishes to appear before the committee to speak to tis submission and these recommendations.

We wish for the following people to appear before the committee:

Philip Kearney, CEO, Arthritis New Zealand

Associate Professor Peter Larmer, Chair, Arthritis New Zealand

Cathie Morton, Manager Health Advice and Research, Arthritis New Zealand

Francesca Holloway, Manager Awareness and Advocacy, Arthritis New Zealand.

References

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[7] NZMJ Jan 2016, *Gout in Aoteoroa New Zealand*

[8] Dalbeth, Dowell, Gerard, Gow, Jackson, Shuker, Te Karu, NZMJ November 2018 editorial, p 8

[9] Director General of Health submission to the Waitangi Tribunal, Wai 2575, #A59, p 3

[10] CM Health Business Case, Owning My Gout, October 2018, p 6