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## eLetter on: Global Health Inequities in Rheumatology

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Sir,

We read with interest the recent editorial by Kumar [1] highlighting the large unmet needs of people with rheumatic and musculoskeletal diseases (RMDs) across the developing world and commend him for raising an important, but often overlooked issue. Few would argue with the importance of rapidly increasing care for RMDs in developing countries where the burden risks further hampering economic development. Whilst we agree with much of the author's plan to improve the treatment of RMDs, we do however note a key omission: developing the non-medical healthcare workforce.

Kumar highlights the examples of sub-Saharan Africa where there are <20 rheumatologists serving a population >800 million, and India where ~100 rheumatologists serve 1.1 billion people. This is inadequate by any measure. With the burden of preventable communicable diseases so high in such countries [2], it is challenging to move RMDs up the public health agenda. Although some of the care gap can be closed by increasing health spending, it is unlikely that sufficient health resources will be found to enable universal healthcare through traditional service models, so scarce healthcare resources must be used in new ways. Indeed the challenge of finite resources, greater patient need, and rising treatment costs is one that faces health systems across the world, not just in developing countries. Yet, this is a challenge that we must all meet if we are to reduce the personal and economic burden RMDs place on individuals, their families, and wider society.

Although, on a much-reduced scale, some countries such as the UK have also been challenged by a health system, which has struggled to meet the changing demands of the population. The growing shortage of doctors in the 1990s meant that the roles of nurses and allied health professionals (AHPs) had to expand to fill the gap through new extended scope roles, conducting tasks that were traditionally the preserve of doctors. This change did not occur overnight, and much work was required to change legislative frameworks to allow such roles to develop safely and effectively. Nurses were the first to pioneer advanced roles. Now highly trained nurse specialists have a range of skills such as joint injections and prescription rights [3]. As care for people with RMDs evolves so do these roles and there is now evidence from high quality multicentre randomised controlled trials which demonstrates that nurse led care is cost effective, safe and patients report higher levels of satisfaction than they do in traditional medically led models of care [4]. Such has been the success of nurse specialists, that they are now an essential part of every rheumatology services in the UK and elsewhere in Europe [5, 6], where they work collaboratively with rheumatologists, within the framework of a multidisciplinary team, rather than in competition.

Much has been achieved by offering early access, regular disease assessment and patient education using a strong team approach, with nurses and AHPs advancing their skills to enhance the care provided by the medical team. Crucially, this allowed for a larger volume of patients to be seen and managed safely. This team approach has served to optimise the role of the rheumatologist, and enable the services to deliver more cost effective care. For example, some clinics now use specialist nurses to undertake routine patient monitoring, freeing the rheumatologist's time to deal with new and more complex cases. We suggest such an approach represents an important part of the solution in developing countries where non-physician providers such as medical assistants and assistant medical officers have been used to great effect for many years [7].

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Advanced nursing practice is established in the UK but in different stages of development internationally [6]. In other parts of the world such as in Asia, nurses are now starting this journey and have recently endorsed rheumatology nurses as a specialist area of practice with appropriate training [8]. Training nurse and AHP workforces to meet this clinical need requires changes in legislation, investment, and a cultural change from all within healthcare. Developing services in such a way does not happen overnight and needs to be managed in a stepwise approach and although individuals are key to the process, it cannot be achieved alone.

In conclusion whilst we agree with much that Kumar proposes, failing to utilise the non-medical workforce would be an important omission. Each country must develop its own solution to meet the specific challenges it faces with differing resources at its disposal, but the principle of up-skilling nurses and AHPs to enable more patients to access appropriate treatment appears transferable and safe.

Disclosure statement: The authors have declared no conflicts of interest

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