

Arthritis

Inquiry—Debate Continued

On the Order:

Resuming debate on the inquiry of the Honourable Senator Comeau, calling the attention of the Senate to the debilitating nature of arthritis and its effect on all Canadians.—(*Honourable Senator Dyck*)

Hon. Lillian Eva Dyck: Honourable senators, it is my pleasure to join the debate on the inquiry of the Honourable Senator Comeau calling the attention of the Senate to the debilitating effects of arthritis and its effects on all Canadians.

Honourable senators who have participated in this debate so far have done an excellent job in outlining the various forms of arthritis, the incidence of arthritis, its differential impact on women and Aboriginals and the lack of equitable funding to arthritis research compared to other diseases such as cancer, diabetes and so on.

I have been contacted by people from Saskatchewan who have asked me to speak to this inquiry and to lobby for more funds to support arthritis research. I met with Anne Dooley, the President of the Canadian Arthritis Patient Alliance, and she provided me with lots of information on arthritis.

Today, I will focus my comments on the greater impact of arthritis on the Aboriginal population. I will also discuss the need for improved information about arthritis on the web, particularly with respect to the Health Canada website.

First, I will review two major forms of arthritis, using information from the Arthritis Society of Canada website. The most common kind of arthritis is osteoarthritis. It affects 1 in 10 Canadians, about 3 million of us; and it affects men and women in equal numbers.

Most people develop osteoarthritis after the age of 45, but it can occur at any age. According to the Public Health Agency of Canada, 85 per cent of Canadians will be affected by osteoarthritis by age 70.

Osteoarthritis is caused by the breakdown of cartilage. Pieces of cartilage may break off and cause pain and swelling in the joint. Osteoarthritis usually affects the hips, knees, hands and spine. Being overweight can increase the risk of osteoarthritis. As well, joint injury or repeated overuse of a joint can damage its cartilage and lead to osteoarthritis.

The warning signs of osteoarthritis are pain, stiffness and swelling around a joint that lasts longer than two weeks. As mentioned above, the joints that are usually affected are the hips, knees, feet and spine, though the finger and thumb joints may be affected also.

The second type of arthritis I will talk about is rheumatoid arthritis, which is an autoimmune disease characterized by redness, pain, swelling or a feeling of warmth or heat in the affected joint. The hands or feet are the most commonly affected.

Rheumatoid arthritis affects 1 in 100 Canadians, about 300,000 people, and women are three times more likely than men to be affected. Most people develop rheumatoid arthritis between the ages of 25 and 50. The warning signs of this type of arthritis are morning stiffness that last more than 30 minutes, pain in three or more joints simultaneously, joint pain lasting all night long and pain in the same joints on both sides of the body.

In general, the key risk factors for the development of arthritis are age, excess weight, injury and complications from other conditions, heredity and lack of physical activity. Preventive measures include exercise such as walking, cycling and swimming, and maintaining a healthy body weight.

As was mentioned previously by other honourable senators, the incidence of arthritis is two and a half times higher in the off-reserve Aboriginal population than in the rest of the Canadian population. Yet, this fact seems to go unnoticed. However, this situation may not be surprising, given the general lack of awareness concerning the incidence and seriousness of arthritis compared to other chronic diseases such as cancer and diabetes.

So far, only limited data on the prevalence of arthritis in the off-reserve Aboriginal population has been collected. The age-standardized prevalence of arthritis was 27 per cent in the Aboriginal population, and 16 per cent in the non-Aboriginal population. The standardized prevalence of diabetes was above 9 per cent in the Aboriginal population, and 5 per cent in the non-Aboriginal population. In other words, arthritis was a far more common chronic medical condition than diabetes in the Aboriginal population.

Though it is well known that diabetes is more prevalent in the Aboriginal population, it is not common knowledge that arthritis is also more prevalent in the Aboriginal population — and that it is more prevalent than diabetes. In addition, it is noteworthy that the most common chronic medical condition for Aboriginals is arthritis, and for non-Aboriginals it is allergies.

According to a news report last month, the severe forms of arthritis are five times more common in Aboriginals than in non-Aboriginals. This situation can be attributed to the inheritance of the gene associated with rheumatoid arthritis, which is present in as many as 70 per cent of the Aboriginal population.

There are also clear gender differences in the self-reported prevalence of arthritis in Canadians 15 years of age and over. In women, the incidence is nearly 20 per cent; while in men, it is only about 12 per cent.

Most people who have hip or knee replacement surgery — 90 per cent — have arthritis. Studies show that women are more likely to be recommended for surgery when their arthritis is at a more advanced stage than it is for a man. In other words, men are recommended for surgery at an earlier stage of disease progression than is the case for women. Similarly, a recent study shows that a man with moderate arthritis is twice as likely to be recommended for knee surgery than a woman with moderate arthritis. This gender discrimination may be due to subconscious bias on the part of physicians and, in my opinion, it may also reflect gender differences in assertiveness. Perhaps men are more vocal than women in articulating their pain or in asking for surgery.

(1450)

Honourable senators, after reviewing the information sent to me and the comments of other honourable senators, I decided to search the web using PubMed, a search engine for biomedical research publications. In the last year there were 775 reviews of arthritis in humans but, of those, only nine papers were listed on Aboriginals and arthritis. Only two of these were published by Canadians. When I checked for First Nations and arthritis, eight other publications were identified. However, I found something interesting: There were 77,932 publications on women and arthritis. My interpretation of these numbers is that there is a crying need for more research on arthritis in Aboriginals.

I then checked the website for the First Nations and Inuit Health Branch, known as FNIHB, to see what information was posted on arthritis. I was surprised by what I found. On the main page there

is a list of diseases of interest, but arthritis is not on the list. Diabetes, HIV/AIDS, influenza, tuberculosis and West Nile Virus were listed but not arthritis.

Given the greater incidence of arthritis in the Aboriginal population and the greater prevalence of arthritis compared to diabetes in the Aboriginal population, one would expect to find information about arthritis on the FNIHB website. Perhaps if and when this inquiry is the subject of a Senate committee report, it should be recommended that the FNIHB website be revised to include prominent information on arthritis.

I next checked the Health Canada website for information about arthritis. Once again, arthritis was not in the main list of diseases but was included under other diseases. Diabetes was, however, included in the main list of diseases. As above, I would argue that given that the incidence of arthritis in the Canadian population is 16 per cent and the incidence of diabetes is less, at 5 per cent, Health Canada's website ought to include arthritis as a separate listing on the main page and not relegate it to a sub-listing under other diseases.

Honourable senators, it is quite clear that the incidence of arthritis and its cost to the physical, emotional and psychological health of Canadians is under-recognized. As has been stated previously, in 2000, nearly 4 million Canadians reported arthritis as a chronic health condition. As stated previously, 85 per cent of Canadians will be affected by osteoarthritis by age 70. The Canadian population is aging. We cannot afford to be complacent.

The Alliance for the Canadian Arthritis Program has outlined three priorities for immediate action. I commend the alliance for the work they have done and the excellent information they have provided. Their three immediate priorities are: First, every Canadian must be aware of arthritis; second, all relevant health professionals must be able to perform a valid, standardized, age-appropriate musculoskeletal screening assessment; and third, every Canadian with arthritis must have timely and equal access to appropriate medications.

I emphasize that the phrase "every Canadian" includes all of us: men, women, Aboriginals and non-Aboriginals. I am in favour of this inquiry being sent to a Senate committee for further investigation, and that a report with recommendations for action be undertaken by such a committee.

Hon. Sharon Carstairs: Honourable senators, I wish to say a few words about this extremely timely inquiry. As we have been engaged in our study of aging, arthritis is one of the debilitating diseases that was identified by a number of witnesses. As Senator Dyck indicated so well in her remarks, it is true that arthritis has been identified as significant not only by the Aboriginal community but by other communities as well.

To some degree, I think arthritis is the "forgotten disease." Perhaps this is because although many of us have arthritis to a minor degree we go about our daily lives and are not particularly affected by it.

Diabetes has become much more "in the eye of the beholder," if you will, for several reasons. First, it is rampant in our Aboriginal communities and has become extremely active among non-Aboriginal Canadians over a certain age. Additionally, diabetes is directly tied to the issue of diet and weight. Interestingly enough, in my family, my father was a diabetic and my older sister became a diabetic at exactly the same age that my father became a diabetic. Both of those cases led to their eventual death by stroke, which is an unfortunately all-too-often progression of diabetes.

Arthritis, on the other hand, is a disease in which people become more and more debilitated but frequently do not die specifically of arthritis; they tend to often die of something else. That does

not mean, however, as Senator Dyck said so eloquently this afternoon, that arthritis is a disease that can be ignored, particularly in a community and a society that is aging. We know that people with arthritis become more and more limited in terms of their physical ability. They are limited in terms of their ability to walk. They frequently have difficulty with the use of their hands. They become debilitated in terms of being able to get out and about within their community. That has a significant effect on the deterioration of the rest of their lives.

Therefore, I thank Senator Dyck for bringing this matter to our attention this afternoon. If I am not mistaken, I think Senator Keon has in the past brought the issue of arthritis to the attention of honourable senators.

I hope that our report due out in September will address the fact that Canadian society is not adequately addressing the demographic changes that are evident. We are not putting in place the resources and programming that will meet the needs of an aging society.

On motion of Senator Eggleton, debate adjourned.

(1500)