THE COST OF MUSCULOSKELETAL PAIN: THE NEED FOR PRIORITY SERVICES.

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The costs of Pain

- In 1998 LBP alone cost £12.3billion (Maniadakis and Gray 2000)
  - £1.63 billion on healthcare
  - £10.668 billion on informal care and societal costs
- In 1999 CHD cost £7.06 billion (Liu et al 2002)
  - £1.73 billion on healthcare
  - £5.33 billion on informal care and societal costs
- In 2000 health care cost for Diabetes £1.77bn (Bagust 2002)
- Estimated that Musculoskeletal pain cost £30 billion in the UK in 2009(CMO 2009)

Costs continued

- Musculoskeletal disorders may cost 2% of the EU domestic product each year (Bevan at al 2009)
- In Sweden back and neck pain patients on sick leave from work account for approx 7 per cent of the nation's expenditure on health services.
- A study in Jersey reported that only 3% of low back pain patients who failed to return to work after 1 yr accounted for 33% of wage replacement costs (Watson et al 1998).

Indirect costs - work

- Musculoskeletal pain may represent as much as 49.9% of the total cost of sickness absence in Europe lasting longer than 3 days (Bevan et al 2009)
- 77% of lost productivity associated with pain relates to reduced performance rather than work absence (Stewart et al 2003)
- The odds of loosing employment seven times higher among people with chronic pain. (Jonson 2000)

The real costs may be hidden

- UK Government figures attribution of Incapacity Benefit costs
  - >40% Common mental illness
  - <22% Musculoskeletal pain

Recent admissions to IB

Table 2.3 Main health condition and disability

Column percentages

	Percentage of all respondents		Percentage with health condition	
	Baseline	Follow-up	Baseline	Follow-up
Mental health	24	15	25	22
Musculo-skeletal	39	33	40	47
Chronic or systemic	18	14	19	20
Other condition	15	8	16	12
No health condition	4	30		
Total	**100**	**100**	**100**	**100**
Weighted base	*801*	*801*	*772*	*560*

Totals may not sum to exactly 100 due to rounding.

Kemp and Davidson 2008

There is also a human cost

Chronic pain patient have increased rates of

- Mental Illness
- Drug abuse
- Early death
- Social exclusion

Increased mortality associated with Chronic Pain?

In people identified with chronic regional and widespread pain compared with those without pain,

- There was a 20% and 30% increased risk of dying over the follow-up period among subjects with regional and widespread pain, respectively due to cancer and cardiovascular disease. (McBeth et al 2009)

Work loss in chronic pain patients

- 1975 patients attending specialist pain clinic in France - analysis of work status in those of working age
- 787 patients (43.3%) were employed at the time of the study (including 53 students),
- 121 were seeking employment (6.7%),
- 469 were on sick leave (23.8%, with a mean duration of 13.1 month ± 10.7, a median of 12 months and a range of 1 to 78 months) and
- 442 (21.4%) were early retired or on an invalid pension.

(Descatha et al 2009)

Chronic pain and Unemployment

- In Denmark 4006 cases of 567 (17.3%) had lost their job, and 135 (23.8%) Health Related Job Loss at 1yr. 51.5% of HRJL was related to pain or discomfort in the neck, the back, arms, or legs, and another 23% to stress or stress related symptoms. (Haahr et al 2007)
- Few chronic pain patients return to work once they become unemployed (Waddell and Watson 2004)

Suicide and Pain

- Patients in Rehabilitation clinic compared to community sample
- 326 Acute pain patient
- 341 Chronic pain patients
- 110 no pain
- CPP raised scores on self reported history of wanting to die, recent frequent suicide ideation, and having a suicide plan
- APP Raise on the above and wanting to die because of pain (Fishbain et al 2009).

Suicide and Pain

- Suicidal ideation in chronic pain patients ~20%
- Death by suicide in chronic pain patients is double the general population (Tang and Crane 2006)

Focusing on single health costs obscures information

- BEAM study compared
  - GP care
  - Exercise
  - Manual therapy
  - Manual therapy followed by exercise.
- Manual Therapy and exercise were more cost effective than other treatments (BEAM 2004)
- UK the National Audit Office - a 10 per cent increase in people with RA being treated within 3 months of diagnosis would cost £11m and may result in productivity gains of £31million for the economy due to reduced sick leave and lost employment. (NAO 2009)

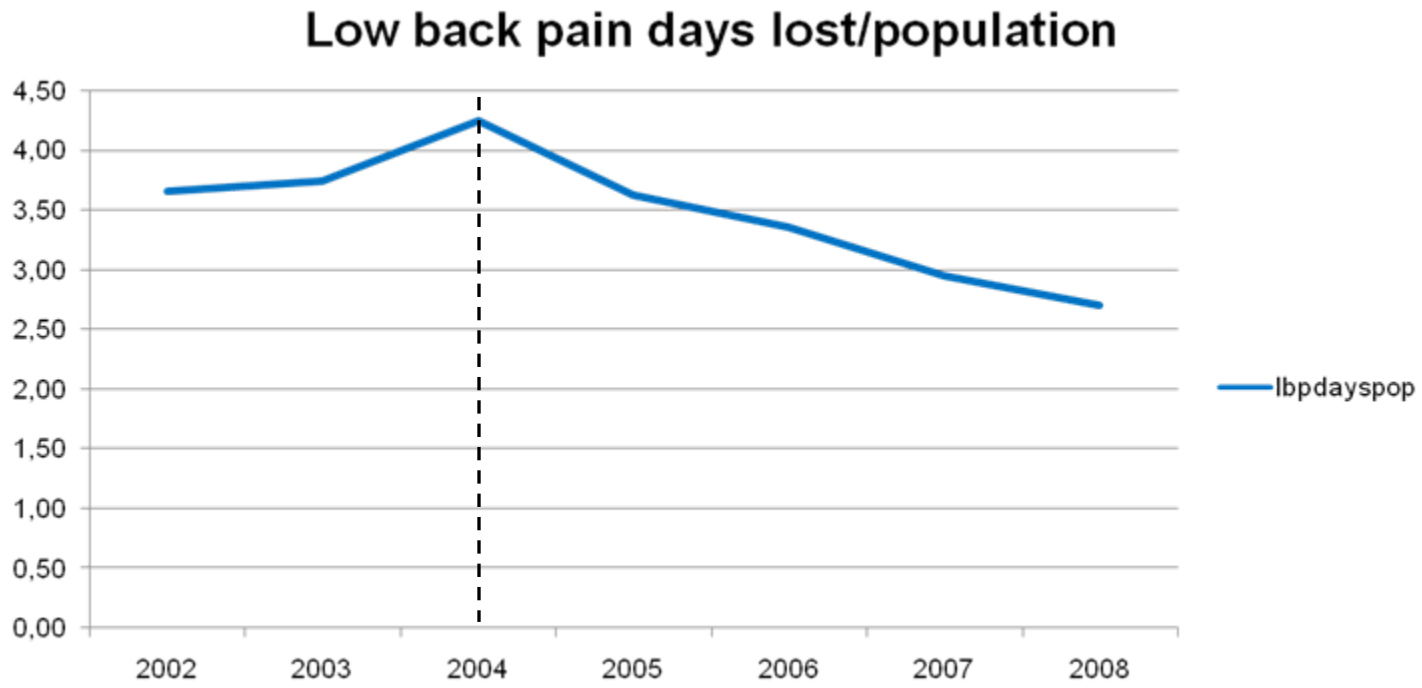
Integrating costs

- Pain treatments often delivered as a package.
- Some systems reimburse cost per item.
- Can mitigate against appropriate care pathways.
- Packages of care may look more expensive but can be more cost effective.

Reducing work loss

- Healthcare less effective than an integrated approach in sub-acute MSP disorders (Waddell et al 2008, Watson et al 2010)
- Healthcare alone relatively ineffective in CLBP with long sickness absence (Waddell and Watson 2004; Watson et al 2010)
- Integrated packages involving employer, occupational health and health providers are cost effective (Waddell et al 2008, Kendall et al 2009)
- Integrating healthcare, work access, training has been demonstrated to be cost effective in UK.

An integrated approach



Message

Sometimes it may be cheaper to provide a more expensive intervention or package of care than a single intervention.

Early prediction of obstacles to recovery

- New assessments can predict who is likely to develop chronic incapacity from a pain episode.
- Early identification of obstacles – frequently psychosocial- early appropriate interventions.
- Screening for risk of poor outcome can target treatment and increase cost effectiveness
  (Haldorsen 2002, Nicholas et al 2010)

Health Technology Appraisals

Government s and health providers are increasingly using HTAs to advise on treatments and produce guidelines

- Most such appraisals only consider medication or health costs (eg: NICE, SMC, TLV)
- Often focus on single treatment Vs usual care
- Should be required to consider the both the health and wider social benefits and costs of treatments when making recommendations.
- Health and Social care costs should be considered when drawing up guidelines.

Continued

- Comprehensive assessment of health and societal costs of chronic pain for all painful conditions.
- Effects of healthcare on societal costs should be collected.
- Research should express cost effectiveness with reference to healthcare AND societal costs.

Pain Specialists' responsibilities

Demonstrate

- effectiveness of treatments
- cost effectiveness of treatments.
- improved social welfare following treatment.

- Assess societal costs.
- Thorough assessment of outcomes.
- Future research should capture representative societal costs.
- Put up or shut up

Policy makers

- Ensure pain is assessed! 5th Vital Sign
- Stop “bunker” mentality
- Focus away from purely healthcare payer perspective.
- Consider all costs in society not simply costs within a department (eg: health v social security.)
- Fund research into cost effectiveness
- More implementation research
- Evidence based policy making.

Getting attention

- Campaign for Chronic Pain to be recognised as a condition in its own right?
- Present the appropriate management of pain as a public health problem?

Problems

- We have very little evidence
- Which costs should be included?
- Different approaches for different patient groups (eg: children, employed, elderly, palliative care)
- Are QALYs overused?
- Mobilising the political will.