

Musculoskeletal disorders:

time for joint action in primary care

THE SCALE OF THE PROBLEM

Most people will experience musculoskeletal pain at some point in their lives. For many, this will be a minor self-limiting problem; however, conditions such as back pain and osteoarthritis are the dominant cause of chronic pain, disability, and work loss in the UK.¹ Up to one-third of GP consultations are for musculoskeletal problems² and these disorders are the most common reason for repeat consultations.³ As our population ages the burden on both health and social care systems will inevitably rise.

Yet despite forming a large proportion of their workload, musculoskeletal conditions can be a challenge for GPs to treat, as often they do not fit neatly into the biomedical model of pathological diagnosis and cure, and might be more expertly managed by other healthcare personnel. There is also a risk that the large number of other clinical areas crowding for GPs' attention, and the absence musculoskeletal indicators in the Quality and Outcomes Framework, result in these conditions being seen as a lower priority, with resultant impact on quality of care.⁴

The stock response to presentations of common musculoskeletal problems can be to reach for the prescription pad, or to request expensive investigations such as magnetic resonance imaging and complex immunological tests, which in many cases will not offer a clear answer to a clinical question. In addition, increasing numbers of patients with musculoskeletal problems are referred out of primary care and, with the rising levels of complexity and sub-specialisation within specialist services, it is becoming more difficult to select the best destination for each referral.⁵

SERVICE MODELS

In response to high referral rates many areas of the country now have access to a range of musculoskeletal services outside of the secondary care environment, often using extended scope physiotherapists and GPs with a Special Interest to triage and treat patients. Service models include 'paper triage' with clinicians directing GP referrals towards the most appropriate service; 'see and treat' models working in the interface between primary care and specialist care; right through to 'prime vendors' responsible for delivering the entire musculoskeletal pathway.⁶ The best

of these services have won popularity among patients by offering timely care closer to home using integrated care pathways,⁷ but there is an inherent danger of services increasing complexity for referrers and needlessly adding extra steps in the patient pathway which could delay definitive treatment as well as drive up costs.

Because of the diverse nature of these services and the heterogeneous populations they serve, comparisons between them are difficult to make. It is clear, however, that there is no one-size-fits-all model. Each service must be responsive to the clearly identified needs of the population based on local epidemiology and the skill-set of clinicians. Integration and communication are key, both along the patient pathway and between services, so as to avoid costly duplication of care and to ensure that referrers and providers have the information they need at the correct time to enable patients to make informed choices about their treatment.

OUTCOMES

The current financial climate in the NHS has given cause for critical reflection on the services we provide for patients with musculoskeletal problems. The NHS allocates well over £4 billion per year to musculoskeletal care, making it the fifth highest area of NHS spending.⁸ Interestingly, the highest spending primary care trusts allocate three times as much for musculoskeletal treatment as the lowest. This degree of variation in investment does not reflect the variation in the incidence, prevalence, or severity of disease, and there is little understanding of the relationship between spend and health outcome.⁶

Clinical commissioning groups, and indeed taxpayers, need to be assured that the money they spend on musculoskeletal care represents good value. As things stand, most of the outcomes data for musculoskeletal care come from orthopaedic cases with

clearly defined episodes of care and measurable end points.

The musculoskeletal community now faces the challenge of developing sensible outcome measures for non-orthopaedic care of the long-term musculoskeletal conditions which account for the majority of clinical activity in this area.⁹ This will involve thinking about 'soft' outcomes — for example, pain or the ability to participate in usual activities including work — rather than 'hard' outcomes, such as inpatient bed days, blood tests, or other disease markers. There is little doubt that patients' experience of care and patient-reported outcomes will be an extremely important financial driver for both providers and those commissioning services.

THE FUTURE ROLE OF GPs

However services are commissioned, investment in improving the outcome of GPs' first contact with patients is crucial. It is worth re-emphasising that integrated care pathways only work if the patient is directed on to the correct one. The ability to distinguish between common minor complaints and uncommon serious conditions, and then to manage them appropriately, is one of the central tenets of general practice. Just as with managing depression or common childhood ailments, basic musculoskeletal clinical skills must be seen as a core requirement for the generalist, rather than an optional extra.

Often GPs learn these skills from hospital specialists in orthopaedics and rheumatology, but management of the common conditions that are the bread and butter of primary care requires a different approach. By applying the principles of management that have driven success in other chronic diseases areas, such as diabetes,¹⁰ we can improve care for common conditions like peripheral joint pain in older people (clinical osteoarthritis), back pain, inflammatory arthritis, and chronic widespread pain syndromes such as

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fibromyalgia. We should start with existing national clinical guidelines and set up disease registers with call/recall systems; use collaborative care-planning and self-management strategies to facilitate self-care; and identify and manage comorbidity such as depression to improve the prognosis for those with musculoskeletal pain.¹¹ By systematising care in this way, GPs and practice teams are uniquely placed to deliver coordinated management of these long-term conditions.

In conjunction with these activities, risk-stratification tools can be used to identify patients at highest risk of adverse events, allowing treatment to be targeted against a defined end-point analogous to stroke or myocardial infarction and cardiovascular disease risk. Examples include the FRAX[®] tool (the Fracture Risk Assessment Tool by the World Health Organization) for assessing risk of fragility fracture in osteoporosis¹² or the STarT Back Screening Tool for back pain, which facilitates early identification and targeted treatment of patients at highest risk of developing chronic back problems, while freeing up service capacity by not referring patients who will improve with advice, reassurance, and medication.¹³

Confident management of chronic musculoskeletal conditions and early identification of those at risk of long-term problems will improve the health and social wellbeing of practice populations. Such approaches could challenge musculoskeletal patients' current preconception that GPs are equipped to offer them little more than a pharmaceutical quick fix. Instead, patients should have confidence that GPs are equipped to manage the increasing burden of musculoskeletal problems on society and have the capacity to rise to new challenges on the horizon.

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Provenance

Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp11X601541

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