Back pain: the Australian experience

Scott Masters, MBBS, FRACGP, GDipMusMed, FAFMM, is President, Australian Association of Musculoskeletal Medicine, Senior Clinical Lecturer, Musculoskeletal Medicine, University of Otago, New Zealand, and a musculoskeletal physician, Caloundra Spinal and Sports Medicine Centre, Queensland.

There is growing recognition of the burden musculoskeletal disorders place on the Australian population. At present, the direct and indirect costs of this burden is over $15 billion per annum.[1] Musculoskeletal problems are the third most common reason for presentation to general practice in Australia,[2] and the most common cause of disability across all age groups.[3]

In 2002, the Australian Health Minister announced arthritis and musculoskeletal disorders as a new national health priority area. There is now an expanding interest in the research, teaching and optimum management of musculoskeletal problems. The Australasian Faculty of Musculoskeletal Medicine (AFMM) was formed in 1993. In 1998, the first Fellowship exams were held by AFMM and there are now over 50 Fellows of the Faculty. In New Zealand, musculoskeletal medicine has been recognised as a vocational branch (discipline) of medicine. In the International Bone and Joint Decade, it would seem that musculoskeletal medicine has now arrived.

National Musculoskeletal Initiative

In 1996, the federal government established the National Musculoskeletal Initiative to identify optimal management of acute musculoskeletal pain. The initiative began drafting evidence based guidelines for the management of acute musculoskeletal pain, overseen by Professor Bogduk and the AFMM. (The Australian Acute Musculoskeletal Pain Guidelines Group updated the evidence based guidelines in 2003[4]).

To test the musculoskeletal guidelines, musculoskeletal medicine clinics were set up around Australia in 13 teaching hospitals and in four primary care settings. Acute musculoskeletal pain was managed according to evidence based guidelines and then compared to outcomes in general practice from four divisions of general practice. Management in the evidence based clinics centred on the principles of: **addressing patients fears**, ie. 'I hurt, I can't move, I'm scared'; **education**, ie. give a convincing explanation of the problem, confident reassurance of the benign nature and good prognosis, emphasise the importance of staying active through simple exercises and graded activity (thus empowering the patient), and arrange adequate follow up to prevent feelings of abandonment; and, **allowing** manual therapy, analgesics, and focal injections.

Patients were followed up for 2 years and a record of pain levels, disability, medication use, investigations ordered and the treatments consumed were kept by research nurses. The outcomes for management of low back pain include – in the short term: slightly less pain, greater satisfaction, less medication use, less radiology, less alternative care, and less expense; and in the long term: less pain, less relapse, less continuing care, and less expense.[5]

Consumers liked evidence based care. Their feedback indicated they were most concerned with reassurance and empowerment. However, patients also did extremely well with motivated general practice care. Compared to their northern hemisphere cousins in primary care, Australian doctors are obtaining much better recovery rates. There were also no missed 'red flags' at 2 year follow up of the evidence based care patients, even though the radiology and pathology ordering was one-quarter of the general practice group. This is very reassuring and indicates that relying on a red flag checklist is a safe practice.

For health economists and insurers, the average cost saving per patient of $200 is of more than passing interest. This only pertained to the first 3 months of the study. It did not take into account the cost savings from reduced continuing care.

Patients now have a wide range of health providers to choose from for the care of their musculoskeletal pain. General practitioners have a central role in guiding patients through the maze of treatment alternatives including physiotherapists, chiropractors, osteopaths, acupuncturists, massage therapists, and kinesiologists. The findings of the National Musculoskeletal Initiative should encourage GPs to take a central and proactive management role in their patients with musculoskeletal pain.

References

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