Editorial

THE PROVISION OF SERVICES FOR SPINAL DISORDERS

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Spinal disability, particularly back pain, is the leading cause of long-term absenteeism from work in the UK and 1% of the adult population is permanently disabled by it.¹ At least five million adults consult their general practitioner annually concerning back pain. The overall cost in health care in 1998 was estimated to be £1.6 billion, to which must be added that of informal care and loss of work which totals £10.6 billion.² This amounts to a back tax of approximately £205 per year for every individual in the UK. The scale of the problem is similar in every industrialised country. How can this best be managed?

Most patients with low back pain can be treated by their general practitioner with the help of a physical therapist. Studies on the management of back pain at this level³⁻⁷ have led to recommendations for a more aggressive policy in regard to treatment, with advice to stay active with suitable medication in the acute state⁸ followed by a structured approach employing back schools, exercise therapy, the use of non-steroidal anti-inflammatory drugs and a multidisciplinary programme for those with chronic pain who are well motivated, to encourage a return to work of some sort.⁹⁻¹¹ About 10% of those who initially consult their general practitioner have more serious conditions¹² and may require further investigation and expert management. This can be expensive but is likely to be more satisfactory for the patient and cost-effective in the long term.

The current arrangements for the management of these two groups are unsatisfactory. Few areas have an efficient cost-effective organisation to look after the less severe group of sufferers. Patients are allowed to linger on with no proper plan of treatment, swallowing analgesics, 'resting' and perhaps carrying out a desultory exercise regime. If they do not improve they may be referred to an orthopaedic department for advice, resulting in a further delay of six months or so. Expensive investigation may then follow, which will usually prove to be fruitless, and many will then graduate to becoming the long-term sick and unemployed-

able. The few with more serious problems may still follow the same dreary path and eventually receive the operative treatment which may have been valuable many months before. They are likely to have an inferior result as a consequence. How can this be improved?

Spinal Assessment Units have been set up in a number of locations with proven value.¹²⁻¹⁵ They ensure that the appropriate patients receive the correct treatment after a thorough and objective assessment of their back at an early stage. These units have been shown to be effective and a proper network needs to be established throughout the country. Computerised systems of data analysis and collection are now available to assist with the processing of larger numbers of patients.^{16,17}

Those with more serious problems require referral to a regional spinal centre, each of which should have at least two and preferably five spinal surgeons, including one or more neurosurgeons, along with other relevant specialists to provide a 24-hour service. In the UK each centre would serve two to three million people. At present, much of this work is undertaken in units with one or two consultants who are extremely busy, with intolerable workloads and waiting times. Disorders such as spinal trauma, tumours and deformity all require access to sophisticated specialist facilities.

The National Health Service in the UK is ideally suited to provide these two levels of service which would lessen the burden of the social and financial costs to individuals, industry and the country.

How can these units be staffed? Spinal Assessment Units are generally manned by extended-role physiotherapists or nurses with special training. Ideally, a general practitioner with an interest or a specialist in physical medicine should be available, along with ready access to psychologists, rheumatologists and surgical specialists as necessary. Chronic patients, if well motivated, require self-management programmes and access to pain clinics. Recent suggested schemes to utilise the expertise of experienced patients and encourage return to work deserve support.¹⁸

There is already a considerable shortage of spinal surgeons to staff regional spinal centres. By 2005, when one-third of our present spinal orthopaedic surgeons will have retired, there will be a shortfall of approximately 30 specialist spinal orthopaedic and neurosurgeons to reach even

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the modest target of 100 in this specialty in the UK. To achieve the European average there needs to be 250. We must make a greater attempt to attract young surgeons to this challenging specialty. Specific numbers should be reserved in years five and six of training for spinal surgery.

There will have to be a rapid and major expansion in the overall training numbers for surgeons if the targets for increases in orthopaedic surgeons in general and spinal surgeons in particular are to be met.¹⁹ The agreed target is to increase the number of orthopaedic surgeons from 1200 to 2000 by 2010. Imaginative training rotations combining spinal orthopaedic surgery and neurosurgery should be more widely available to encourage future spinal surgeons.

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