

Result after discussion during SIP Focus Group 2
European Parliament, Brussels, Belgium
15 May 2013



**SIP Proposal for Action:
Using European Best Practices for the Reintegration
of Chronic Pain Patients into the Workforce**

Draft version as proposed and aligned with:

Harry Kletzko, German Pain League, Germany
Dr Françoise Laroche, President of CEDR (Cercle d'Étude de la Douleur en Rhumatologie), France
Jacqueline Lyttle, Director of Commissioning, Jackel solutions ltd., United Kingdom
Professor Michiel Reneman, Universitair Medisch Centrum Groningen, the Netherlands
Dr Clairi Wiholm, Swedish Social Insurance Agency, Sweden

List of Contents

1. Introduction to the Societal Impact of Pain (SIP).....	3
2. Chronic Pain in the European Working Population – Epidemiology and Societal Costs	5
3. SIP Proposal for Action: Using European Best Practices for the Reintegration of Chronic Pain Patients into the Workforce.....	7
4. National Best Practices: Economic Costs and Re-integration of Chronic Pain Patients into the Workforce.	8
5.1 France.....	8
5.2 Germany.....	9
5.3 Netherlands	10
5.4. Sweden.....	12
5.5 United Kingdom	14
5. Supporting SIP 2013 Proposal for Action: Using European Best Practices for the Reintegration of Chronic Pain Patients into the Workforce.....	18

1. Introduction to the Societal Impact of Pain (SIP)

The European, multi-stakeholder platform [Societal Impact of Pain \(SIP\)](#) was created in 2010 as a joint initiative of the European Federation of IASP® Chapters (EFIC®) and the pharmaceutical company Grünenthal GmbH. The aims are to

- raise awareness of the relevance of the impact that pain has on our societies, health and economic systems;
- exchange information and share best-practices across all member states of the European Union;
- develop and foster European-wide policy strategies & activities for an improved pain care in Europe.

As multi-stakeholder platform SIP provides discussion opportunities for health care professionals, pain advocacy groups, politicians, insurances, representatives of health authorities, regulators and budget holders. The scientific framework of the SIP platform thereby is under the responsibility of EFIC®. Grünenthal is responsible for funding and non-financial support (e.g. logistical support).

In the past three years [EFIC®](#) and [Grünenthal](#) have organized three European scientific symposia on the societal impact of chronic pain in Europe:

The first symposium [SIP 2010](#) established the multi-stakeholder network and thus a platform for sharing best practices of pain management throughout Europe.

The second symposium [SIP 2011](#) took place in the European Parliament and was supported by all three European institutions: Members of the EU Parliament, the EU Commissioner for Health & Consumer Policy, as well as the Hungarian Presidency holding the EU Presidency from Jan-Jun 2011. Furthermore, it was endorsed by more than 85 international and national patient advocacy groups, scientific organisations and health authorities. Key result from SIP 2011 was the [SIP Road Map for Action](#) outlining seven policy dimensions on how the EU institutions and member states can effectively address the societal impact of pain at EU level.

The third symposium [SIP 2012](#) took place in Copenhagen, Denmark. More than 400 stakeholders from more than 30 countries participated in the meeting, which was officially held under the high patronage of the Italian Prime Minister and the Italian Ministry of Health and Welfare, and which was endorsed by more than 161 organisations. For the first time concrete national policies on pain management were shared with the participants reflecting how EU Member States succeeded to implement the SIP Road Map for Action on national level.

Following these national examples from SIP 2012 and the general SIP stakeholders' feedback to intensify the work on concrete projects to leverage outcomes for EU level, the *SIP Programme Committee* decided to implement the so-called *SIP Focus Groups*. In contrast to the past three European symposia, the SIP 2013 Focus Groups will concentrate on two concrete policy topics, which are following closely one of the seven policy dimensions of the SIP Road Map for Action.

Topic for the SIP 2013 Focus Group 2 as selected by the SIP Programme Committee was "Chronic Pain in the Working Population", where best practices from different European Member States for re-integrating chronic

pain patients back into the workforce should be presented and possible cost-saving strategies be discussed. This topic thereby follows policy dimension No 6 of the SIP Road Map for Action: “6. Establish an EU platform for the exchange, comparison and benchmarking of best practices between member states on pain management and its impact on society¹.”

In times of austerity and economic crisis, employment and productivity of the working population are a central topic discussed on national and European level. Rationale for the SIP Programme Committee for selecting this topic for Focus Group 2 was the commonly agreed significance of a healthy European workforce and the impact, which chronic pain has on the latter. The importance of both preventive measures and rehabilitation programmes have been discussed as part of an effort to ensure that the working population is able to re-enter the workforce even if they have been affected by chronic pain. Five best practice examples from different EU Member States have been presented highlighting the social and economic benefits of re-integrating chronic pain patients into the workforce.

Due to the need for sharing best practices and exchanging models among EU Member States for keeping our workforce healthy, the SIP Focus Group 2 aimed at developing this “Proposal for Action”, giving national examples of rehabilitation and integrated care programmes and proposals for concrete measures on EU policy level. A draft version of this “SIP Proposal for Action: Using European Best Practice for the Reintegration of Chronic Pain Patients into the Workforce” was developed by the five best practice speakers, and presented during SIP Focus Group 2:

- Harry Kletzko, German Pain League, Germany
- Dr Françoise Laroche, President of CEDR (Cercle d’Etude de la Douleur en Rhumatologie), France
- Jacqueline Lyttle, Director of Commissioning, Jackel solutions Ltd., United Kingdom
- Professor Michiel Reneman, Universitair Medisch Centrum Groningen, the Netherlands
- Dr Clairiy Wiholm, Swedish Social Insurance Agency, Sweden

The draft version was distributed to all SIP 2013 Focus Group 2 participants 06 May 2013 for optimal preparation. The SIP 2013 Focus Group 2 took place in the European Parliament in Brussels/Belgium on 15 May 2013. The Focus Group was chaired by Marian Harkin, Member of European Parliament (Ireland) and Liam Conroy, Irish Councillor of the European Federation of IASP® Chapters (EFIC®). The draft version was discussed and finally agreed upon during the working session by all SIP Focus Group 2 participants. The final report was published and made available for download on the [SIP website](#)² on 17 May 2013.

¹SIP – A Road Map for Action, 2011:

<http://www.efic.org/userfiles/file/THE%20SOCIAL%20IMPACT%20OF%20PAIN%20%20A%20ROAD%20MAP%20FOR%20ACTION%20%20document%206%2005%202011.pdf>

²www.sip-platform.eu

Chronic pain is one of the major reasons why people exit the labour market prematurely¹⁰. In fact, the risk of pain patients having to give up their occupation due to their health status has been calculated to be seven times greater than for the healthy population¹¹.

In his speech on “EU policy on health and safety at work: myths and facts”¹² by the Institute of Occupational Safety and Health in London (United Kingdom) on 26 February 2013, Lázló Andor, EU Commissioner for Employment, Social Affairs and Inclusion, explains the consideration by the EU Commission to giving priority to “[...] *tackling health issues and preventing work-related health problems more effectively - these include occupational and work-related diseases, work-related musculo-skeletal disorders, work-related psycho-social risks, and potential risks of new technologies. [...] Europe needs to continue improving working conditions, but future work in this area cannot ignore the broader economic, employment and demographic situation*”.

According to an ad hoc module of the Eurostat Labour Force Survey¹³ from 2007, which covers the 27 Member States in the European Union, 23 million persons between 15 and 64 who were working or had worked before reported a work-related health problem in the previous 12 months. This is about 10% of the EU workforce. Work-related health problems were estimated to have resulted in at least 367 million calendar days of sick leave.

Regarding the economic burden these sick leave days put on society, it has been shown that those cases of work-related accidents and ill-health translate into a very substantial cost: A study by the European Agency for Safety and Health and Work¹⁴ puts it at between 2.6 and 3.8% of the GDP.

Another study published by the EU Commission in 2011¹⁵ states that apart from reducing costs related to absenteeism, accidents and disease, occupational safety and health measures can help to improve outcomes on organisation level, such as a company’s image, its position on the labour market and customer satisfaction. They also reduce employee turnover and increase productivity. On an individual level, high-quality working conditions may trigger job satisfaction and may indirectly influence workers’ health.

Based on the above mentioned data and national best-practice examples presented during the SIP 2013 Focus Group 1 on 15 May on how to tackle these societal and economic challenges by improving chronic pain

¹⁰ Phillips C, Main C, Buck R, Aylward M, Whyne-Jones G, Farr A., *Prioritising pain in policy making: The need for a whole systems perspective*, Health Policy 88, 2008, 166-175

¹¹ Jonsson E., *Back pain, neck pain*, Swedish Council on Technology Assessment in Health Care Report, NoP: 145: Stockholm, 2000 (<http://www.sbu.se/en/Published/Yellow/Back-and-neck-pain/>)

¹² http://europa.eu/rapid/press-release_SPEECH-13-162_en.htm

¹³ A. Venema, S. van denHeuvel, G. Geuskens: *Health and safety at work: Results of the Labour Force Survey 2007 ad hoc module on accidents at work and work-related health problems*, December 2009: http://circa.europa.eu/irc/dsis/employment/info/data/eu_lfs/lfs_main/adhoc_modules/2007/ExplanatoryNotes/Final_LFS_2007_dec_2009_v3_1.pdf

¹⁴ European Agency for Safety and Health at Work: *Economic Impact of Occupational Safety and Health in the Member States of the European Union*: <https://osha.europa.eu/en/publications/reports/302>

¹⁵ EU Commission, Directorate-General for Employment, Social Affairs and Inclusion, Unit B.3, Final Report: „Socio-economic costs of accidents at work and work-related ill health“, November 2011.

management and supporting the maintenance and improvement of a healthy European workforce, the SIP Focus Group 2 has developed the following “SIP Proposal for Action”, as stated in the following Chapter 4. Chapter 5 will give an overview of the underlying best practice projects, upon which this SIP Proposal for Action has been based.

3. SIP Proposal for Action: Using European Best Practices for the Reintegration of Chronic Pain Patients into the Workforce

The following Proposal for Action is based on the key success factors of the five best-practice projects from France, Germany, the Netherlands, Sweden and the United Kingdom. The information was gathered ahead of the SIP 2013 Focus Groups and developed and agreed upon with participants during Focus Group 2 on 15 May 2013.

In times of austerity and economic crisis, employment and productivity of the working population are central topics of discussion at national and European level. During the second Societal Impact of Pain (SIP) 2013 Focus Group, the significance of a strong and healthy European workforce, the impact that chronic pain has on it, and the importance of both preventive measures and rehabilitation programmes were discussed as part of an effort to ensure that the working population is able to re-enter the workforce, even if they have been affected by chronic pain.

Based on experience and best practice examples from different EU Member States, the European, multi-stakeholder Platform “Societal Impact of Pain” calls upon European governments to develop, promote and implement preventive measures and rehabilitation programmes for the reintegration of chronic pain patients into the workforce to secure a healthy and productive employment sector. The European Institutions are asked to provide guidance and support the exchange of best practice across the EU.

In order to ensure the successful implementation of such measures, the SIP Proposal for Action calls on the following factors to be taken into account:

- 1. Strong, early involvement of stakeholders (e.g. patients, health authorities, employers, pain specialists, insurance companies, budget holders, policy makers, scientific organisations, etc.) to ensure a holistic and collaborative approach towards the successful implementation of future projects.***
- 2. Development of guidelines for healthcare professionals to ensure that pain services are commissioned based on need and take into account best practice.***
- 3. Development and implementation of chronic pain patient education programmes and chronic pain patient activity/work programmes to keep patients involved and active and strengthen optimal pain management.***
- 4. Continuous monitoring/governance and evaluation systems (e.g. incentives for good performance) and risk-management procedures to ensure consistent, quality outcomes.***

The SIP 2013 Proposal for Action is supported and signed by [the following](#) European delegates / organisations.

4. National Best Practices: Economic Costs and Re-integration of Chronic Pain Patients into the Workforce

5.1 France

Chronic low back pain patients' management – Psycho-educational programs: Impact on disability and sick-leave days

Chronic low back pain (CLBP) is frequent and may be responsible for limitations and disability. The main objective of Therapeutic Patient Education (TPE) is to help patients stay active and involved, as much as possible, in the shared medical decision process. This may be a major condition of success. Different publications have shown that multidisciplinary approaches, including TPE are active among low back pain patients. In 2013, there is a consensus indicating that the bio-psycho-social paradigm is the most appropriate model to evaluate and manage these patients. Co-morbidities should be taken into account, such as cognitions, emotions (anxiety, depression, algophobia, kinesiphobia), coping strategies, patients' expectations, and preferences. Involving patients in a TPE process at the earliest possible stage of the disease - when still working - improves results. Furthermore, TPE should be adapted to patients' characteristics. Therefore, an appropriate treatment programme, including information, re-learning, cognitive reformulation, activity-exposure, problem solving is proposed. Different modalities may be available; individual or collective education, training workshops focused on one specific objective, relaxation, medication self-management...

TPE programme for LBP patients allows decreasing fear, catastrophizing and limitations, to restore function and interpersonal interactions. The improvement could also decrease impact on work ability. As an example, a multidisciplinary intensive functional restoration programme was developed in Angers by Dr Isabelle Richard and seems promising with a decrease of sick-leave days.

The objective was to compare in a CLBP population, the effectiveness of a functional restoration programme (FRP), including intensive physical training and a multidisciplinary approach, to an outpatient active physiotherapy programme with 1-year follow-up.

Summary of Background Data

Controlled studies conducted in the United States and in Northern Europe showed a benefit of FRPs, especially on return to work. Randomized studies have compared these programmes with standard care. A previously reported study presented the effectiveness at 6 months of both functional restoration and active physiotherapy, with a significantly greater reduction of sick-leave days for functional restoration.

Methods

This study was a randomized parallel group comparative trial with a 1-year follow-up period. A total of 132 patients with low back pain were randomized to either FRP (68 patients) or active individual therapy (64 patients). One patient did not complete the FRP; 19 patients were lost to follow-up (4 in the FRP group and 15 in the active individual treatment group). The number of sick-leave days 2 years before the programme was similar in both groups (180 ± 135.1 days in active individual treatment vs. 185 ± 149.8 days in FRP, $P = 0.847$).

Results

In both groups, at 1-year follow-up, pain intensity, flexibility, trunk muscle endurance, Dallas daily activities and work and leisure scores, and number of sick-leave days were significantly improved compared to baseline. The number of sick-leave days was significantly lower in the FRP group.

Conclusion

Both programmes are efficient in reducing disability and sick-leave days. The FRP is significantly more effective in reducing sick-leave days. Further analysis is required to determine if this outweighs the difference in costs of both programmes.

Key Success Factors

- Therapeutic Patient Education programmes for chronic low back pain patients are more and more developed, and have proven to help patients stay active in their daily work activities.
- Active involvement of different pain specialists and specialists' associations to share good practices and to establish treatment guidelines
- Involvement of French Regional Health Agencies for the decision, agreement and implementation process of such programmes.

5.2 Germany

IVR-Medical Results of an Integrated Health Care Concept for (Low) Back Pain Patients

Patients suffering from chronic (low) back pain [(L) BP] are responsible for the vast majority of (L) BP-related costs in industrialized countries worldwide. Despite enormous efforts, the standard medical care approaches for this patient group failed. Research identified unimodal, primarily procedural driven interventions as the principal cause for this dilemma and suggests a multimodal performance-/outcome-focused treatment/reimbursement approach to improve this situation.

Method

Since 2007, IVR – an integrated health care project established by the Integrated Managed Care (IMC) Company in corporation with the German Pain Association and some health insurance companies (e.g. “Techniker Krankenkasse”, one of the largest national compulsory health insurance companies in Germany) - offers (L) BP patients with a sick leave duration of ≥ 28 days a multimodal treatment concept specifically tailored to meet their very unique healthcare needs. Patient allocation is conducted by specialized case managers of the TK. Reimbursement is based on a bonus/malus system and incorporates treatment duration as well as distinct treatment effect parameters (primarily the back to work rate - BTWR). Benchmarking analysis was performed with respect to efficiency differences between participating centres.

Results

Until April 12th, 2013, 7569 (L) BP patients were allocated. 4992 patients (age: 46.3 ± 9.8 yrs., 52% male, sick leave duration: $90, 0 \pm 178$ days, median 61) – most of them suffering from chronic (MPSS stage II/III: 73, 6%) and dysfunctional pain (v. Korff grade III/IV: 90, 3%) – participated in the multimodal tailored treatment period. Within 4-8 weeks, 4299 patients (86.1 %) returned back to work and 86 (1%) remained there without relapse for at least 6 months. The average total savings add up to around 1000.-€ per IVR-patient.

Conclusion

A highly individualized multimodal treatment approach in combination with a merit-rating (bonus/malus) reimbursement proves to be not only highly efficient, but also highly cost-effective, opening perspectives for alternative reimbursement concepts.

Key Success Factors

- **Risk-Management-Procedure based on usage timeframes**
- **Involvement of the insurance companies as designated allocators**
- **Global budget**
- Governance through individual self-disclosure of the patient
- Intensity of treatment depends on individual needs of the patient
- Weekly benchmarking of all medical professionals
- Bonus-/Malus – System according to success of treatment

5.3 Netherlands

Working on work: Practice examples from the Netherlands

Introduction

Demographic trends tell us that in an ageing workforce and a higher retirement age the incidence of chronic conditions will increase. A separate trend is the increase of overweight and obesity. Natural ageing processes and (multiple) chronic diseases will have a negative impact on work capacity. Obesity is known as a major contributor to chronic diseases, which will further increase this impact.

Evidence tells us that early and appropriate clinical interventions, which prevent premature job loss or support return to work, can be both cost-effective and have a significant impact on workforce productivity and quality of life. At the moment, for too many people of working age, work is not considered a desirable or attainable clinical outcome by many healthcare professionals¹⁶. Because good work and good health are related, this narrow perspective may actually harm patients.

During the best practice contribution during SIP 2013 Focus Group 2, examples have been presented of integrated care aimed to help workers with chronic pain back to work and to improve work productivity. After a short introduction of the programmes, estimates have been presented on the outcomes, both in terms of work participation and economy.

Example 1: A comprehensive university based multi-specialist spine centre (Groningen Spine Centre)

Why can this be considered an example of best practice?

1. Patient driven. Patient's questions and expectations guide assessment and treatment. Patient satisfaction with care is constantly monitored.
2. Coordinated. Patients are triaged by specially trained Physician Assistants, who also serve as case managers.
3. Multi-specialist. This Spine Centre is unique in the Netherlands, and as we know in Europe, because it offers coordinated and truly comprehensive interdisciplinary care, provided by a team of medical and non-medical

¹⁶ Making work count – how Health Technology Assessment can keep Europeans in work. A Fit for Work Europe paper. December 2012. <http://www.fitforworkeurope.eu>. Accessed March 5, 2013.

specialists derived from 8 departments: rehabilitation, anesthesiology, neurosurgery, orthopedics, traumatology, neurology, and psychiatry. Currently, more than 1600 patients per year are assessed, diagnosed, advised and treated.

4. Stepped care. Patients are referred to primary care close to home whenever possible.
5. Self-management. We have translated the ‘Pain Toolkit’¹⁷ into Dutch, which will assist patients to self-manage pain and function optimally.
6. Shared model. All Spine Centre workers embrace the bio-psycho-social model, realizing that pain and functioning are influenced negatively and positively by a wide range of biomedical, psychological and social factors.
7. Data driven. As part of clinical care as usual, all patients fill out an electronic questionnaire before entering the Spine Centre (demographic and clinical measures), at discharge, and at 3 and 12 month follow-up (outcome measures). Up to February 2013: database is filled with ~7000 patients at baseline.)
8. Research driven. All care is provided according to evidence-based guidelines. When guidelines are insufficient: this special centre can and does generate unique research questions and answers, beyond the traditional borders of uni-specialist care.

Example 2: A national network of 14 vocational rehabilitation centres (VR).

Why can this be considered an example of best practice?

- Patient driven. Patient’s questions and expectations guide assessment and treatment.
- Evidence based. As advised in evidence-based guidelines, standardized VR is offered to workers with sub-acute and chronic non-specific pain. Guiding principles:
 - a. Multidisciplinary. Physiatrist, psychologist, physical therapist, vocational specialist and case manager.
 - b. Shared plan. All stakeholders (patient, VR team, work) share the same goals, rehabilitation and return to work plan.
 - c. Coordinated. VR services are coordinated with the patient, work and occupational physician.
 - d. Work driven. Both assessment and treatment are aimed towards optimizing work participation (reduction of absenteeism and increase of presenteeism). Standardized questionnaires and an abbreviated Functional Capacity Evaluation are included to assess work capacity. Work participation is gradually increased during VR.
- Close to home/work. A network of 14 VR centres throughout the Netherlands.
- Data driven. A standardized dataset based on the ICF VR core set and the IMMPACT recommendations will be implemented in spring 2013. This dataset will be part of clinical care as usual, but also used for outcome measurements. Outcome measures: pain disability, absenteeism, presenteeism, medical consumption, (work-) disability costs.

Key success factors

- Because good work has been shown to enhance health and well-being, ‘work’ contributes to good patient care.

¹⁷ <http://www.pain toolkit.org/>

- Stakeholders from the following fields are needed to facilitate such projects: patient representatives, health care (workers, institutions, and representatives), employers, policy and reimbursement. Policies and reimbursement structures should facilitate effective and efficient care.

5.4. Sweden

REHSAM – A National Research Programme in Sweden, enhancing return to work

Introduction

In the beginning of the 2000s, Sweden had among the highest numbers of people of working age sick-listed or on disability pension compared with other European countries. Sweden experienced a tremendous increase in long-term sickness absence due to unspecified pain and/or psychological illness resulting in increased health care costs and personal suffering for the individual. In order to change this up-going spiral, different measures were taken. The biggest change was implemented in the sick insurance regulations: The time limit for sick-leave was changed to a maximum of 360 days and no one under 30 years of age was approved to receive disability pension. Furthermore, diagnoses specific sick-leave guidelines were launched, as well as new time limits when assessing work capacity:

1-3 months: In relation to currently held position

4-6 months: In relation to alternative positions at current employer

>6 months: In relation to the total labour market

SALAR – Stimulating Rehabilitation Work

In order to stimulate the rehabilitation work, the Social Ministry of Health introduced a programme called the “Rehabilitation Guarantee” involving people with the following diagnoses who already were on sick-leave or at risk of being sick-listed.

	ICD code
Anxiety	F40-F42
Depression	F32-F39
Stress-related disorders	F43-F48
Musculoskeletal pain	M50-M54, M70-M79

One part of the programme or guarantee was a promotion programme for those County Councils that offered evidence-based rehabilitation to patients diagnosed with these symptoms. For each treatment based on evidence-based methods the County Council received an extra sum.

The above programme, the “*Swedish National Rehabilitation Guarantee*”¹⁸, was introduced in 2009 and was an agreement, between the government and The Swedish Association of Local Authorities and Regions (SALAR) with the purpose of

¹⁸ More information at www.skl.se

- Preventing and reducing sickness absence
- Offering early intervention
- Enhancing availability of evidence-based rehabilitation

It was clearly stated in the Guarantee that the rehabilitation methods used should be evidence-based, that rehabilitation activities should start as soon as possible based on medical evaluations and that the target group was people of working age.

What is evidence-based treatment for these groups of patients?

According to the Swedish Council on Health Technology Assessment (SBU) the evidence-based methods recommended for mild to medium mental disorders are:

- Cognitive Behavioural Therapy (CBT)
- Cognitive Therapy (CT)
- Interpersonal Psychotherapy (IP)
- Well-structured therapies
- Brief; 8-10 sessions

There is evidence showing symptom relief and enhanced function; however, the evidence for return to work is insufficient or non-existent. For musculoskeletal disorders the recommended treatment is:

- Multimodal rehabilitation (MMR)
- Team-oriented (physician, psychologist, physiotherapist)
- 2-3 times a week, 8-12 weeks
- Scheduled activities, psychological approach

MMR show evidence for symptom relief and enhanced functions and also for return to work.

REHSAM Global Research Program

In order to enlarge the evidence-based knowledge of which interventions within the multi-modal rehabilitation and CBT or similar techniques have a documented effect on working capacity and return to work, the Ministry of Health allocated 100 MSK for research within this area. The research programme is called REHSAM ("rehabilitation and collaboration").

The overall purpose of the research programme was to find the best methods of retaining and restoring working capacity in people who have developed mental ill-health and or unspecified pain in neck and back. REHSAM has taken a somewhat new approach by pointing out the County Councils as main applicants for the research funding. However, the project manager has to be a senior researcher affiliated to a university. The reason for this constellation is that the County Councils are responsible for most rehabilitation activities for this group of patients and the potential participants for the studies are mainly found in Primary Health Care.

This constellation with County Council coordinators and university researchers working together in the project team is expected to facilitate later implementation of the project results in everyday clinical work, depending on the research findings. In order to promote high quality research, an expert group consisting of national and

international researchers was formed. The group was responsible for evaluating the applications and recommending projects which should be funded. Approximately 20 % of the applications were approved. Most projects were partly funded and the County Councils were expected to contribute with their share.

The programme has had three calls for applications: the first in August 2009, next in March 2010, and the last one in March 2011. At the moment, there are 24 projects running from the north to the south of Sweden. The project time is 2 years including 1 year follow-up. Compulsory exit criteria are workability and return to work measurements; decrease in symptoms and other health measurements are welcomed but regarded as secondary results.

This new approach to conduct research might be complicated initially, as County Councils and universities have total different cultural and administrative routines. In order to facilitate this process it was decided to establish a “knowledge sharing” programme for the project teams. During this period different activities were arranged by the REHSAM Global programme, all with the goal of promoting high-quality research and facilitating the upcoming implementation process, or up-scaling process into practical rehabilitation.

The first REHSAM conference attracting people, researchers, policymakers, practitioners, and politicians took place in May 2012. All 24 projects presented their work either as abstracts or in poster sessions. The key note speakers brought up subjects on how to proceed from research results to clinical practice i.e., implementation research. Furthermore, roundtable discussions between all participants (250) were highly appreciated, as well as the panel discussions.

This programme is believed to provide a lot of new knowledge, not only research results, but also valuable information and knowledge of what is needed to promote clinical rehabilitation research, how to upscale and implement research result into clinical work. The results from these projects are expected to be presented from now on until beginning of 2015. If the programme is found to be beneficial, a more permanent establishment for rehabilitation research aiming to enhance return to work will be established.

Key Success Factors:

- **Initiation** of the programme by the Swedish government in agreement with the SALAR (The Swedish Association of Local Authorities and Regions)
- **Involvement** of Swedish County Councils to scientifically evaluate the rehabilitation activities performed within the “Swedish National Rehabilitation Guarantee” programme
- Generation of opportunities for **closer collaboration** between primary health care and research groups at various universities
- **Continuous monitoring and evaluating** of the REHSAM (“rehabilitation and collaboration”) programme to measure contribution in the enlargement of the scientific knowledgebase for people suffering from unspecific pain conditions and mild-to-moderate mental ill-health.

5.5 United Kingdom

Counting the cost of pain

Pain represents an enormous burden to the NHS and wider society in the UK. It has been estimated that back pain alone costs the UK economy £12.3 billion per year, with the cost of pain from all causes being considerably higher. Patients in pain, especially chronic pain are high consumers of healthcare resources accessing primary and secondary care on a frequent basis. In addition to face to face activity more than £584million is spent annually on prescriptions for pain. An estimated 11% of adults and 8% of children suffer severe pain representing 7.8M people in the UK. Primary care management of patients with chronic pain, accounts for some 4.6million appointments per year, this is the equivalent of 793 whole time GPs at a cost of £69 million. In addition to the healthcare burden there is a wider economic and societal burden due to absenteeism from work and the associated reductions in productivity. Annually more than 5 million people in the UK develop chronic pain, but only 2/3 will recover.

Despite these facts pain is not currently seen as a priority by the NHS or the coalition government. There is currently no standard approach to the commissioning of pain services in the UK, which leads to vast variation in:

- Access to services
- Clinical outcomes
- Management of analgesia
- Service delivery

Whilst pain is as resource intensive as long-term conditions, such as asthma and diabetes, 'patients with chronic pain are more likely to use the NHS 5X more frequently than patients who do not suffer', it does not have the same profile, being seen as less important and a lower priority.

In order for pain to be part of the NHS and coalition agenda in the UK, we need to raise its profile. It is imperative that we raise it as a priority with commissioners at both a public health level through the health and wellbeing agenda, and at a service delivery level, to ensure that best practice is encouraged and adopted across the UK, so as to reduce avoidable waste across the whole system.

In order to understand the whole system impact of pain, and to develop opportunities for raising the profile of it within the NHS in particular, a small task group was convened in the summer of 2012, to look at its impact on patients and the system. The group was multidisciplinary and multi-organisational, and consisted of GPs, therapists, pharmacists, commissioners and public health professionals.

The main aims of the group were to:

- look at the issues facing patients when pain is not well managed
- identify the waste within the system when best practice was not followed
- calculate the burden across the whole pathway of care
- gain an understanding of the impact on the system when best practice is not followed

Methodology

Following the initial task group meeting, 6 pathways of real patients were mapped in great detail, and coasted from initial presentation with a GP to the point in their pathway when the patients and their leading clinician considered that their pain was successfully managed. The mapping took into account ALL of the healthcare steps in the patient's journey and considered the impact of all healthcare and analgesia costs, together with a

calculation of the cost of delays within their treatment pathway, the cost of waste and avoidable healthcare activity. The mapping also looked at the impact of the patient's ability to function normally and their ability to work, as 5 of the 6 were of working age and were in employment.

Once the pathways were mapped they were road-tested with a number of GPs and consultants to check both the robustness of the approach taken, and to ascertain whether they considered the patients mapped were a reflection of a typical chronic pain patient. In all cases the clinicians felt that the 6 patients mapped were typical of 80% of their pain patients.

Counting the cost of pain – system impact

The detailed mapping of these patients identified the following;

- The cost burden of these patients on the NHS was much larger than their registered GPs or commissioners realised.
- The WHO pain ladder was not consistently used, by the patients' GP
- None of the patients ever had a full medication review, with their medication merely being; 'topped up'
- All 6 patients had inadequate control of their pain resulting in
 - Unnecessary and avoidable visits to their GP, range 6 – 13, mean of 10
 - Multiple visits to hospital this range 4 – 11, mean of 7
 - High levels of analgesia costs, range £848 - £2364, mean of £1383
 - Avoidable steps and delays in their pathways range 5 – 9, mean of 7
- 3 of the patients had avoidable
 - Accident and emergency attendances, range 1 – 3, mean of 2
 - Emergency admissions, range 1 – 3, mean of 2
 - Invasive diagnostic tests, range 2 – 5, mean of 2
- All 6 patients had low mood, with 3 of the 6 being prescribed anti-depressants
- All 6 patients took time off work due to their pain, range 11 to 127 days, mean of 37
- Of the patients mapped a high proportion of their secondary care activity was directly related to the poor management of their pain, range 41% – 80%, mean of 60%
- In terms of costs this equated to a mean of £1935, which was more than the mean allocation per head of population to a PCT in 2012/13.
- All 6 patients experienced avoidable delays in their journey as a result of inconsistent approaches to the management of pain, poor understanding of the WHO pain ladder and referrals to multiple specialities
- None of the patients mapped were initially referred to a pain specialist, in all but one case, the pain specialist was the final referral at the end of their pathway, by which time their condition had worsened and was more complex.
- Only when the patients were referred and treated by the specialist pain team, did they feel that their pain was adequately controlled.

Success factors

Whilst this review was small, it has since been rolled out to another cohort of patients and the findings were similar, indicating that the overall burden is both real and consistent across the UK. The approach is easily

managed, uses tested methodologies and if used by commissioners could facilitate service redesign and integrated care pathway development.

The mapping showed the 'REAL' burden of pain for the first time across the entire care pathway, and clearly identified the cost and consequences to the system when pain is not well managed, together with waste, delays and un-added value steps. In addition the mapping identified the touch points at which incorrect decisions are made, ultimately affecting the patients care, outcome and system costs

The work identified not only the burden within and across the NHS due to avoidable activity, analgesia, duplication and repetition, but also the social and economic burden due to lack of productivity.

As a consequence of this mapping

- Co-operation with commissioners at a local level to raise the profile of pain has been intensified.
- Work is now underway with the British Pain Society, Royal College of General Practitioners, and the Royal College of Anaesthetists (Faculty of Pain) to raise the profile of pain at a more strategic and national level
- Guidance is now being developed to ensure that pain services are commissioned based on need and following best practice, thus working towards the best possible outcomes for the majority of the population
- The identification of important touch points within the system which if better managed would allow patients to have improved outcomes, less delays, better controlled pain, less interaction with the healthcare system and less time off work. These include:
 - Improved guidelines and referral protocols for GPs
 - Enhanced education around the management of pain from a pharmacological perspective
 - Better access to diagnostics
 - Better access to psychological support to help patient live with their pain
 - The need to have full medication reviews
 - Development of seamless integrated care pathways which allow patients to be seen by the **“right professional, at the right time, in the right place, first time”**.

The mapping identified that by following best practice and raising the profile of pain, the NHS would not only reduce clinical variation, but it would:

- Reduce the number of steps taken within a typical patient pathway
- Reduce waste and delays within the system
- Improve quality of life
- Reduce the overall costs of healthcare resources consumed
- Improve productivity within the whole system
- Directly contribute to a reduction in the amount of time taken off work

The data on chronic pain in the European working population and practices from other EU Member States have been not examined at this stage.


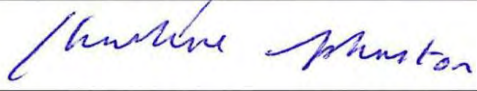


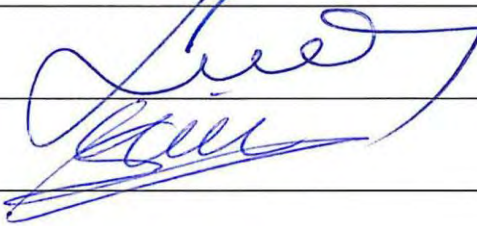
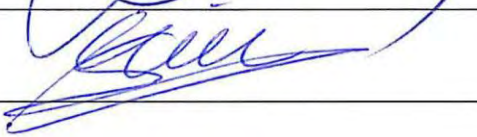



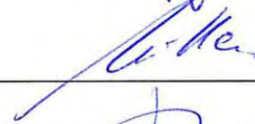


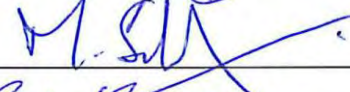
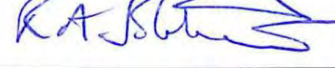
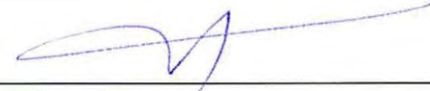
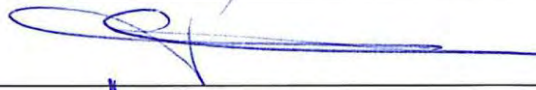
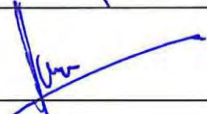

5. Supporting SIP 2013 Proposal for Action: Using European Best Practices for the Reintegration of Chronic Pain Patients into the Workforce

The following delegates/organisations show their support of the SIP 2013 Proposal for Action, as described in chapter 4 on page 7:

I support the "SIP 2013 Proposal for Action" to call European Governments as described in this document

- *to develop, promote and implement preventive measures, and rehabilitation programs for the reintegration of chronic pain patients*
- *to make use of the described existing best practice models from five European Countries, and*
- *to take into account the derived key success factors for future projects.*

	Name of person / organisation / association / institutions	Signature
1	NEVENKA KRČEVSKI SKVINEC	Mun
2	Frank Hagen / Vereniging Fysio in	
3	LARS Bye Møller FAKS - Danish Association of chronic pain patients	
4	JOHN LINDSAY CHRONIC PAIN IRELAND	John Lindsay
5	Antonio Torrel Gilman SEMG SPAIN	
6	TRAVESCO DUARTE CORREIA APED (Associação Portuguesa de Estudos de Dor)	
7	ETIENNE MASQUEHEN	
8	JORIS Bernaert FOCUS Fibromyalgie Belgique	
9	NICA SARAH ADRIANA ROMANIAN SOCIETY FOR STUDY OF PAIN (ARSA)	Nica
10	EUROPEAN FEDERATION OF NEUROLOGICAL ASSOCIATIONS [EFNA] DORNA WALSH	Dorna Walsh
11	PATRICIA PLANAS RUFINO LIGA REUMATOLOGICA CATALANA	Patricia
12	ANA VAZQUEZ LOJO LIGA REUMATOLOGICA GALEGA	
13	PEJRO J. IBOR VIDAL / SEMERGEN. SPAIN	

14	JORDI MOYA RIERA S'INE DOLORE SPAIN	
15	CHRISTINE JOHNSTON PAIN CONCERN	
16	NEIL BETTERIDGE, NEIL BETTERIDGE ASSOCIATES.	
17	AMADO CORDADO FERNANDEZ S.E.S. LA.P.	
18	CSO MERC - MACEDONIA KIRIL SOLESKI, CEO	
19	THILL-NEIERTZ Sandra ALPADOC a.s.b.l	
20	Bucciarelli Denise ALPADOC	
21	Grier, Daniel MedAix - D	
22	HENDRIX, KURT MedAix - D	
23	Hiller Josiane ALPADOC	
24	Françoise WATEL (AFCI)	
25	LAUWERSKOEN AZ KLINA BRASSCHAAT / DPS	
26	MARTIN SCHWARZ TRIGEMINAL NEURALGIA ASSOC. UK	
27	ROBERT JOHNSTON	
28	Jet Van Roel PUR	
29	DE ROOVERE KRISTEL PU VS	
30	Jérôme GIERER, Luxembourg. CLA Cercle Luxembourgeois d'Algieologie	
31	GERTRUDE BITTIGIEG MALTA HEALTH NETWORK	
32		

33	Stefano Coaccioli Perugia University School of Medicine Perugia - (Italy) Dept of Internal Medicine - General Hospital, Terni (Italy)	Stefano Coaccioli
34	DANIELE BATELLI ASSOCIAZIONE SAHARINHOSS PER LO STUDIO DEL DOLORE	Daniele Battelli
35	LIENE SULCE-REVELE PATIENTS' OMBUD OFFICE OF LATVIA	Liene Sulce-Revele
36	TILI KOJIC ZAVOD VIVA SLOVENIA	Tili Kojic
37	Eli Alon Zurich Switzerland	Eli Alon
38	GIUSTINO VARRASSI on behalf of Regione Abruzzo Soc. Sec. System, Italy	Giustino Varrassi
39	MARIANO VONNA ACTIVE CITIZENSHIP NETWORK	Mariano Vonna
40	PETER MOORE PAIN TOUCHIT	Peter Moore
41	Prof. MARIJANA BRAS School of medicine University of Zepreb	Marijana Bras
42	VICOMEA CUMSAM PAIN ALLIANCE EUROPE	Vicoméa Cumsam
43	Heldge Weibernik - Tolman Pain Platform Nederland	Heldge Weibernik
44	Pain Alliance Europe Jeroen van Griensven	Jeroen van Griensven

45	Liisa Mikkonen PAE / Suomen Kipu ry	Liisa Mikkonen
46	Konrad Labuschagne Kampel.	Konrad Labuschagne
47	Jose Luis Sotom. TRENAP. SPAIN.	Jose Luis Sotom.
48	EURAZ ÖSTERREICH ERIKA FOLKES	Erika Folkles
49	ANA MANGAS, MD CHLP - PORTUGAL	Ana Mangas
50	M. TERESA FLOR-DE-CIMA MD, PAIN DOCTOR - PORTUGAL	M. Teresa Flor-de-Cima
51	JENNY GULLIFORD THE WORK FOUNDATION	Jenny Gulliford
52	JENNA SEYMOUR MUNDIPHARMA INTERNATIONAL.	J. Seymour
53	BILLY KUO MUNDIPHARMA INTERNATIONAL	Billy Kuo