"the time has come to liberate the NHS frontline." Amen, say all of us.

The first reaction to Mr Milburn's speech is, however, likely to be one of cynicism. At one time or other all secretaries of state for health—Conservative as well as Labour—have rhetorically embraced the notion of devolving power. But this has not stopped a seemingly unstoppable trend towards ever greater centralisation, culminating with the present government. However, it is worth giving Mr Milburn the benefit of the doubt on two counts. Firstly, his speech marks public recognition of the fact that government policies depend on engaging the enthusiasm of those working in the NHS and that there is a danger that staff may feel "disempowered or disillusioned" as well as overloaded. Not before time, it might be said, but at least the sinner shows signs of repentance. Secondly, his speech represents an attempt to show why the new vision should be seen not as a retreat from the previous emphasis on centralisation but as evidence that the government's command and control strategy has worked. This contention is not self evidently convincing but is worth exploring.

Mr Milburn's argument runs as follows. Given that the aim of the government's strategy is "to make the best practice in one part of the health service the norm in all of its parts"—or, as Aneurin Bevan, the politician responsible for establishing the NHS in 1948, put it, to universalise the best—then it follows that a strong machinery of control has to be established. National standards have to be set. National service frameworks have to be promulgated. There has to be a system of inspection. Otherwise anarchy rules: variation would continue to be the norm in the NHS as it has been for the past half century. But once the corset of control has been created, then it becomes possible to allow more freedom within it in the knowledge that liberty is not a licence for poor standards or inadequate performance. The emphasis can switch from hierarchical managerial control to adopting a missionary, developmental style of promoting best practice through the new Modernisation Agency.

The logic is persuasive. But there are problems. Not only is "universalising the best" an oxymoron. The phrase also assumes that the "best" can be determined by central government rather than being defined variously and experimentally in the light of local circumstances: not for nothing was the NHS, as created by Bevan, a monument to paternalistic technocracy. Narrowing the range of quality and performance is unquestionably desirable. So is prodding poor performers towards achieving what the best do already. But it is far from clear from Mr Milburn's pronouncement how much discretion trusts and others will have to diverge from national norms or to experiment. Freedom for them will lie in the knowledge of necessity: if they deliver the government's goals, they will be allowed a degree of (unspecified) discretion. Clearly therefore there is a need for much more debate about what are, or are not, acceptable variations, as well as for a cull of the ever proliferating range of targets and goals set by the government.

If scepticism is the inevitable first reaction to Mr Milburn's vision, a more considered verdict might therefore be to welcome it as providing the criteria against which the record of a second term Labour government can be assessed. And given this government's dedication to setting targets, perhaps the next step would be for the secretary of state to announce a set of devolution performance indicators. The National Plan committed itself to a reduction in the number of circulars produced by the centre. Other indicators might be the number of telephone calls from the secretary of state's private office to NHS managers and the volume of reports demanded by and flowing into the Department of Health. No doubt many others could be devised. The challenge to Mr Milburn—or his successor—will be to demonstrate that reality can match rhetoric.

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1 Milburn A. Shifting the balance of power in the NHS. Speech delivered on 25 April 2001. http://tap.ccta.gov.uk/doh/intpress.nsf/page/2001-0200

Understanding the burden of musculoskeletal conditions

The burden is huge and not reflected in national health priorities

Musculoskeletal conditions have an enormous and growing impact world wide. "Health 21," the health for all policy framework for the World Health Organization's European region,[1] identifies musculoskeletal conditions as a target, yet national health care priorities in the United Kingdom and most European countries do not include them. To address this imbalance the United Nation, the WHO, governments, and professional and patients' organisations have declared 2000-10 the "bone and joint decade" with the aim of improving the health related quality of life of people with musculoskeletal conditions.

Although one of the aims of the decade is to increase the recognition and understanding of the burden posed by musculoskeletal conditions, there are already enough data to show the size of the problem. Musculoskeletal impairments ranked number one in chronic impairments in the United States,[2] and chronic musculoskeletal pain is reported in surveys by 1 in 4 people in both less and more developed countries.[3] Musculoskeletal conditions were the most expensive

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disease category in a Swedish cost of illness study, representing 22.6% of the total cost of illness.[4] Measured in terms of disability adjusted life years (DALYs), osteoarthritis is the 4th most frequent predicted cause of health problems worldwide in women and the 8th in men[5]; rheumatoid arthritis restricts work capacity in a third of people within the first year[6]; fractures related to osteoporosis will be sustained by about 40% of all white women aged over 50[7]; the one year prevalence of low back pain in the UK is almost 50%[8]; 23-34 million people are injured world- wide each year in road traffic accidents[9]; and work related musculoskeletal disorders were responsible for 11 million days lost from work in 1995 in the UK.[10] Yet only 5% or less of national research councils' spending is allocated to musculoskeletal conditions in established market economies.

From large areas of the globe incidence and prevalence figures are rudimentary or lacking, but epidemiological studies in less developed countries[11] show that musculoskeletal conditions are just as important a problem as in more developed countries. The impact of musculoskeletal conditions and trauma varies between different parts of the world and is influenced by social structure, expectation, and economics. Nevertheless, with population growth and increased longevity, urbanisation, and more use of cars, the burden is increasing.

Why is the importance of musculoskeletal conditions underappreciated? Is it because they are rarely fatal, are considered irreversible, and are associated with age? Older people place a very high marginal value on maintaining independence and dignity,[12] and preventive measures and effective treatments are now available that can significantly improve the outcome of musculoskeletal conditions. However, the recently demonstrated underuse of hip and knee arthroplasty[13] reflects the lack of knowledge, negative attitudes, and low expectations that surround these conditions.

A primary objective of the bone and joint decade is to provide, in collaboration with the WHO Global Burden of Disease 2000 Project, information on the burden caused by musculoskeletal conditions to inform debates on priorities and strategies. In addition, defining methods of measuring and monitoring these conditions will enable trends to be predicted and allow planning of research and development, training, and investment in health services.

For these largely chronic non-fatal conditions, disability assessment is more important than mortality figures, and the WHO revised classification of effects of health conditions, the ICIDH-2, provides a framework to describe these consequences and factors that may influence them. Summary measures of population health, such as disability adjusted life years (DALYs), facilitate comparisons between different conditions by combining information on mortality and non-fatal health outcomes, but estimating these for chronic, progressive conditions with variable outcomes poses challenges and can undervalue life with disability. Indicators that can also integrate evidence from randomised controlled studies with evidence gained in clinical practice to identify interventions that improve health are needed to assess the consequence of a disease for both the individual and the population.

At present few indicators relevant to musculoskeletal conditions are routinely collected either in national health statistics or by the WHO Health for All 2000 statistical databases. We need to identify such indicators and advocate their use. At the level of the individual better measures of long term morbidity need to be agreed and data collected. A recent WHO scientific group meeting considered pain, mobility, and independence to be the most relevant domains for musculoskeletal conditions, and it identified the need for simpler instruments usable in all populations to monitor these aspects. The meeting represented the first phase of a global health needs assessment exercise for musculoskeletal conditions, the bone and joint monitor project, which also aims to show what can be achieved by effective evidence based strategies to reduce the burden.

Recognition of the burden of musculoskeletal conditions will result in greater awareness of the pervasive effects they have on individuals and of their cost to society. Measuring the burden should ensure they receive higher priority in health strategies. The application of agreed indicators will allow these conditions to be monitored and interventions evaluated. In these ways understanding the burden will ultimately improve outcome for individuals.

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On behalf of the participants of the WHO and Bone and Joint Decade scientific group meeting on the burden of musculoskeletal conditions at the start of the new millennium, Geneva 2000.

1 World Health Organization. *Health 21: the health for all policy for the WHO European region—21 targets for the 21st century*. Copenhagen: WHO Regional Office for Europe, 1988.
2 National Center for Health Statistics. *National health interview survey, 1995*. Hyattsville, MD, US Department of Health and Human Services, 1995.
3 White KP, Harth M. The occurrence and impact of generalised pain. *Baillière's Clin Rheumatol* 1999;13:379-89.
4 Jacobson L, Lindgren B. Vad kostar sjukdomarna? [What are the costs of illness?] Stockholm: Socialstyrelsen (National Board of Health and Welfare), 1996.
5 Murray JL, Lopez AD, eds. *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard University Press, 1996.
6 Jäntti J, Aho K, Kaarela K, Kautiainen H. Work disability in an inception cohort of patients with seropositive rheumatoid arthritis: a 20 year study. *Rheumatology (Oxford)* 1999;38:1138-41.
7 Genant HK, Cooper C, Poor G. Interim report and recommendations of the World Health Organisation task-force for osteoporosis. *Osteoporosis Int* 1999;10:259-64.
8 Palmer KT, Walsh K, Bendall H, Cooper C, Coggon D. Back pain in Britain: comparison of two prevalence surveys at an interval of 10 years. *BMJ* 2000;320:1577-8.
9 *Estimating global road fatalities*. Crowthorne, Berks: Transport Research Laboratory, 2000. (TRL Report 445.)
10 Jones JR, Hodgson JT, Clegg TA, Elliott RC. *Self-reported work-related illness in 1995. Results from a Household Survey*. London: Health and Safety Executive, 1998.
11 Darmawan J, Valkenburg HA, Muirden KD, Wigley RD. Epidemiology of Rheumatic Diseases in rural and urban populations in Indonesia: a World Health Organisation International League Against Rheumatism COPCORD study, stage I, phase 2. *Ann Rheum Dis* 1992;51:525-8.
12 Salkeld G, Cameron ID, Cumming RG, Easter S, Kurrle SE, Quine E. Quality of life related to fear of falling and hip fracture in older women: a time trade off study. *BMJ* 2000;320:241-6.
13 Hawker GA, Wright JG, Coyte PC, Williams JI, Harvey B, Glazier R, et al. Differences between men and women in the rate of use of hip and knee arthroplasty. *N Engl J Med* 2000;342:1016-22.

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