Availability of services to treat patients with acute low back pain

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SUMMARY

Guidelines for the management of acute low back pain were published in 1994. This national survey, conducted soon after, showed that the availability of services for general practitioners (GPs) to treat acute back pain fell short of the guideline recommendations. A repeat survey will be performed to measure the impact of guideline publication and dissemination.

Keywords: back ache; physical therapy; fundholding; treatment availability.

Introduction

LOW back pain (LBP) is an important medical and social problem with an increasing economic cost.[1] The Clinical Standards Advisory Group (CSAG) in 1994,[2] and the Royal College of General Practitioners in 1996,[3] recommended that acute, simple LBP should be treated with early physical therapy in order to prevent chronic disability. We describe a survey of the availability of eight services (Table 1) recommended by the CSAG for acute LBP patients, which was conducted immediately after its report was published.

Method

Questionnaire

General practices were sent a questionnaire asking if they thought that the services recommended by the CSAG were available for their patients, and whether they would use them if they were available or became available. Purchasers received a questionnaire asking if they thought the services were available to typical fundholding or non-fundholding practices in their area. Services provided by the National Health Service (NHS) without a special arrangement or an extra-contractual referral during the 1994–95 financial year were specified.

Practices

A random selection of up to six practices served by each Family Health Services Authority (FHSA) or Health Board, stratified by size and fundholding status, was made from the 870 practices in the Medical Research Council's General Practice Research Framework (GPRF).

Purchasers

The questionnaires were addressed to named individuals, identified by telephoning 115 FHSAs and health boards in the UK responsible for placing contracts for back pain services.

Analysis

Categorical variables were compared using a chi-square test or Fisher's exact test as appropriate. When applicable, a logistic regression model was used to correct for typical fundholding practices being larger.

Results

Practices

Questionnaires were returned by 307 of the 342 practices selected (89.8%); 133 (43.3%) were fundholding. The principal results are summarized in Table 1. The proportion of GPs who would use the services if available ranged from 91.1% for an urgent pain relief service to 99.3% for an urgent referral for possible serious pathology. Fitting list size as the sole continuous variable in a logistic model showed that larger practices, regardless of fundholding status, were more likely to have access to a multi-disciplinary team ($\chi^2 = 5.58$, df=1, $P = 0.02$). None of the other recommendations were found to be dependent on list size.

Purchasers

Questionnaires were returned by 98 of 115 purchasers (85.2%). Seven returned the form blank because the data were not available. The overall response rate to individual questions ranged from 44% to 68%. The reported service availability ranged from 43%, for non-fundholders' access to routine physical therapy in less than two weeks, to 96% for all practices' access to an urgent opinion for possible serious pathology within two weeks. Only the access to routine physical therapy was reported to be significantly greater for fundholding practices ($P = 0.01$). The purchasers consistently reported a higher level of service availability than did the general practices.

Discussion

The high response rate and national distribution suggest that the practice-based findings are generalizable. The information from purchasers is less reliable because of the large number of incomplete replies.

The availability of services does not match that recommended by the CSAG. A surprising finding was that 80.2% of practices reported access to an NHS physical therapist before patients had been off work for six weeks. Increasing this service is part of the CSAG's strategy to reduce long-term sickness absence from back pain. However, if this service is already widely available, and is used effectively, increased resources may not greatly reduce the numbers of individuals unable to work and claiming benefit because of chronic LBP.

Compared to non-fundholders, the fundholding practices have better access to appropriate physical therapy services that can be provided within the practice, but they have similar access to services usually provided in hospitals. If the recommended services were available, GPs would use them. Any campaign to improve services for LBP should therefore target service provision by

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Table 1. Availability of services to treat acute low back pain as reported by general practitioners.

Service recommended by the CSAG	All responders n = 307 (%)	Non-fundholders n = 174 (%)	Fundholders n = 133 (%)	P value*
For patients with suspected cauda equina compression or widespread neurological disorder, there is a locally agreed contact for emergency referral who would assess the patient within hours.	154/269 (57.2)	93/149 (62.4)	61/120 (50.8)	0.06
Patients referred with possibly serious spinal pathology are seen by a consultant within two weeks of referral. This may involve a telephone call to the consultant.	272/297 (91.6)	153/166 (92.2)	119/131 (90.8)	0.68
Patients with possible nerve root problems (sciatica) not resolving after six weeks are seen by a consultant within two weeks of referral.	95/293 (32.4)	53/169 (31.4)	42/124 (33.9)	0.65
Urgent telephone referrals for simple back pain to a physical therapist are seen within 72 hours.	131/279 (47.0)	56/155 (36.1)	75/124 (33.9)	<0.0001
Routine referrals for simple acute back pain to a physical therapist are seen within two weeks of referral.	132/295 (44.7)	63/167 (38)	69/128 (53.9)	0.01
An acute back pain relief service is available within 48 hours of a telephone request for patients with severe, acute pain and distress not responding to standard treatment.	91/291 (31.3)	42/163 (25.8)	49/128 (38.3)	0.02
Patients with simple acute LBP are seen by a physical therapist (physiotherapist, osteopath or chiropractor) before they have been off work for six weeks.	243/303 (80.2)	122/170 (71.2)	121/133 (91.0)	<0.0001
Patients with chronic back pain after failed primary care management are seen and assessed by a multi-disciplinary team before they have been off work for six months.	93/298 (32.3)	49/162 (30.2)	44/127 (35)	0.07**

*Comparing access to the service between fundholders and non-fundholders using chi-square test; **logistic regression model used.

hospitals. The large proportion of purchasers who were unaware of current services suggests that LBP has a low priority, or possibly that knowledge of service provision is generally poor. This study will be repeated when there has been sufficient time to review service provision for acute LBP.

A limitation of this study is that it depends upon GPs' and purchasers' beliefs as to which services are available. The actual process of care for patients with acute LBP has not been studied; however, in practical terms, if GPs do not think that a particular service is available, their patients are unlikely to receive it. A large prospective community-based study is still required to examine the process of care for these patients.

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