**Versus Arthritis’ representation to Autumn Budget and Spending Review 2021**

September 2021

1. Versus Arthritis welcomes the opportunity to provide input into the Autumn Budget and Spending Review 2021.
2. Versus Arthritis is the charity formed when Arthritis Research UK and Arthritis Care joined together in 2018. We work alongside volunteers, healthcare professionals, researchers and people with arthritis to do everything we can to push back against arthritis. Together, we develop breakthrough treatments, campaign for arthritis to be a priority and provide support. Our remit covers all musculoskeletal conditions which affect the joints, bones and muscles including osteoarthritis, rheumatoid arthritis, back pain and osteoporosis.[[1]](#endnote-2)
3. Arthritis and related musculoskeletal conditions affect 20.3 million people in the UK and are the single biggest cause of pain and disability in the UK.[[2]](#endnote-3) Cumulatively, the healthcare costs of osteoarthritis and rheumatoid arthritis will reach £118.6 billion over the next decade.[[3]](#endnote-4) In 2018, MSK problems were the second most common cause of sickness absence, accounting for 27.8 million days in work lost and a fifth (19.7%) of all sickness absences.[[4]](#endnote-5)
4. This representation focuses on the following areas of budget which are important to people with arthritis and related musculoskeletal conditions:

* **Healthcare services**: improving outcomes for people with musculoskeletal conditions through treatment, prevention, care and support.
* **Public Health and prevention:** preventing and mitigating the impact of arthritis and musculoskeletal conditions in society.
* **Employment**: enabling people with musculoskeletal conditions to be in work and recognising the negative impact of musculoskeletal conditions on individuals and on the economy.
* **Cutting-edge research**: supporting the economy through a vibrant science sector and addressing musculoskeletal conditions through long-term investment in research.

1. **Summary points:**

Health services (treatment)

* Waiting times for Trauma and Orthopaedic surgery (including hip and knee replacements) were already rising before the pandemic. COVID-19 has accelerated this trend with a significant increase in the number of people with arthritis now waiting a year or more for joint replacement surgery in England.
* Evidence shows that delaying surgery can lead to worse outcomes for people who have been referred for hip and knee joint replacement, particularly waiting times beyond 6 months.[[5]](#endnote-6)
* Safely reducing the backlog for elective surgery in the fastest possible time will require optimising existing resources in new ways such as via ‘surgical hubs’, increasing capacity within the NHS, and expanding capacity by partnering with the independent sector.
* Longer waiting times mean that those who have been referred for surgery are more likely to require greater support while they wait.
* We welcome the recent announcement of funding for elective recovery. Versus Arthritis believes that any plan for recovering elective care should prioritise these three outcomes to make sure this additional funding is spent effectively:
  + Reducing the backlog and waiting times for elective surgery (including joint replacements)
  + Supporting people on waiting lists for elective surgery (including joint replacements)
  + Providing clear communication to people on waiting lists for elective surgery (including joint replacements)

Public Health and prevention

* A renewed focus on and investment in effective, preventative public health programmes should be a core part of the Spending Review.
* This can be achieved through committing to reverse the cuts to the Public Health Grant since 2013/2014 at a local level, and providing the new Office of Health Improvement and Disparities (OHID) with the long-term funding needed to be an effective leader on public health issues at a national level.
* We welcome the Government’s commitment to require a set level of NHS spending to be directed towards preventative health initiatives. As one of the leading causes of preventable pain and disability, musculoskeletal conditions must be a core focus of this workstream.
* The NHS Health Check has been a core part of the NHS’ preventative healthcare offer for over a decade and is cost-effective, through the delivery of savings to the NHS budget.
* The NHS Health Check programme is currently undergoing a review to understand how it can deliver the best value for patients and the NHS. As a leading cause of preventable ill-health, the inclusion of musculoskeletal conditions within the scope of the check has the potential to significantly improve the rates of early detection, and ensure people have access to the resources they need to manage their musculoskeletal health effectively.
* The Government should ensure that, after the current ongoing review is completed, the renewed health check offer either in the form of an updated Health Check programme or a new National Prevention Service, includes a musculoskeletal health element and has sufficient resources for it to be implemented effectively.

Employment

* As a result of the pandemic and the shift to home working, data suggests that more people are now at risk of developing a musculoskeletal condition that could affect their productivity and ability to remain in the workforce. Factors influencing this include a lack of appropriate adaptations to home working, such as not having suitable ergonomic office equipment, reduced access to support from occupational health services, and working patterns that encourage sedentary behaviour.
* The Spending Review should include dedicated funding to expand the support available to home workers who now require adjustments and support via the Access to Work Scheme as a result of working outside of office spaces. The Department for Work and Pensions (DWP) should also look to expand promotion of the Access to Work scheme on an ongoing basis to improve uptake amongst people with musculoskeletal conditions, who represent a significant proportion of individuals with long-term conditions in the workforce.

Cutting-edge research

* We support the five-point roadmap to making the UK a “science superpower” that has been proposed by the Campaign for Science and Engineering (CaSE).[[6]](#endnote-7)
* Versus Arthritis welcomes the Government’s stated commitment to increase public R&D investment to £22 billion per year by 2024-25 and asks that the Government continues to prioritise R&D investment as a central pillar of the UK’s post-COVID economy.
* The Government must ensure a balanced combination of funding strategies to support basic discovery science, incremental, progressive R&D and high risk, high return R&D through a variety of funding mechanisms offering both responsive and challenge-led funding.
* The National Institute for Health Research (NIHR) should be adequately resourced to deliver the commitments around research and innovation as set out in the NHS Long Term Plan.
* As part of its comprehensive R&D plan and focus on research sustainability brought about by COVID-19, we ask that the Government commit to an increase in the Charity Research Support Fund (CRSF) to keep pace with levels of charity R&D investment and to protect the unique partnerships between universities and charities.

**SUBMISSION**

**HEALTH SERVICES (TREATMENT)**

1. Waiting times for Trauma and Orthopaedic surgery (including hip and knee replacements) were already rising before the pandemic. COVID-19 has accelerated this trend with a significant increase in the number of people with arthritis now waiting a year or more for joint replacement surgery in England. [[7]](#endnote-8)
2. Trauma and Orthopaedic surgery was particularly affected by the postponement and cancellation of elective operations in 2020. In frameworks used by clinicians to prioritise surgery, patients requiring planned operations like hip and knee replacements were designated as lower risk and priority compared to other treatment.[[8]](#endnote-9) There has also been significant ongoing capacity constraints in terms of the number of operating theatres and staff available to deliver surgical care, partially due to the redeployment of resources during the peak of pandemic.[[9]](#endnote-10) This has contributed to orthopaedic surgery recovering at a slower pace compared to other specialties and to higher waiting lists which has had a significant impact on the quality of life for people waiting for joint replacement surgery.
3. Recent analysis from the Health Foundation has provided further insight into the length of time people were waiting for a hip replacement operation, the impact on the quality of life of those waiting and the pace that operations were recovered across England last year.[[10]](#endnote-11)
4. As of January 2021, the Health Foundation estimated that 58,000 people had waited an additional 25 weeks for a hip replacement operation, equivalent to a loss of 80 days in “perfect health” (as measured by the EQ-5D model). This impact was also reflected in the post-surgery outcomes of those waiting for care.[[11]](#endnote-12)
5. The Health Foundation analysis also showed the regional variation in the recovery of hip replacement operations last year. Their analysis found that only London and the South East managed to recover their pre-pandemic rates of admissions for hip replacement operations in 2020. In addition, the number of admissions for hip replacement operations in England were only half (60,000) of what they were projected to be, with regions like the Midlands (15,000) and North East & Yorkshire (11,000) facing a greater deficit of admissions compared to London (3,000).
6. Furthermore, evidence published in April 2021 found that patients living in the most deprived CCG areas in England (as measured by the Index of Multiple Deprivation) had experienced the most disruption from the fall in elective activity, with lower numbers of completed treatment pathways compared to the least deprived CCG areas.[[12]](#endnote-13) Recent analysis from the King’s Fund found that those living in the most deprived areas are now nearly twice as likely to wait over a year for elective treatment compared to those in the least deprived areas.[[13]](#endnote-14)
7. NHS England and Improvement reflected the growing urgency to tackle waiting lists for MSK and orthopaedics by designating these areas a priority for recovering non-COVID services, in guidance to local areas in both December 2020 and March 2021.[[14]](#endnote-15)
8. The Referral to Treatment (RTT) figures that were published by NHS England and Improvement in early August showed the size of the Trauma and Orthopaedic waiting list in June 2021 as follows:[[15]](#endnote-16)

* 668,763 people are on the waiting list in England for Trauma and Orthopaedic (T&O) treatment. This represented an increase of 3% since the previous month (647,450) and is around 23% higher than the average number of people waiting in 2019 (511,834).
* 269,204 (40%) of people on the waiting list for Trauma & Orthopaedic treatment had been waiting longer than 18 weeks. This compares to 280,994 (43%) the previous month and around 87,250 (17%) in 2019. The total number waiting over 18 weeks has decreased slightly (by 4%) since the previous month’s figures.
* 64,277 (10%) of people on the waiting list for Trauma & Orthopaedic treatment were waiting longer than 52 weeks/one year, a decrease of 9% (6,078 people) since last month. (May 21 – 70,355; April 21 – 81,056; March 21 – 92,165; Feb 21 – 84,447 (14%); Jan 21 – 67,173 (11%); Dec 20 – 49,450 (9%).
* However, as Table 1 below indicates, the numbers of people waiting between 72 and 102 weeks for Trauma and Orthopaedic treatment actually increased between May and June 2021.

1. Whilst the number of people waiting more than 52 weeks has decreased in the last two months (reflecting NHS priorities), the overall numbers waiting for this length of time has increased significantly since the start of the pandemic.
2. NHS England has also started to record the numbers of people waiting up to two years or 104 weeks for Trauma and Orthopaedic treatment. As the figures below demonstrate, at least 64,277 people had been waiting between 52 and 104 weeks for treatment as of June 2021.

Table 1: RTT Waiting Times, June 2021 (52-104 weeks)

|  |  |  |
| --- | --- | --- |
| **Waiting time** | **June 2021** | **Previous month (May 2021)** |
| GT 52 to 62 weeks | 13,053 (2.0%) | 10,566 (1.6%) |
| GT 62 to 72 weeks | 18,734 (2.8%) | 31,523 (4.9%) |
| GT 72 to 82 weeks | 17,906 (2.7%) | 15,725 (2.4%) |
| GT 82 to 92 weeks | 9,229 (1.4%) | 8,191 (1.3%) |
| GT 92 to 102 weeks | 3,719 (0.6%) | 3,198 (0.5%) |
| GT 102 to 104 weeks | 407 (0.1%) | 304 (0.1%) |
| GT 104 weeks (2 years) | 1,229 (0.2%) | 812 (0.1%) |
| **GT 52 weeks** | **64,277** | **70,355** |

1. Lengthening waiting times for joint replacement surgery over the last year have had a significant impact on people with arthritis. Between 22nd October and 4th December 2020, Versus Arthritis surveyed people waiting for joint replacement surgery and found that[[16]](#endnote-17):

* 79% reported their physical health had worsened
* 89% said their pain levels had deteriorated
* 90% reported reduced mobility
* 79% said they were now less independent
* 72% reported a deterioration in their mental health

1. These findings have been reinforced in a more recent survey of 549 respondents waiting for joint replacement surgery carried out by Versus Arthritis in May and June 2021. In response to the question “What has been impacted by the wait for surgery?” (respondents could choose more than one option) the results were as follows:[[17]](#endnote-18)

* 46% - Mobility and staying physically active
* 44% - Physical health and managing my pain
* 32% - Mental Health
* 40% - Daily life (e.g. at home, getting out, relationships)

Workforce and capacity

1. Since the onset of the COVID-19 pandemic, there has been severe disruption to the delivery of elective surgery in England due to an increase in demand for hospital bed space linked to COVID-19 infections. Elective surgery was postponed across the whole of England from April to July 2020, and some local areas chose to suspend elective surgery during periods where COVID-19 infections had increased (particularly during Winter 2020-21 and the start of July 2021).
2. Survey work carried out by the British Orthopaedic Association (BOA) and the British Orthopaedic Directors Society (BODS) in 2020 highlighted the challenges faced by Trusts when orthopaedic services were restarted last Summer. BOA/BODS found significant regional variation in the recovery of elective orthopaedic services, recommending that additional resources were required to help Trusts meet NHS England targets.[[18]](#endnote-19)
3. The disruption to elective surgery during 2020 and 2021 has led to significant increases in waiting lists and highlighted the limits in the current capacity within the NHS to be able to deliver elective surgery alongside being able to respond to future COVID-19 infection outbreaks.
4. Safely reducing the backlog for elective surgery in the fastest possible time will require optimising existing resources in new ways such as via ‘surgical hubs’, increasing capacity within the NHS and expanding capacity by partnering with the independent sector.
5. A study published in Bone Joint Open last year concluded that through the development of COVID-free pathways, it is possible for elective surgery to restart safely with low viral transmission rates from COVID-19.[[19]](#endnote-20) However, analysis of data from the National Joint Registry recently suggested that capacity would need to be increased by at least 10% over five years to sustain the recovery of joint replacement operations.[[20]](#endnote-21)
6. To increase capacity within the NHS, the Royal College of Surgeons and other professional bodies have supported expanding the adoption of surgical hubs across England for specialties like orthopaedics to help increase capacity within the NHS.[[21]](#endnote-22) Recent analysis from the Health Foundation has suggested that adopting the surgical hub model could be a factor in explaining the degree of elective recovery in London last year compared to other regions.[[22]](#endnote-23) A survey contained in the Royal College of Surgeons’ Action Plan for England cited that six in ten (58%) UK adults said that it would be “important for them to be treated in a surgical hub hospital” if they needed an operation.
7. Alongside increasing capacity in the NHS, more effective deployment of independent sector capacity could help reduce NHS waiting lists for elective surgery (especially orthopaedic treatment like hip and knee joint replacements).
8. It is important that the NHS in England learns lessons from last year, where an estimated two-thirds of independent sector capacity block booked by the NHS was not used between June and the end of September 2020.[[23]](#endnote-24) Such arrangements contributed to a missed opportunity to reduce the backlog of non-COVID treatment that increased following the suspension of elective surgery between April and July 2020. In this case payment to independent sector providers was based on making capacity made available, rather than activity they delivered.[[24]](#endnote-25)
9. The think tank Policy Exchange has suggested that such an outcome could be averted by the NHS issuing long-term contracts with clear volume-based outcomes that ensure the maximum number of operations can be delivered for the money spent. [[25]](#endnote-26)
10. Increasing capacity to reduce waiting lists for elective surgery (including hip and knee joint replacements), and to support patients whilst they wait for surgery will also require the workforce to deliver this treatment and care. Versus Arthritis’ Joint Replacement Support Package report highlighted the role of a range of primary and secondary care professionals in providing the range of support required by people with arthritis on waiting lists.[[26]](#endnote-27)
11. Policy Exchange has submitted a number of recommendations to expand the elective care workforce, including investment in diagnostic capacity, a fund to hire data managers to improve the quality of waiting lists and ensuring planned care is a priority within a national workforce strategy.[[27]](#endnote-28)
12. The British Orthopaedic Association (BOA) has also highlighted a number of issues that need to be addressed to ensure the orthopaedic surgical workforce is sustainable and can meet the growing demand for orthopaedic surgery (such as hip and knee joint replacements) in the near future. This includes resolving issues around pensions and tax liability, and delays to training for newly qualified staff.
13. **We support the policy solutions to both increase the workforce needed to reduce the surgery backlog and resolve existing workforce issues that present a barrier to recovering elective care services that have been proposed by Policy Exchange, the Royal College of Surgeons and British Orthopaedic Association.**

Financial investment required to tackle the backlog – and how funding should be allocated

1. In May 2020, the Health Foundation measured the cost of returning NHS waiting times to 18 weeks for routine treatment in the period before the COVID-19 pandemic. [[28]](#endnote-29)
2. The Health Foundation’s base estimate was that £380m per year was required to keep pace with demand (200,000 additional patients being treated), plus £3.6bn to clear the backlog (1.3 million patients). If spread evenly over next four years, this would amount to a total annual cost of £1.3bn.
3. For the Spending Review in November 2020, the Health Foundation estimated that tackling the backlog of demand for elective care and restoring waiting times standards by 2023/24 would cost an extra £1.9 bn in each of the next three years.[[29]](#endnote-30)
4. In August 2021, the Institute for Fiscal Studies outlined a range of funding options for reducing the overall elective care backlog. One of their scenarios estimated an annual cost of at least £1 billion (even before accounting for the need for any additional infrastructure). This scenario assumed 75% of patients returned, the NHS operated at 100% capacity (i.e. at 2019 levels of activity) in 2021 and 2022, as well as adding an additional 5% of capacity from 2023 (equivalent to treating an additional 800,000 patients per year).[[30]](#endnote-31)
5. According to this estimate, waiting lists would rise before falling gradually by the end of 2025. However, by this stage waiting lists would still be at double the pre-pandemic level at around 8.6 million people.
6. The Elective Recovery Fund was announced as part of the UK Government’s Spending Review in 2020[[31]](#endnote-32) to provide £1 billion to local systems *“to begin tackling the elective backlog, enough funding to enable hospitals to cut long waits for care by carrying out up to one million extra checks, scans and additional operations or other procedures.”* This Fund is designed to cover the range of elective procedures, including hip and knee replacement surgery.
7. In March 2021, NHSE/I published the Elective Recovery Framework which provided the criteria that local systems would have to meet to qualify for funding. This included the level of activity delivered and a number of other criteria such as waiting list management and using waiting list data to support the most vulnerable patients.[[32]](#endnote-33)
8. The recovery of elective care has begun in England, but there is still a significant backlog of operations that will require investment (alongside service reform) to reduce waiting lists and the times that people with arthritis are waiting.
9. In addition, the increase in Covid-19 infections in early July 2021 led to further cancellations of surgery in some NHS Trusts in England, putting services under renewed pressure. The situation for Autumn 2021 is also uncertain. Finally, some people with arthritis may not have come forward for treatment during the pandemic which could exacerbate pressures further if they now present for treatment.
10. The legacy of elective surgery and other health services being postponed or cancelled across England during 2020 has also contributed to the condition of many people with arthritis deteriorating over the last eighteen months. This means that those who have been referred for joint replacement surgery are more likely to require greater support while they wait.
11. In September 2021, the UK Government announced £9 billion investment to replenish the Elective Recovery Fund to the end of this Parliament (Financial Year 2024/25).[[33]](#endnote-34). Further details will need to be provided by NHS England and Improvement on how they will invest these resources over this time period to tackle the elective backlog in England in the most efficient way possible.
12. **Versus Arthritis believes that any plan for recovering elective care should prioritise these three outcomes to make sure this additional funding is spent effectively:**

* **Reducing the backlog and waiting times for planned surgery (including joint replacements)**
* **Supporting people on waiting lists for planned surgery (including joint replacements)**
* **Providing clear communication to people on waiting lists for planned surgery (including joint replacements)**

**PUBLIC HEALTH**

1. Effective public health interventions, particularly those designed to increase physical activity and improve weight management amongst the general population, are essential to maintaining good musculoskeletal health. Improving musculoskeletal health at a population level is a key part of reducing long-term demand on healthcare services and ensuring fewer people are unable to work due to the pain and disability associated with musculoskeletal conditions.
2. Furthermore, these public health programmes can also help individuals with existing musculoskeletal problems, as physical activity and good nutrition are essential to the effective management of many musculoskeletal conditions. Addressing musculoskeletal problems including pain and fatigue within broader public health initiatives can also help unlock healthy behaviours like physical exercise for people with these conditions, which in turn makes it easier to prevent and manage common comorbidities, such as cardiovascular disease.
3. Research also shows that effective prevention focused public health interventions are largely cost-effective, providing a strong return on investment in the long term.[[34]](#endnote-35) [[35]](#endnote-36) Therefore, strong local public health programmes that address the underlying drivers of preventable ill health, including musculoskeletal problems, are vital to improving the nation’s overall health, resilience and productivity.
4. Analysis has shown that since 2014/2015, investments made in public health through the core public health grant have fallen across successive years. By 2019/20, the value of the public health grant meant that planned spending on public health services by local authorities was £3.3 billion, a 15% reduction in spending compared to 2013/14.[[36]](#endnote-37)
5. Although the public health grant did increase marginally between 2019/20 and 2020/21, this had a negligible effect in counteracting the impact of cuts made over the longer term. In real terms, the public health grant in 2020/21 was still 24% lower than in 2015/16.[[37]](#endnote-38)
6. In terms of health and wellbeing, the COVID-19 pandemic has not hit all communities equally. Those who have been the most affected by the pandemic, both in terms of direct risk from the virus, and also the impacts of restrictions and reduced access to healthcare, are those who were most likely to already be living in poor health. This includes people living in high areas of deprivation, individuals from specific ethnic minority backgrounds and people with existing health conditions or disabilities.[[38]](#endnote-39) [[39]](#endnote-40)
7. Data shows that individuals from these backgrounds, as well as being at an increased risk of being in general poor health, are specifically at a greater risk of developing a musculoskeletal condition and are more likely to report experiencing chronic pain.[[40]](#endnote-41) [[41]](#endnote-42)

1. These are the same communities who have been disproportionately impacted by reductions in public health spending pre-COVID-19. Analysis of the estimated real term cuts to public health services between 2014/15 and 2019/20 clearly shows that local authority areas with the highest levels of deprivation have seen the largest reductions in public health spending; Almost £1 in every £7 cut from public health services has come from England’s ten most deprived communities.[[42]](#endnote-43)
2. In a speech on the hidden costs of COVID-19 and the social backlog of the pandemic, the Secretary of State for Health and Social Care, Sajid Javid, acknowledged that “we can only level up economically if we level up in terms of health too”, but also that this moment was an opportunity to build “not just a healthier society, but a fairer society too.” [[43]](#endnote-44)
3. Based on analysis from the Health Foundation, an extra £1.4 billion each year by 2024/25 must be provided to local public health budgets as part of the Spending Review, in order to reverse long-term cuts and invest in the most deprived areas where the level of unmet need is highest. The public health system needs an increased, sustainable, and defined budget for prevention, health promotion and improvement activity at all levels.
4. **The Spending Review should commit to providing an additional £1.4 billion every year to local public health budgets by 2024/25, in order to the real term cuts in the public health grant and provide additional long-term funding in areas of greater deprivation and be targeted in ways that aim to address health inequalities.**

Office for Health Improvement and Disparities (OHID):

1. In October 2021, Public Health England (PHE) will be replaced by the Office for Health Improvement and Disparities (OHID), which will sit within the Department of Health and Social Care (DHSC) and provide national leadership on prevention, addressing health inequalities and actions to address the social determinants of health.[[44]](#endnote-45)
2. Since the announcement of plans to establish OHID within DHSC, no further announcements have been made on the level of funding OHID will receive to tackle some of the most significant challenges to our nation’s health.
3. Estimates suggest that over the next 3 years, the Government’s newly announced health and social care levy will raise £30.3 billion pounds, £9.1 billion of which has been designated as unallocated DHSC spending.[[45]](#endnote-46)
4. When the reorganisation of the public health system in England was first announced, Versus Arthritis signed an open letter along with 67 other health organisations stating that one of the key tests for Public Health England’s replacement would be whether it had sufficient and secure funding to scale up health improvement interventions and invest in long term solutions.[[46]](#endnote-47)
5. Any additional investment in health protection spending given to the UK Health Security Agency (UKHSA) should not come at the expense of national health prevention and promotion programmes delivered by OHID, which improve our nation’s health resilience and help reduce the impact of acute public health threats like COVID-19.
6. **OHID should have a defined and ringfenced budget within DHSC to invest in prevention and health improvement workstreams, to ensure both existing and new long-term projects receive the resources and prioritisation required to be successful. The Comprehensive Spending Review should outline a long-term funding plan for OHID, which places it on sustainable footing to deliver the long-term large-scale improvements needed on issues like health inequalities.**

1. **OHID should be provided with the funding need to deliver on existing commitments made by the Government on prevention and health improvement . As part of this, commitments to develop new tools for employers to better support people with musculoskeletal conditions in the workplace must be met, and appropriately resourced. This includes ongoing PHE musculoskeletal health programmes like the** [**Musculoskeletal Health 5-year prevention strategic framework**](https://www.gov.uk/government/publications/musculoskeletal-health-5-year-prevention-strategic-framework)**.**

Prevention

1. Contrary to common misconceptions, musculoskeletal problems, and the economic burden they place on society and individuals, are not an inevitable part of ageing. There are a wide range of complex and interacting factors which can increase a person’s risk of developing a musculoskeletal condition, some of which are unavoidable.[[47]](#endnote-48)
2. However, there are also modifiable risk factors, including obesity, low physical activity, poor nutrition and smoking, which can be minimised through prevention programmes designed to make healthy lifestyle changes possible and sustainable. For example, meeting the recommended levels of physical activity can reduce the risk of joint and back pain by 25% and lower a person’s fall risk by 30%.[[48]](#endnote-49) [[49]](#endnote-50)

1. As well as the direct health benefits, the economic case for investing specific in prevention workstreams focused on preventing avoidable musculoskeletal problems is strong. In terms of NHS resources, musculoskeletal conditions account for the third-largest area of NHS spend, about £5 billion each year.[[50]](#endnote-51) Osteoarthritis and rheumatoid arthritis alone cost £10.2 billion in the NHS and healthcare system, and this figure is expected to reach an estimated £118.6 billion in the next decade.[[51]](#endnote-52)
2. Reducing the number of people needing care for musculoskeletal problems, like osteoarthritis and back pain, which can potentially be reduced through effective primary prevention programmes focused on reducing obesity and physical inactivity would reduce this level of spend and help alleviate pressure on these services.
3. The broader economic impact of musculoskeletal conditions to the UK economy is also significant, as the data shows that people with musculoskeletal conditions are less likely to be in work than people without health conditions, and more likely to retire early.[[52]](#endnote-53)
4. In 2018, 27.8 million working days were lost due to musculoskeletal problems; the highest number for any long-term health condition measured.[[53]](#endnote-54) Analysis suggests that the UK economy lost £91.9 billion in 2019 as a result of ill-health related absence and presenteeism in the workplace.[[54]](#endnote-55) Musculoskeletal conditions are a prime contributor to this burden, and the cost is likely to rise as a consequence of our ageing workforce, because as out workforce continues to age.[[55]](#endnote-56)
5. Strong prevention programmes focused on protecting and improving our workforce’s musculoskeletal health would help reduce the economic impact musculoskeletal conditions have on our economy through sickness absence and presenteeism, and ensure fewer people are driven out of employment as a result of poor musculoskeletal health.
6. Before the COVID-19 pandemic, the Government set out an ambitious vision to make the 2020s the “decade of prevention” as part of their Advancing our health: prevention in the 2020s consultation.[[56]](#endnote-57) Post-COVID-19, the Build Back Better plan acknowledges that “Prevention must be a central principle in delivering a sustainable NHS and levelling up”.[[57]](#endnote-58)
7. While this rhetorical acknowledgement the importance of prevention is welcome, it must now be matched by consistent, strategic long-term investment in prevention programmes and workstreams, which focus on the key causes of preventable health conditions and address the social determinants of health that put certain groups at higher risk of developing these conditions.
8. Research suggests that currently in the UK as much as 40% of healthcare provision is being used to manage potentially preventable conditions, however, the estimated proportion of health expenditure directed at prevention programmes is likely to be closer to 4%.[[58]](#endnote-59)
9. The Build Back Better plan outlines the Government’s plan to introduce a NHSE/I “yearly prevention spend, outcome and trajectory reporting criteria, including an assessment of the 10-year spend and outcome trajectories (what will happen to patients over the decade following diagnosis) of the major preventable diseases such as diabetes”.[[59]](#endnote-60)
10. No further detail has been provided on which preventable diseases will be targeted as part of this prevention initiative. There is a risk that if the programme limits its view of “major preventable diseases” to only include conditions that are already the focus of significant prevention initiatives (such as a cardiovascular disease, diabetes and lung disease), the opportunity to target the morbidity burden associated with musculoskeletal conditions as the leading cause of pain and disability in the UK will be missed.
11. **As a leading cause of preventable pain and disability in the UK, and especially one which disproportionately impacts disadvantaged groups, musculoskeletal conditions should be viewed as one of the UK’s major public health priorities, and therefore must be prioritised in any national level prevention programmes.**

1. **The Government and NHSE/I should consult widely before deciding which outcomes and measures will be used to evaluate the effectiveness of the yearly NHS prevention spend that has been proposed.**

NHS Health Check review

1. Versus Arthritis has been supporting the work of Public Health England in reviewing the NHS Health Check to understand how the programme can deliver more value by expanding the range of conditions it covers, including the early detection of musculoskeletal health problems.
2. Economic modelling carried out by Public Health England in 2013 found that the programme is cost-effective; the estimated savings to the NHS budget delivered by the NHS Health Check nationally are around £57 million over four years, rising to £176 million over a fifteen-year period.[[60]](#endnote-61)
3. As previously highlighted, musculoskeletal conditions are estimated to cost the NHS about £5 billion each year in direct spending.[[61]](#endnote-62) A significant proportion of these cases could be identified earlier and better managed to prevent further pain and disability, through improved detection, minimisation of risk factors, and self-management support. This in turn would help reduce the financial burden musculoskeletal conditions place on individuals and the NHS, through reducing the demand for complex and expensive treatment and care. Analysis shows that interventions designed to help stop or slow the development of musculoskeletal problems by targeting key modifiable risk factors are cost effective, through the prevention of further disability and the delivery of long-term healthcare cost savings.[[62]](#endnote-63) [[63]](#endnote-64)
4. Better identification of musculoskeletal conditions would also help the system signpost people towards self-management resources for these conditions which have also been shown to be highly cost effective. For example, by the Government’s own estimates, for every £1 invested in the “ESCAPE-Pain” self-management programme for people with chronic joint pain, £5 is saved in healthcare costs.[[64]](#endnote-65)
5. Within the Build Back Better Plan, the Government announced that it will “explore turning the NHS Health Check programme into a National Prevention Service so that people can access health checks, supporting individuals to be healthier and access the right treatments.”[[65]](#endnote-66) The current Health Check programme is currently commissioned by local authorities and funded through the public health grant and no announcement has been made on how a potential new prevention service would be funded.

1. **Any expansion of the NHS Health Check, or evolution of the programme into a National Prevention Service, should include the assessment of musculoskeletal health. This will strengthen early detection of musculoskeletal conditions and provide a robust pathway for individuals to access cost-effective self-management resources. If implemented effectively this should lead to meaningful improvements in musculoskeletal health outcomes, and deliver savings for the NHS and the wider health system.**
2. **The Government should ensure that the renewed health check offer, either in the form of an updated Health Check programme or a new National Prevention Service, has sufficient resources in order for it to be implemented effectively. The Department of Health and Social Care should consult extensively with stakeholders from across the sector before making any significant changes to the way these checks are funded and delivered.**
3. **The Government should also consider ring-fencing the funding required to deliver this programme, to prevent resources being re-prioritised to other areas of the system and ensure this offer can be implemented consistently across all local authorities.**

**EMPLOYMENT AND SUPPORTING HOME WORKERS**

1. People with musculoskeletal conditions are significantly less likely to be in work, especially full-time employment, and are less likely to be economically active. In 2018/2019, the employment rate for people with musculoskeletal conditions was 57.8%, compared to 82.2% for people without a long-term health condition.[[66]](#endnote-67) While some individuals with musculoskeletal conditions may not be able to work because of their health, many do want to be in employment and are able to do so with the right support in place.
2. As a result of the COVID-19 pandemic and the move to more people working from home, the impact of musculoskeletal pain on the workforce in the UK is at risk of increasing significantly; an impact assessment carried out by the Scientific Advisory Group for Emergencies (SAGE) estimated that the burden of musculoskeletal conditions is likely to increase in response to COVID-19, principally due to the guidance for employees to work from home, often without suitable ergonomic office equipment.[[67]](#endnote-68)

1. Our own research work, conducted between 25 August – 1 September 2020 among 1,040 UK workers who have started to work from home during the pandemic found 81% of desk workers who switched to home working had developed musculoskeletal pain. Of those individuals, 23% reported that pain affected them either often or all the time and 22% admitted to being less productive because of the pain.[[68]](#endnote-69)
2. Access to Work is a programme designed to help people with disabilities and long-term health conditions find and stay in work through providing financial support to overcome work-related barriers. We know that, with the right adjustments and support from employers and schemes like Access to Work, people with musculoskeletal conditions can remain in the workforce and thrive in their careers.[[69]](#endnote-70)
3. However, awareness of the support that is available is a key barrier to access. Despite being the leading cause of disability in the workforce, only 11.9% of the total Access to Work spend for 2017/2018 was allocated to support people with musculoskeletal conditions.[[70]](#endnote-71) A 2018 Versus Arthritis survey indicated that 59% of respondents who had a musculoskeletal condition had never heard of the Access to Work scheme.[[71]](#endnote-72)
4. In the Government’s 2021 National Disability Strategy, the DWP committed to improving awareness of the Access to Work scheme and confirmed that it was currently delivering a paid communications campaign to widen their reach with employers and employees in order to improve uptake of grants.[[72]](#endnote-73)
5. **The Spending Review should assess the level of funding invested in the Access to Work scheme and ensure that it is keeping pace with demand, taking into account that the number of people needing support for a musculoskeletal problem is likely to have increased as a result of COVID-19 and the higher levels of sedentary working.**
6. **The DWP should publish its findings on the effectiveness of their Access to Work campaign, and commit to funding in the promotion of Access to Work on an ongoing basis, including specific targeted messaging on the forms of support that are available to support employees with musculoskeletal conditions.**

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