Trends in Health and Disability 2002

UnumProvident

Peter Dewis

Peter joined UnumProvident in July 2000 having spent 16 years with the Department of Social Security. He qualified in medicine in 1977 and became a member of the Royal College of Physicians, working in general internal medicine before joining the DSS. Within the DSS he has held a number of claims assessment, managerial and policy roles. He is a recognised expert in the developing discipline of Disability Assessment Medicine. He has been instrumental in the setting up of the diploma of Disability Assessment Medicine of the Faculty of Occupational Medicine of the Royal College of Physicians. He continues to work as an examiner for that diploma.

Chief Medical Officer's Report 2002

Peter Dewis BSc MB ChB DDAM MRC

The need for a thorough understanding of medical issues is essential if UnumProvident is to maintain its position as the UK's leading provider of income protection insurance. Whilst we frequently emphasise the fact that a medical diagnosis does not equate to a certain level of disability, it is nevertheless true that a knowledge of the range of effects which can arise from a particular medical condition is an essential starting point for us in the way we deal with individuals, whether as applicants for insurance cover in the Underwriting arena, or as claimants for income protection benefits.

Medical research is advancing rapidly on a number of fronts and thus the expectations we may form on how a person might be affected by a particular disease and condition today, in a number of areas might be considerably different to what they were a few years ago. This however has to be set against the fact that the media will frequently highlight particular areas of medical research and raise public expectations of cures and advances which are way in excess of what can be permitted from a detailed knowledge of what the research actually shows.

It is against this background that we need to be in a position to understand where medical advances are taking us and to be able to form a balanced view on what the implications are for us as an insurer over the years to come. To this end, I have commissioned a number of papers from leaders within the medical profession whose disciplines are particularly relevant to those people we see most frequently making claims for benefit, or whose claims most frequently pose us difficulties in their management.

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Each contributor was asked to highlight the most recent developments in their particular discipline and to speculate on how things are likely to develop over the next few years. Some of the contributors have worked closely with us in either underwriting, claims or appeals over the last year or so and have been able to concentrate on issues, which are likely to be of greatest importance to us.

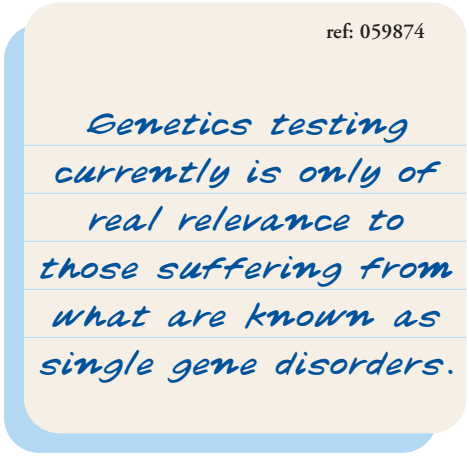
Mental health issues have been of particular importance to us recently and thus Maurice Lipsedge who until very recently was consultant psychiatrist at Guy's Hospital, has reviewed the range of developments within psychiatry in general. Complementing this, is a paper from Michael Sharpe, consultant in liaison psychiatry from Edinburgh who has reviewed the developments, not only in chronic fatigue syndrome, but also the range of disorders where the symptoms experienced by

individual patients appear to be out of proportion with the physical findings or objective evidence of disease in its traditional sense.Our other large area of work involves musculo-skeletal disorders. Tony Clarke who is Medical Director of the National Rheumatic Diseases Hospital in Bath, has chosen to concentrate on the issue of chronic back pain, upper limb disorders and inappropriate pain. His paper therefore has many points of similarity with those from the psychiatric field.

Charles Pumphrey, Consultant Cardiologist from St George's Hospital in London, has highlighted many of the exciting recent developments within cardiology. Many of these have also been picked up by Geoffrey Robb who has been associated with UnumProvident for a number of years and fully understands how medical issues and insurance interact. He has also described a number of other relevant developments from the field of general medicine.

Finally, Mansel Aylward who is Chief Medical Advisor to the Department of Work and Pensions has set out the current trends in government strategy relating to both health and social security. Clearly any organisation working in this area needs to set its activities in a context of government policy both in the short and long term.

Hopefully, each of these papers speaks for itself. I would however like to draw out a few specific points both in terms highlighting the technical advances, but also describing those areas which are likely to present us with the greatest challenges as we move forward. My intention would be for this report to be repeated on an annual basis and so become an authoritative and informative document on the current state of medical thinking on those issues which are of greatest importance to us.



Medical Genetics

Before moving on to discuss the detail of the individual papers, I need to make some reference to the field of medical genetics. I have not commissioned a paper on this particular subject which may appear to be an omission in light of the publicity which has surrounded the subject over the past year and which has culminated in the ABI announcement of the moratorium on the use of genetics testing for insurance purposes.

The field of medical genetics is one in which I believe the media is portraying a future which is currently way beyond the current ability of medical technology to meet the expectations being put forward. Clearly some fundamental advances have been made in medical research in this area, but it will still be some time before the benefits will be seen for the majority of people.

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the issue of genetics testing does not pose the sorts of significant problems as have been highlighted in the papers commissioned.

The insurance industry developments in this field have centred around the ability of DNA testing to detect those who are at risk of developing inherited diseases. For most diseases seen commonly, genetics usually plays only a part in determining who will develop the disease. Genetics testing currently is only of real relevance to those suffering from what are known as single gene disorders. These are usually relatively uncommon disorders whose incidence can be predicted accurately from their pattern of inheritance. Many also have their manifestations in childhood so that by the time these people are making applications for insurance, we already know whether or not they are going to develop the disease. All of this means that even before the recently announced moratorium, the only genetic test which had been approved for use by the government's Genetics and Insurance Advisory Committee, was that for Huntington's disease for life insurance purposes.

From a practical day to day point of view, the issue of genetics testing does not pose the sorts of significant problems as have been highlighted in the papers commissioned. We are more often in a position to use the results of a genetics test favourably to an applicant that to exclude them from cover and will continue to do this. This does not mean that I am dismissing this issue, since it will undoubtedly assume greater practical importance as medical research continues to develop. We need to play our full part in helping the industry establish its position during the course of the five year moratorium. Almost certainly there will be scope for an expert paper specifically on this subject in subsequent editions of the CMO report.

Technical Advances

Both Dr Robb and Dr Pumphrey have referred to the changes which have taken place in the diagnosis of heart attack (myocardial infarction) through the discovery of a new very sensitive biochemical marker of heart muscle damage known as Tropinin T. This has changed the criteria for the diagnosis of heart attacks in the clinical setting, to the extent that a diagnosis of a heart attack may well be made now in people whose episodes of chest pain might have remained undiagnosed. Moreover, this has important implications since the life expectancy of such people may well not be impaired in the way that is traditionally the case for people who have had heart attacks and indeed for some might in fact be enhanced. Dr Robb, however urges caution in the wholesale adoption of these new diagnostic criteria within the critical illness arena and this has been reflected in the definitions for heart attack (both major and minor) adopted for the new individual critical illness product. This is an area which will need to be kept under active review in discussion with our re-insurers. The overall prognosis of people with coronary artery disease has also been referred to, especially

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in relation to the more widespread use of the lipid lowering drugs known as the statins. Dr Robb has also identified the fact that with greater attention to detail in control of blood sugar, the prognosis for people with diabetes mellitus can be much better than has previously been the case. I will, in discussion with the Chief Medical Underwriter, be looking critically at our underwriting policies in these particular areas over the coming year.

Dr Pumphrey has identified the improvements which have taken place in the surgical treatment of established coronary artery disease, which should lead us to expect an increasing trend in people being able to return to and remain in work. This is important information for benefits claims managers in forming their expectations on individual cases. The increasing use of Percutaneous Coronary Intervention (coronary angioplasty) should also cause them to expect that this will be used more and more routinely so that uncontrolled ischaemic chest pain will become less and less common.

Within the musculo-skeletal field, the advances Dr Clarke describes relate more to those of understanding of the nature of chronic painful conditions rather than to any particular technical breakthrough. Most such conditions do not have a serious underlying pathological basis. Stemming from this is the increasing realisation of the need for people to remain active and for clinicians to intervene early in the process to ensure that optimum recovery and rehabilitation is achieved. Much of what Dr Clarke has described has been mirrored by Dr Sharpe in his description of the apparent rise in the prevalence of conditions for which no underlying disease process can be identified.

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Dr Lipsedge has referred to a number of developments in the way in which imaging techniques are starting to delineate the neurological basis for a number of psychiatric disorders. However, many of these currently are at a purely academic level and he points out that the treatment of depression has not improved significantly since the first discovery of antidepressant drugs.

Ongoing Challenges

The fact that there have been few advances in the treatment of depression represents a challenge. This is particularly so since all the authors have identified this as being of significance in their own particular field. Dr Lipsedge for example, has highlighted the importance of symptoms which fall short of producing a definite depressive illness, but which may well have an influence on overall disability. Its impact in the field of cardiology and general medicine has been particularly identified by Dr Robb. This presents us with a

particular challenge in being able to identify those claimants where depression may be having a significant impact at an early stage of their incapacity and where possible being able to influence their treatment since it is clear that these issues are not always being adequately addressed within the constraints of primary care.

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the importance of psychological factors in determining long term disability emerges

Dr Lipsedge, Dr Sharpe and Dr Clarke have identified the importance of cognitive behaviour therapy of influencing the outcome in depression, chronic fatigue syndrome and chronic pain. This again represents a challenge in ensuring that people are directed towards this approach. This can be particularly difficult in relation to the availability of such services under the NHS. All of this needs to be considered in relation to the other common theme, which has been emphasised particularly by Dr Sharpe and which relates to the need to intervene early in the course of a disability to achieve a positive outcome.

Message for UnumProvident

Although contributions were sought from specialists across a wide variety of disciplines, when looking at those areas which are likely to pose particular challenges, the importance of psychological factors in determining long term disability emerges. In addition, in such people there will frequently be a predominance of subjective complaints with little in the way objective findings to support these. All the findings presented by Dr Aylward on the trends in social security statistics show that these are also major issues for the public sector. Dr Aylward's data also supports strongly the view that early intervention appears to be the only way of influencing this situation. He has also identified a number of government initiatives, such as the New Deal for Disabled People and NHS Plus, which signify the government's intention of addressing these issues. Clearly however, there is a tremendous amount of work that needs to be done to make these a reality.

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We need to continue to develop our capability within Medical Services and Rehabilitation Services to be able to intervene earlier

Within UnumProvident, I believe that we need specifically to continue to develop in two particular areas and that the information presented by the experts contributing to this report, support this view.

- We need to continue to develop our capability within Medical Services and Rehabilitation Services to be able to intervene earlier in the course of any disability. This means increasing our ability to have an integrated approach within UnumProvident and to be able to engage with employers as well as individual disabled people.
- We need to continue to develop the disciplined thinking required to assess fairly those claims from people, which are based entirely on subjective factors.

Maurice Lipsedge

Maurice Lipsedge is Emeritus Consultant Psychiatrist to the South London and Maudslay NHS Trust. He is also Honary Senior Lecturer in the Department of Psychological Medicine within Guy's, King's and St Thomas's school of medicine. His special interests include the fitness for work in patients with mental health problems. He has made a significant contribution as an author, to a number of standard reference works in the fields of occupational and insurance medicine, including "Fitness for Work", "Life and Disability Underwriting" and "Medical Selection of Life Risks". He is a former member of the Home Office Parole Board and of the Nolan Committee: Review on Child Protection in the Catholic Church in England and Wales.

Recent Developments in Psychiatry

Maurice Lipsedge M.Phil FRCP

Introduction

In this brief review of recent developments in psychiatry, I have drawn on both the American and the British psychiatric journals published over the past couple of years. The basis of selection has been developments in research which have potential implications for long term or recurrent occupational disability arising from psychiatric disorders.

Given the current emphasis on neurological research, the bulk of the literature deals with those disorders, which have a basis in cerebral dysfunction, especially schizophrenia, the affective disorders and dementia. Although the clinical onset of Alzheimer's disease can be prior to the age of sixty it is, of course, typically a disorder of old age. The first phase of Alzheimer's disease, which can last for two to three years, is characterised by failing memory, muddled inefficiency over everyday tasks and spatial disorientation. Moreover, because disturbance of mood can be prominent and since a degree of depressive pseudodementia is not uncommon, presenile dementia has to be considered as a differential diagnosis in the occupational setting in all people who are referred for a psychiatric assessment after the onset of middle age.

For this reason consideration of recent developments in the cause and potential treatment of Alzheimer's disease merit inclusion in a review such as this. In view of the increasing prevalence of schizophrenia and the established high level of affective disorders in the community, these "non-organic" disorders require no such justification.

The 1990s were designated the "Decade of the Brain" by Time Magazine and significant advances were made during that period in the basic sciences of neurobiology and genetics. So far, however, these developments have had virtually no impact on psychiatric clinical activity. Thus, in the field of depressive illnesses, which have a wide prevalence, the efficacy and speed to onset of response to antidepressants has changed little since the serendipitous discovery of the MAOI's (monoamise oxidase inhibitors) over forty years ago.

Neuroimaging

The neurochemical pathology of the major psychiatric disorders has been elucidated recently by the use of functional brain imaging techniques namely Positron Emission Tomography (PET), Magnetic Resonance Spectroscopy (MRS), Functional Magnetic Resonance Imaging (MRI) and Single Photon Emission Computed Tomography (SPECT).

Recent studies on the functional neuroanatomy of depression using SPECT and PET imaging techniques have compared the effects of pharmacotherapy with a form of psychotherapy. Surprisingly, both the administration of antidepressant drugs and the psychosocial intervention were associated with increased blood flow to the left temporal or right basal ganglia regions. Furthermore, both the interpersonal psychotherapy and the antidepressant treatment normalised metabolism in the prefrontal cortex and left anterior cingular gyrus.

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Although these results have emerged only from preliminary studies and some methodological reservations have been expressed, the tangible cerebral effects apparently brought about by psychotherapy are an interesting sequel to the earlier work on the changes induced in the brain by the cognitive-behaviour therapy of obsessional compulsive disorder.

Working forwards conceptually from psychological trauma to neurobiological changes, recent MRI studies have demonstrated hippocampal atrophy in post traumatic stress disorder. In functional terms, this reduction in hippocampal volume is associated with explicit memory deficits. The same picture has already been demonstrated in depression. It is still not clearly established whether the hippocampal atrophy arises from the clinical disorder or precedes it and whether a disturbance of glucocorticoids is the underlying cause.

Early Detection of Alzheimer's Disease

Recent studies of longitudinal changes in cognitive performance during the preclinical phase of Alzheimer's disease show that in the near future it may be possible to identify people at risk of developing this type of dementia and to administer prophylactic treatments in order to delay or stop the progression of this disease. The possibility of identifying people at risk of developing Alzheimer's disease carries implications for potential therapeutic interventions. A number of recent studies have attempted to identify the cognitive markers of preclinical Alzheimer's disease and it has been found that people who later developed Alzheimer's disease experienced greater changes across multiple cognitive domains compared with those who did not develop dementia. The most prominent changes were an accelerated decline in episodic memory and in executive functioning.

By carrying out multiple measures longitudinally, it is possible to identify changes in cognitive performance when people are still regarded as free of dementia and recent research shows that cross sectional deficits in cognitive performance can appear years before the actual diagnosis of Alzheimer's disease. It is likely that individuals at risk of Alzheimer's disease will be more precisely identified before the clinical onset of the disorder by combining longitudinal studies of cognitive performance with genetic and neuroimaging techniques, since more individuals who go on to develop Alzheimer's disease show prediagnostic changes in neuroanatomy. These changes have been demonstrated both in neuro-pathological studies as well as magnetic resonance imaging which has demonstrated changes in the hippocampus and entorhinal cortex.

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Prevention of Relapse in Residual Depression by Cognitive – Therapy

It is known that marked morbidity and disability occurs as a result of the significant rates of relapse and recurrence in major depression and that depression is a risk factor for the onset of both physical and psychosocial disability while the effective treatment of depression improves functional outcomes. The rate of relapse and recurrence can be reduced by patients continuing to take antidepressants. It is recognised that many patients still achieve only a partial remission and have persistent residual symptoms. Residual depression can occur in about a third of patients suffering from major depression who have been treated with appropriate doses of antidepressants for an adequate trial period. A recent meta-analysis of the drug treatment of depression found response rates to be no better than 50 per cent for active treatment by comparison to 32 per cent for placebo (Agency for Healthcare Policy Research, 1999). Furthermore, patients with residual depression are particularly prone to relapse. It has now been shown that cognitive therapy is highly effective in reducing relapse rates in cases of severe residual depressive symptoms, despite antidepressant treatment. Cognitive therapy is a cost effective form of treatment for depression requiring less than 20 weekly sessions. In this study, cognitive therapy was added to antidepressants and this psychological intervention was shown to prevent relapse into a further episode of major depression.

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depression is a risk factor for the onset of both physical and psychosocial disability

Long-Term Disability Associated with Depression

A prospective study of psychosocial disability in relation to the severity of depressive symptoms was conducted over a ten year period. The results show a progressive gradient of psychosocial impairment, which parallels the severity of depressive symptoms. It was found that there is a significant stepwise increment in psychosocial disability as one progresses from subthreshold depressive symptoms through dysthymia to unipolar major depressive disorder. This common-sense relationship between the severity of depression and occupational impairment (ie, the synchrony of change in depression and disability) shows that effective treatment of depression will improve functional outcome.

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Recent studies have shown that there is an increased risk of ischaemic heart disease among depressed patients.

This synchrony may be predictable, but an unexpected recent finding was the link between depression and the course of coronary artery disease. Recent studies have shown that there is an increased risk of ischaemic heart disease among depressed patients. Furthermore, patients with depression following a myocardial infarction are over three times more likely to die than non-depressed patients. It has been suggested that association between depression and coronary artery disease might be based on changes in the autonomic nervous system or in a disturbance of platelet function. It has also been shown that major depression is a significant risk factor for the development of stroke.

Assessing and Measuring Psychiatric Disability

There is an important and challenging contribution to the literature on the assessment of disability in a recent communication in the American Journal of Psychiatry (Janca, 2001). Janca has critically evaluated the disability axis of the Multi-Axial Presentation of ICD-10 for Use in Adult Psychiatry which is an instrument comparable in purpose to the DSM-IV Axis V scales, ie The Global Assessment of Functioning Scale, The Global Assessment of Relationing Scale and The Social and Occupational Assessment Scale.

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In contrast to the impressively high levels of inter-rater reliability found with the DSM-IV Axis V scales, Janca found a very low inter-rater reliability when the World Health Organisation's Short Disability Assessment Schedule was subjected to trials by 274 clinicians from 21 different countries. The question is therefore asked as to whether DSM-IV Axis V scales have a "true" inter-rater reliability or whether the claimed satisfactory psychometric properties are merely a reflection of "extensive instrument administration training and high motivation of the clinicians"? (I must say that I have some sympathy for Janca's sceptical view since the operational guidelines supplied by DSM-IV for the determination of disability are difficult to apply with any degree of confidence, eg on the SOFAS one would allocate a score of 41-50 – "serious impairment in ....occupational....functioning" on the basis of the example "unable to keep a job", when the alleged inability to keep a job might arise from a "genuine" disability but completely fails to take into account motivational and "illness behaviour" factors).

In assessing disability we tend to set the boundary at ICD-10 or preferably DSM-IV defined conditions, relying on clinical significance criteria. Dysthymic disorder which was first introduced as a separate diagnostic category in DSM-IV-R, is found in about 5 per cent of the population. This chronic low grade depressive condition is generally punctuated by episodes of major depression and the condition tends to become more severe with increasing age. The level of functional impairment in dysthymic disorder equals or exceeds that in major depressive disorder.

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A prospective 5 year follow-up study has shown that the course and outcome of dysthymic disorder are rendered unfavourable by a family history of psychiatric disorder, adversity in childhood, chronic stress and an avoidant, dependent or obsessive-compulsive personality disorder. Interestingly a family history of bipolar disorder is associated with a higher probability of recovery.

Although dysthymic disorder has achieved the status of a DSM-IV recognised category, there has been a proliferation of substhreshold disorders over the past few years. Synonyms include "minor depression", "subsyndromal symptomatic depression" etc. some of these subthreshold conditions lack validity as formal psychiatric disorders and they are often difficult to distinguish from common-or-garden unhappiness. It has been suggested that these subthreshold conditions should be more precisely defined and studied on a longitudinal basis, but it is also recognised that providing formal identifying criteria and quantifying these symptoms might exacerbate the current tendency to pathologise conditions that may be within the normal spectrum. Grief would be a case in point.

Antidepressants of all types cause an increase in the release of presynaptic monoamines, which activate a range of post-synaptic receptors. These are coupled to second messenger signal transduction factors that control gene expression. This knowledge has been derived from recent research with animal models, providing new perspectives on the pathophysiology of depressive disorder, the biology of stress and the mode of action of antidepressant drugs.

In summary, antidepressants of different classes all appear to increase the expression of neuroprotective proteins which are important for the function and growth of neurones.

Cost-Effective Psychological Treatment of Common Psychiatric Disorders

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Cognitive-behavioural therapy now has an established track record in terms of cost effectiveness

The past few years has seen the consolidation of the role of psychological treatment methods in both depression and the anxiety-based disorders. Cognitive-behavioural therapy now has an established track record in terms of cost effectiveness and its methods can be applied either in conjunction with medication or without concurrent pharmacological treatment. Post-traumatic stress disorder and chronic fatigue syndromes provide examples of common and often disabling conditions in which the optimal treatment might be cognitive-behaviour therapy administered by a nurse therapist or clinical psychologist backed up by antidepressant medication prescribed by a general practitioner or psychiatrist. Cognitive therapy has also, perhaps surprisingly, become recognised as an effective way of helping patients with refractory schizophrenia and chronic paranoid psychoses to learn effective strategies for challenging delusional ideas and for dealing with distressing hallucinations.

Schizophrenia

The recent application of quantitive methods in schizophrenia research has been a first step in identifying an anatomical substrate for schizophrenia. Stereological analysis of the prefrontal cortex has shown the presence of increased density of neurones in patients with schizophrenia. This is now known to be due to a reduction in the elements of neural connectivity rather than the actual destruction of nerve cells. This deficit appears to occur in a specific area of the prefrontal cortex in patients with schizophrenia suggesting that the large pyramidal cells in that particular area (layer 3c) receive fewer synapses from modulatory dopaminergic and exitatory afferent inputs.

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Since the pathology in the prefrontal cortex of patients with schizophrenia appears to be confined to neuronal processes and synaptic connections rather than actual loss of neurones, it is hoped that highly targeted pharmacological treatments can be developed which will have a selective action on specific neuronal cells and connections.

Michael Sharpe

Michael Sharpe is Reader in Psychological Medicine at the University of Edinburgh and is an Honorary Consultant Psychiatrist to the Edinburgh Hospitals. His interests have focused on the interface between psychiatry and medicine. He is particularly interested in the role of depression in physical illness, in poorly understood syndromes, such as chronic pain and chronic fatigue and in how biological and psychological factors interact to cause symptoms and disability. He is currently chair of the Scottish Liaison Psychiatry Group, Director of Psychological Medicine Research and Teaching at the University of Edinburgh and provides a consultation service to the Department of Neurology at the Western General Hospital in Edinburgh.

Functional Symptoms and Syndromes: Recent Developments

Michael Sharpe MA MD MRCP MRCPsych
Reader in Psychological Medicine
University of Edinburgh

The Nature and Size of the Problem

It is becoming increasingly clear that the problem of patients who have illness that is defined only subjectively and not clearly explained by disease is a large one. Recent research has shown that such presentations are extremely common in general practice in a range of countries and cultures. They also account for a quarter to a half of all new medical hospital outpatient consultations. The most common symptoms are pain in various sites (back pain, head pain, chest pain and generalised pain) and fatigue. Other common symptoms are tingling, dizziness, weakness, breathlessness, bowel disturbance and palpitations. Although not due to any recognised disease these symptoms may nonetheless be associated with severe and persistent disability.

Terminology and Classification

Terminology

There is a great deal of confusion about what to call such illness. A wide range of general terms has been used including "hysteria", "abnormal illness behaviour", "somatisation", and "somatoform disorders". Recently the terms "medically unexplained symptoms (MUS)" and "functional" symptoms have become popular amongst researchers, as they do not assume any particular aetiology.

Classification

Classification is also confusing as there are parallel medical and psychiatric classifications. The medical classification defines "functional syndromes" such as tension headache, irritable bowel, and so on based on the bodily system or part apparently most affected. Hence, patients attending gastroenterology with functional symptoms tend to receive the label of irritable bowel syndrome, those attending rheumatology be diagnosed as having fibromyalgia, those attending infectious disease as having (post viral) fatigue syndrome and so on (see Table 1).

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Table 1: Common medically defined functional syndromes listed by medical speciality	
Gastroenterology	Irritable bowel syndrome (IBS), non-ulcer dyspepsia (NUD)
Gynaecology	Pre-menstrual syndrome (PMS), chronic pelvic pain (CPP)
Rheumatology	Fibromyalgia (FMG)
Cardiology	Atypical or non-cardiac chest pain; benign palpitation.
Respiratory medicine	Hyperventilation syndrome (HVS)
Infectious diseases	(Post-viral) fatigue syndrome (CFS)
Neurology	Tension headache
Dentistry	Temporal-mandibular joint dysfunction, atypical facial pain
ENT	Globus syndrome
Allergy	Multiple chemical sensitivity

There has recently been increased awareness that these individual "functional syndromes" are not as separate as they seem. There is not only overlap in the symptoms patients report but also in associated characteristics and response to treatment (see below). It has therefore been proposed that these conditions be considered together as a "general functional somatic syndrome". Whilst this may be too extreme a view, substantial commonality between them is now generally accepted.

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patients may become chronically disabled because of a treatable but untreated psychiatric disorder.

The psychiatric classifications provide alternative diagnoses for the same patients (See Table 2). The majority, but not all patients will meet criteria for depressive or anxiety disorders and most of the remainder of those for the so-called somatoform disorders of which hypochondriasis (severe anxiety about disease) and somatisation disorder (a long term tendency to present repeatedly with a range of medically unexplained symptoms) have most clinical utility.

Table 2 : DSM-IV and ICD-10 categories for medically unexplained syndromes

DSMIV	ICD-10
Somatoform disorders	Somatoform disorders
Somatisation disorder	Somatisation disorder
Undifferentiated somatoform disorder	Undifferentiated somatoform disorder
Conversion disorder	
Pain disorder	Persistent somatoform pain disorder
Hypochondriasis	Hypochondriacal disorder
Body dysmorphic disorder	
Somatoform disorder NOS	Somatoform autonomic dysfunction Other somatoform disorders Somatoform disorder unspecified Dissociative (conversion) disorders Disorders of movement and sensation Other neurotic disorders
Neurasthenia	
Depressive disorders	Depressive disorders
Anxiety disorders	Anxiety disorders

Neither classification is ideal. However, the psychiatric classification has important treatment implications. Because patients present somatically (and may not want a psychiatric diagnosis) this may be missed. Hence, patients may become chronically disabled because of a treatable but untreated psychiatric disorder. This is not an uncommon finding both in clinical practice and in IMEs. We need better classifications – in the meantime, the best practice is to always seek evidence for and record diagnoses from both medical and psychiatric systems for example "irritable bowel syndrome with anxiety".

The Aetiology of Functional Syndromes

The best ways of understanding such syndromes is to consider a range of biological, psychological and social factors. Table 3 illustrates such an approach to chronic fatigue syndrome.

Table 3: Possible causal factors in chronic fatigue syndrome

	Predisposing	Precipitating	Perpetuating
Biological	Genetic Previous depression	virus	HPA axis disturbance inactivity
Psychological	Personality (perfectionism)	response to stress	disease attribution, avoidant coping style
Social		stresses	life conflicts, iatrogenic factors

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there is strong evidence that symptoms and disability are shaped by psychological factors.

Biological factors

Recent research using functional brain imaging (PET and fMRI) has started to identify altered brain functioning in patients who have functional syndromes (as well as in those with depression and anxiety). This does not mean the patients have brain disease, but that their experience of symptoms has a neurophysiological correlate. On the one hand this is merely evidence of mind-brain identity, on the other hand it does remind us that these symptoms are not purely psychological phenomena but that they have a biological reality, albeit a potentially reversible one.

Psychological factors

Whatever their biological basis, there is strong evidence that symptoms and disability are shaped by psychological factors. Especially important are the patients' beliefs and fears about their symptoms. Research in several functional syndromes has found that a strong belief and preoccupation that one has a "medical disease" and a helpless and passive attitude to coping is associated with persistent disability (as it is in recovery from acute medical condition such as myocardial infarction). The presence of depression is similarly associated with greater disability and worse outcome. Some persons appear to exaggerate symptoms but this is often hard to prove.

Although harder to research, social factors are almost certainly of great importance in shaping functional illness. Relevant factors include the information patients receive about the symptoms and how to cope with them. This information may be helpful or may stress the chronicity of the illness and promote helplessness. Such unhelpful information is found in "self-help" (!) books and increasingly on the Internet (see for example www.meassociation.org.uk). Unfortunately, doctors and especially "specialist private doctors" and complementary therapists may be as bad. Other social factors that perpetuate illness are anger with the person or organisation the illness is attributed to, or toward the insurer for not believing them. It has been pointed out that: " if you have to prove you are ill you can't get well". Both State and private insurers pay people to remain ill. Litigation for poorly understood and functional illness appears to be on the increase and a recent large study from Canada provided evidence that it does increase the duration of so-called whiplash symptoms.

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Treatment

Evidence based treatment

Recent systematic reviews of randomised controlled trials have confirmed that psychologically informed rehabilitative treatments (often called cognitive behaviour therapy or CBT) and "antidepressant" drugs have some effectiveness in treating most functional syndromes. There is however a great shortage of skilled providers of CBT in particular and rehabilitative facilities in general.

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The current system of state benefits, insurance payments and litigation remain potentially major obstacles to effective rehabilitation.

Obstacles to recovery

In practice, even if treatment is available, there may be obstacles to recovery. Over time, the patient's beliefs may be become entrenched and be driven by anger and the need to explain continuing disability. The current system of state benefits, insurance payments and litigation remain potentially major obstacles to effective rehabilitation. It is often unrealistic to expect medical treatment alone to overcome these. Furthermore patient groups who champion the interest of individuals with functional complaints (particularly for chronic fatigue and fibromyalgia) are increasingly influential; they are extremely effective in lobbying politicians and have even been threatening towards individuals and organisations who question the validity and permanence of the illness they champion. Again the ME lobby is the best example.

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Possible new functional syndromes are likely to include those associated with pollution of the workplace... and work stress

Functional symptoms are not going to go away. They will be driven by factors such as work stress and disaffection, information about new illness from the media and the Internet and the persisting stigma of psychological problems. However, the form that they take is likely to continue to change. Although there are a limited number of symptoms that people can have, there are an almost infinite range of factors that these symptom can be attributed to. Such illness attributions tend to be to external factors and often those, which individuals feel fearful of, wronged by and which are outside their control. Possible new functional syndromes are likely to include those associated with pollution (chemical, biological and radiological) of the work place and work stress, and perhaps now in relation to "terrorism" and fear of terrorism.

A shift towards a more consumer-based approach to health is also likely to increase the prominence if not the prevalence of such syndromes as the authority of medicine to define what is a legitimate illness is diminished. Indeed, increasingly consumer oriented and privatised doctors will collude with the patient's views that they have a disabling and permanent disease. In other words, it may be difficult for those who wish to champion rehabilitation and return to work to "hold the line" without seeming to be "anti-patient".

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The demands such persons make on health service, social benefit systems, and insurers are likely to increase.

The demands such persons make on health service, social benefit systems, and insurers are likely to increase. It is hard to see how an increasingly pressed health service will be able to deal effectively with the demand. An increase in insurance claims is to be therefore anticipated.

What can be done?

Generally

It will be imperative that health and social policy addresses this problem. Benefits and medical services need to be more rehabilitation orientated. This will not be easy. However, there are glimmers of progress.

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Benefits and medical services need to be more rehabilitation orientated.

An example is recent developments in the politics of CFS. After a failure of patient organisations to accept a report on the condition produced by the Royal Colleges, the previous CMO for England set up a working party that included both patient advocates and professionals. The meetings were difficult and there was a failure to agree the final report. Nonetheless, the current Chief Medical Officer released the report early in 2002 (www.doh.gov.uk/cmo/cfsmereport). It is "mixed", in terms of the relationship of its contents to the research evidence as opposed to advocacy – but does accept the increasingly strong evidence for rehabilitation. Furthermore, one of the

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As long as the economy remains strong and skilled workers are sought after, it will be in employers' interests to rehabilitate sick but valued employees.

major patient charities (Action for ME) is aligning itself with a more evidence-based approach. These are early days but if this convergence of rehabilitation oriented clinicians and a patient advocacy group is successful, there could be very positive implications for patients and for insurers.

There is a major need for effective rehabilitation for treatable patients. Existing pain and rehabilitation services would provide a useful basis. However, their capacity and skills are currently far too limited. Funding of rehabilitation by commercial bodies has begun in the UK (with organisations such as PRISMA) and is likely to continue. As long as the economy remains strong and skilled workers are sought after, it will be in employers' interests to rehabilitate sick but valued employees.

By the insurance industry

From the insurance point of view, efforts need to be made to minimise the risk of their policyholders getting ill and to minimise the obstacles to their recovery. There are implications for pre-acceptance medical assessment and for the work practices of employers. When policyholders do fall sick with a functional syndrome it is likely to help if both insurer and employer maintain a positive relationship with the claimant. An early but positively planned return to work (even in a very limited capacity) is desirable. If the claimant becomes hostile toward employer or insurer the position is likely to be difficult to retrieve.

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Much could be gained from having an early biopsychosocial assessments of patients that ensured the identification of psychiatric as well as medical diagnoses. There is also a need to minimise iatrogenic harm both from family doctors who misguidedly encourage the patients to "take time off" at the insurer's expense and from certain "specialists".

For those with established disability an increased availability of rehabilitative treatment facilities is highly desirable. The NHS is not likely to pay for these.

Summary

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how much is it costing you doing nothing?

The problem of medically unexplained or functional illness is a large one. It is not going to go away and it is likely to get bigger. Social factors are more likely to influence the trends in the prevalence, presentation and cost than are medical developments. Both health services and insurers now need to take a more positive approach. To those who say that this will cost money I would reply – how much is it costing you doing nothing?

Anthony K. Clarke

Anthony K. Clarke is Consultant in Rheumatology & Rehabilitation at the Royal National Hospital for Rheumatic Diseases in Bath, where he is also Director of Rehabilitation and Medical Director. Among his other appointments, he is Civil Consultant in Rheumatology & Rehabilitation to the Royal Air Force and is a Past President of the British Society of Rehabilitation Medicine and the South Wales, South West and Wessex Rheumatology Club. He is also a past member of the Disability Living Allowance Advisory Board and helped in the initial training of the Benefits Agency Medical Service for the introduction of Incapacity Benefit.

Among his clinical interests are general rheumatology, pain, chronic fatigue and community rehabilitation. He has a particular interest in the injured employee and regularly provides expert opinion in litigation and insurance disputes.

"Doctor, I have a pain"

Anthony K Clarke FRCP Medical Director
The Royal National Hospital for Rheumatic Diseases, Bath

Pain is one of the commonest symptoms experienced by human beings. It is extremely difficult to quantify pain and the only way that we know that a person is suffering is on the basis of what he or she tells us. We have to put the patient on trust to tell us the truth. Compared to, say heart disease, we do not have an objective test of the type of exercise with the Bruce Protocol for angina or changes on x-ray to confirm heart failure. Yet, musculoskeletal pain is among the commonest reasons for people to be on long term absence from work. Back pain accounts for more loss of productivity than industrial action and the problems relating to work related upper limb pain has threatened to shut down whole areas of commerce. This short review aims to look specifically at the problems of low back and upper limb work related pain, with some comments on inappropriate pain and what steps can be taken to avoid long term disability.

Aetiology

The majority of patients with low back pain are suffering from mechanical pain, that is pain which arises from relatively minor injury to the soft tissues in the back, including the ligaments, muscles and joints. The physician should always be aware of the possibility of the rarer and more serious causes of pain, such as prolapsed intravertebral disc, osteoporotic collapse, and malignant disease. However, the overwhelming majority of symptoms relate potentially treatable and reversible mechanical problems. Experience has shown that if a proper diagnosis is made and treatment commenced early, then the prognosis is almost always good. One of the most difficult problems however in Britain is the difficulty of early access to adequate diagnostic and treatment facilities.

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musculoskeletal pain is among the commonest reasons for people to be on long term absence from work. Back pain accounts for more loss of productivity than industrial action

Upper limb work-related pain consists of a collection of usually mild and reversible soft tissue problems in the arm or arising from the neck. By definition, these problems may be precipitated or worsened by work or overuse of the limb. Among the recognised causes are carpal tunnel syndrome, tennis and golfer's elbow, capsulitis of the shoulder, brachial neuralgia and very occasionally true tendonitis. The term repetitive strain (or stress) injury

(RSI) should be avoided if for no other reason that as a term it is emotive and carries significant diagnostic and social baggage which may make it difficult to reach an objective decision about treatment. Without a doubt, the most important issue from the upper limb pain is to reach a sustainable diagnosis.

It is important to realise that the incidence of upper limb pain is just as common in the general population as it is in, say, keyboard workers. It is also important to realise that with proper treatment the overwhelming majority of patients will get better and be able to return to work, including doing work with keyboards.

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History

The taking of an adequate clinical history remains the cornerstone of any clinical evaluation of the patient. With low back pain it is possible for the pain to arise spontaneously. There are a number of "red flags" which should alert the physician to serious causes of pain, such as neurological signs and symptoms and unremitting night pain. It is more common for the episode of pain to arise following a specific precipitating incident, such as lifting an inappropriately heavy object.

With upper limb pain, a careful clinical history will often reveal features, which will direct the physician in the correct direction as far as the diagnosis is concerned. An example might be a story of the pain being precipitated when gripping and twisting at the wrist, a frequent story in tennis elbow, or the typical history of numbness and tingling in the fingers, sparing the little finger, which is seen in carpal tunnel syndrome.

Examination

As important as a good history is a good examination. In the back it should be possible to exclude by examination such conditions as ankylosing spondylitis or neurological problems related to prolapsed intervertebral disc. General examination will help exclude systemic problems such as secondary deposits from carcinoma of the lung.

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With upper limb pain, again general examination is essential. In particular a proper neurological examination is always required looking for, among other things, carpal tunnel syndrome and cervical spine nerve root pressure. One needs to be able to identify or exclude such conditions as algodystrophy or osteoarthritis producing pain referred to the deltoid insertion and neck related problems. It is most unusual not be able to make a definitive diagnosis.

Investigation

As long as "red flag" conditions are excluded on the history and examination, for the majority of low back pain suffers, investigation is not indicated. There is virtually no correlation between symptoms arising from the low back and changes seen on plain x-ray. It is only when an acute attack of low back becomes chronic that further investigation should be considered. As a rule, it is as valuable to get a full blood count and sedimentation rate as a plain x-ray.

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In many centres in Britain the wait for non-urgent MRI is measured in months and waiting for this investigation may delay proper rehabilitation and the return to work

Even in patients with long term problems, the value of such investigations as magnetic resonance imaging (MRI) is doubtful. It rarely reveals significant changes that will change clinical management in the absence of obvious neurological signs. The one exception to that is in those patients suffering with significant complaints of pain in the legs on walking, who may well be suffering from spinal stenosis. This usually occurs in later life and is rarely a problem in the working population. In many centres in Britain the wait for non-urgent MRI is measured in months and waiting for this investigation may well significantly delay proper rehabilitation and the return to work.

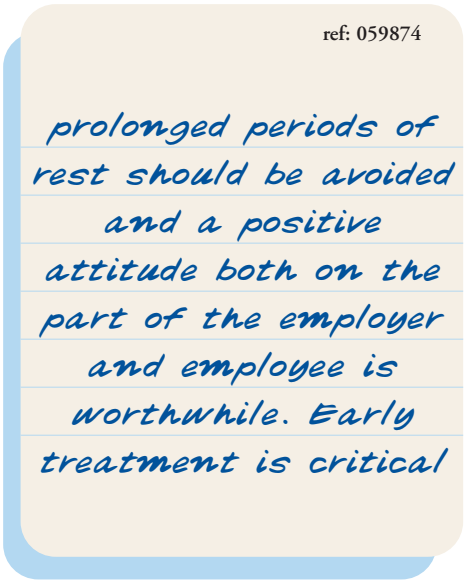
In upper limb pain, the presence of neurological signs may well trigger further investigation. Therefore with evidence of a carpal tunnel syndrome there is an argument for undertaking nerve conduction studies. However, again frequently there is a significant delay in the performance for this investigation and the majority of rheumatologists and hand surgeons will be prepared to treat a patient with a carpal tunnel syndrome if the signs and symptoms are sufficiently clear. MRI may be indicated if there is a suggestion of nerve root pressure in the neck. Plain x-rays can be helpful in identifying significant osteoarthritis, but as with low back pain frequently the best way of arriving at a diagnosis is by taking an adequate history and undertaking a proper examination.

Treatment

The Clinical Standards Advisory Group a decade ago showed conclusively that with acute low back pain the best approach was to give adequate analgesia, avoid bed rest, and encourage very early return to work. This would prevent long-term disability in the majority of cases. The evidence currently available suggests that a majority of people with back pain will respond to physiotherapy arrived at muscle strengthening and education on correct lifting technique. This should leave only a small hard core of people who might require intensive investigation, occasionally surgery and perhaps other forms of therapy such as cognitive therapy.

Even if there is failure to treat the acute episode rapidly and appropriately, as long as the patient receives proper evaluation and treatment within six to nine months, then long term disability will frequently be avoided, mainly by the use of physical rehabilitation. Small doses of mild analgesics can be helpful and of course care attention to working practices to avoid a re-injury.

Pain in the arm should be treated on its merits. If there is a positive diagnosis of a carpal tunnel syndrome or De Quervain's, for instance, then injection or possibly decompression should be considered. Simple tennis elbow should respond to injection or to other strategies, such as the use of an epicondylitis splint. Physical therapy for the cervical spine is always worth considering. Again, it is important to pay attention to the work station and with working practices. Wherever possible, prolonged periods of rest should be avoided and a positive, attitude both on the part of the employer and employee is worthwhile. Early treatment is critical. If the problem is allowed to drag on, chronic pain will almost certainly appear and unnecessary work disability will emerge. In particular it appears to be important to avoid a blame culture and the use of terms such as RSI which will encourage workers and their representatives to feel that they have a progressive and untreatable disorder which will inevitably lead to severe disability. The experience in Australia, where the so-called "kangaroo paw" threatened to bring commerce to a halt, shows that a constructive approach by the various interested parties, including the trade unions, employers and government, will lead to a considerable reduction in disability from this group of disorders.



Inappropriate pain and Fibromyalgia

On occasion, we see people who develop pain which appears to be out of proportion to the insults suffered and which often has a distribution and a nature which is unusual. Fibromyalgia is now a commonly diagnosed condition. The hallmarks of this problem are a pre-existing painful condition, trigger spots that occur at specific sites on the body and sleep disturbance. It is not a disease in the sense that measles or appendicitis, but rather a syndrome which appears to be due to deconditioning of muscle. Some argue that it is in fact depression while others that it does not exist at all. However, the consistency of the history and the distribution of the trigger spots leads most rheumatologists to believe that it is a true entity, although many authors do accept that there is a large psychological aspect and that it may represent the somatic end of

the fatigue syndrome spectrum. Typically, the history is one of chronic pain from problems such as back or neck pain, which leads to sleep disturbance and then considerable pain in muscle particularly across the shoulders.

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inappropriate pain is becoming more common and can be very disabling

There is a general consensus that the correct approach to treatment for these patients is to correct sleep disturbance, usually by using a mild tricyclic such as Amitriptyline and then to put the individual on to paced activities and then a paced exercised programme. Many sufferers report that on good days they try catch-up with things that they have got behind with and that they then pay for it over the next day or two. The point of pacing is to try and prevent over-stressing the muscles on the good days, producing a steady improvement with the physical rehabilitation. If this is undertaken at an early stage, this is a highly successful strategy.

Inappropriate pain is becoming more common and can be very disabling. Typically, the story is one of a painful syndrome of some description which does not get better within the normal time frame expected. Pain becomes persistent, usually with disturbed sleep and frequently is increasingly disabling. Physical examination and investigation usually fails to reveal any serious underlying cause. Most authors agree that the problem is due to sensitisation of pain fibres.

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The reason why this condition is so difficult to treat is that the underlying cause is almost always settled by the time the patient presents. The pain bears many of the hallmarks of phantom limb pain experienced by amputees. In both conditions it would appear that the pain fibres have been so severely stimulated that any sensory stimulus to the skin or underlying tissues in the problem area will produce pain signals in the brain rather than the more appropriate sensations such as tickle, heat or propioception. There is some evidence to suggest that the central processing of incoming sensory signals is also disordered leading to the continuing inappropriate pain. The main consequence of this sequence of events is that it is very unlikely that treatment to the original underlying cause will lead to significant reduction in pain. Indeed in many cases the precipitating cause may well have gone away completely, often months or years before.

Treatment therefore should be directed at assisting the patient to cope with the pain. The first task is to properly explain to the patient the nature of their pain and why simple treatments, including things like surgery and physiotherapy are unlikely to be helpful. It is important that the patient understands some of the underlying principles in the

generation of the pain they are experiencing and in particular to appreciate that all sensory experiences are in the end psychologically generated in the brain. This is often a difficult concept, if for no other reason that many patients when hearing the words brain and psychological will immediately start to equate the explanation with a belief that the doctor suspects that the patient is malingering or is psychiatrically unwell, both of which are untrue.

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outstanding litigation makes it more difficult to succeed with cognitive behavioural therapy

The next task which is frequently more difficult than the first, is the need to explain that the pain they are experiencing does not indicate serious underlying disease and that the undertaking of activities which temporarily increase the pain is not harming the individual. This is of course counter-intuitive because we used the idea that pain represents a serious problem, such as putting one's hand on a hot plate or having acute appendicitis. The individual has to be convinced that the time the pain they are experiencing is not "useful" and therefore it is quite safe for them to work through the pain. This is particularly occupationally important as far as "work hardening" is concerned. Many low back pain sufferers are afraid that doing quite simple tasks such as lifting light weights will actually be doing more damage to the back because it hurts when they do it. The role of the physiotherapist in demonstrating to the individual that increasing amounts of activity is not only not harmful, but that the effects are beneficial is very important.

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Cognitive behavioural therapy is being increasingly used to help people with chronic pain from any cause.

Cognitive behavioural therapy is being increasingly used to help people with chronic pain from any cause. The techniques are reasonably well understood by the general public because they are used as a management for phobia and have been featured on popular television programmes on more than one occasion. This technique does not abolish pain, but it does help patients to cope with pain and get on with a more normal life and in all the studies that have been done, there is clear evidence that the technique will allow return to work in a significant number of patients. Not all individuals are susceptible to the technique, particularly if they cannot grasp the concept of the psychological nature of the pain or the fact that the pain is not particularly dangerous. Outstanding litigation makes it more difficult to succeed with cognitive behavioural therapy because of the secondary gain that is achieved by continuing to be symptomatic until the legal case is settled.

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rapid treatment of these problems, coupled with good ergonomic assessment and modification of working practices will lead to a successful outcome for a majority of patients.

As noted above, inappropriate pain and fibromyalgia appear to becoming more frequent and there is something to suggest that this group of disorders is related to other increasingly common problems like chronic fatigue and allergy syndromes which maybe reflects the increasing stress associated with modern lifestyles, including the requirement for increased productivity at work. Malingering as such is rare, although it does occur, but exaggeration, particularly if there is litigation outstanding, is relatively common. Many people have unrealistic expectations of the effectiveness of modern medicine. In particular they believe that if they have a pain or some other bodily dysfunction, that not only should doctors be able to cure them but that they have a duty to do so. Regrettably that is not true. It would be of considerable benefit to society if an educational programme was put in place which taught people that it is normal to expect some pain and discomfort, particularly as we get older and that there is no magic treatment, nor is treatment necessary in the overwhelming majority of cases. It would also be of considerable benefit if more people could be convinced of the importance of physical fitness and the need to take regular exercise to keep muscles strong so that joints, including the back, can be protected.

Conclusion

Musculo-skeletal symptoms are common and potentially disabling. There appears to be something of an epidemic of back related and upper limb pain, as well as an increase in inappropriate pain and fibromyalgia. There are reasons for believing that some of these represent life-style difficulties but there is also good evidence that rapid treatment of these problems, coupled with good ergonomic assessment and modification of working practices and workstations, will lead to a successful outcome for the majority of patients. In those patients in whom chronic symptoms develop such techniques as cognitive behavioural therapy may be helpful.

Geoffrey H Robb

Geoffrey Robb is Consultant Physician at Epsom General Hospital where he has a particular interest in diabetes. He is currently Consultant Medical Officer to UnumProvident and has a long and active association with the insurance industry. He has been instrumental in shaping UnumProvident's current active approach to claims management and has also had central role in shaping the company's underwriting policy in relation to a number of diseases and conditions. He is also Chief Medical Officer for Friends Provident Life Office and to the Health Claims Bureau. He was president of the Assurance Medical Society from 1999-2001 and was an invited lecturer at the International Congress of Life Assurance Medicine in Sydney in 2001.

Recent Advances in General Medicine

Geoffrey H Robb MB ChB FRCP, Consultant Physician,
Epsom General Hospital

What we know about the human body and what can go wrong with it increases all the time. In writing a short article on "Recent Advances", inevitably I am reflecting my own interests in medicine, together with those of the insurance industry and in no way can this article pretend to be a comprehensive review of such a vast subject. I trained in cardiology and more recently in diabetes. Over the years I have developed a special interest in the management of obesity and also fatigue syndromes as these were conditions for which the general practitioner frequently sought my assistance. This article therefore, addresses some of the developments in these areas, together with others which affect principally critical illness and cancer, some areas of neurology and psychiatry.

Coronary Thrombosis

There has been rapid progress in both the prevention and treatment of CORONARY THROMBOSIS. Large and well structured studies using statins (such as 4S and WOSCOPS) have demonstrated important reductions in mortality in both primary and secondary prevention of coronary thrombosis with a statin. In any one who is at risk of having a coronary thrombosis because of adverse family history, diabetes, existing vascular disease or a high cholesterol, there is a compelling evidence that a statin will reduce the risk of a major vascular complication. Although one of the five statins available in the UK (Cerivastatin) has been withdrawn because of muscle damage, the evidence in favour of this group of drugs remains overwhelming. There are important economic implications as if all those who should be on a statin for prevention of coronary disease were prescribed them, the cost to the health service would be enormous. The government of Australia have already expressed concern and other countries where drugs are available either free or on a subsidised basis will also be worried. The potential prolongation of life may well have an adverse effect on pension funds.

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while these definitions may be appropriate for clinical practice, the insurance industry will surely need additional safeguards

It is not only statins that are proving useful in preventing adverse effects from vascular disease. Aspirin, Clopidogrel and ACE inhibitors have all been shown to help those who have had a myocardial infarction. Multiple drug therapy should not necessarily be regarded as an indication that disease is severe, but rather that they have a caring and up to date physician who is aware of how further cardiac damage can be prevented.

Acute Myocardial Infarction

The definition of ACUTE MYOCARDIAL INFARCTION has changed recently, which is of importance to those of us involved in critical illness policies. The old definition was of characteristic cardiac chest pain, together with ECG changes and an elevation in cardiac enzymes. The new definition as recommended in a consensus document of the joint European Society of Cardiology and the American College of Cardiology defines a myocardial infarction as "a typical rise and gradual fall in biochemical markers of myocardial necrosis such as Tropinin or CK-MB, together with at least one of the following:

a) Ischaemic symptoms
b) ECG changes
c) Coronary artery intervention such as angioplasty

A pathological diagnosis is still acceptable.

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there is new objective evidence to show that depression is extremely common in those who have had cardiac surgery

This will pose a problem for critical illness insurers in that only one Tropinin estimation is usually requested in clinical practice and false positives may occur. It would be difficult to refute a claim for an individual who presented with chest pain who had an isolated high tropinin but no other indication of myocardial infarction and while these definitions may be appropriate for clinical practice, the insurance industry will surely need additional safeguards.

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It is possible for some diabetics to be insured at ordinary rates of premium.

There has been further refinement in coronary angioplasty over the past two or three years in that stenting of narrow coronary arteries is now almost universally practiced. There is some evidence that those who have had either successful angioplasty or coronary artery surgery can be regarded as preferred lives as their mortality is lower in the short term than the general population. Newer forms of immunosuppression have improved the prognosis of those with cardiac transplants and over 50% of such patients are expected to survive for over 10 years.

There are important lessons here for those underwriting disability policies or managing claims. The first is that survivors of ischaemic cardiac episodes who have been appropriately treated are likely to have a long life expectancy provided left ventricular function as judged by ejection fraction is reasonable. There is new objective evidence to show that depression is extremely common in those who have had cardiac

surgery and our claims assessors will be all too aware of policy holders who have had successful cardiac intervention yet are not prepared to return to their insured occupation. Sometimes this can be due to cerebral embolism of clots detached or formed during surgery but frequently the underlying reason is depression, perhaps exacerbated by the understandable concern of spouses and other family members following a cardiac event. Such episodes are less likely to occur in centres where there is a vigorous early cardiac rehabilitation programme.

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It has been shown that the risk of developing complications of diabetes is closely related to the post prandial blood sugar so in theory these drugs should reduce vascular disease, but that has yet to be proven.

Diabetes

My other major interest is that of DIABETES. Most Type 1 (or insulin dependent) diabetes of working age will be on a basal bolus regime whereby they have an injection of quick acting insulin with each of their 3 meals and a long-acting insulin at night – the so-called basal bolus regime. This endeavours to reproduce the activity of the normal pancreas and the majority of diabetics can maintain adequate control on such a regime. Blood sugar monitoring will still be necessary but that is being made easier by the introduction of tissue fluid sugar estimations such as the glucowatch. Insulin injections are virtually painless but finger prick blood sugar testing is painful and measurement of tissue sugar levels which can be painless should enhance blood sugar control. It is possible for some diabetics to be insured at ordinary rates of premium, if all their risk factors are controlled but such diabetics are still a minority.

There are exciting developments for those who have Type 2 diabetes. The mainstay of treatment with Metformin and a sulphonylurea can now be supplemented by a Glitazone which will reduce insulin resistance (and hopefully reduce the risk of macrovascular disease). The other recent introduction is the prandial glucose regulators such as Nateglinide, which stimulate the release of insulin from pancreatic beta cells and reduce post-prandial hyperglycaemia. It has been shown that the risk of developing complications of diabetes is closely related to the post-prandial blood sugar so in theory these drugs should reduce vascular disease, but that has yet to be proven.

Insulin pumps and pancreatic cell transplantation are in the process of development and are likely to help individual diabetics but are unlikely to affect the overall burden of vascular disease in the short or medium term. Insulin pumps are for those whose blood sugars fluctuate so wildly that it is difficult to maintain a relatively normal lifestyle. They are intrusive in that the diabetic has a needle in the abdomen and they have to wear a syringe containing insulin and a small pump at all times. They can only be detached for short periods such as bathing or swimming.

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in the field of CANCER, the most important development from the insurance point of view is the increased awareness about cancer of the prostate and the use of the PSA test

They are not for the majority of diabetics, who are best controlled on a basal bolus regime. The problems with islet cell transplantation are three-fold. Firstly, one has to have an adequate supply of the functioning islet cells and in the Edmonton series which has been the most successful so far, islet cells were taken from two or three donors. The supply of donor organs inevitably is limited so in the absence of some form of stem cell transplant, this can only benefit a tiny minority of diabetics. The other problem is that of immuno-suppression, which the Canadian team have improved, but the big breakthrough in preventing rejection has yet to occur.

Cancer

In the field of CANCER, the most important development from the insurance point of view is the increased awareness about cancer of the prostate and the use of the PSA test as a screen for this. Although cancer of the prostate is relatively uncommon in men under the age of 60, it still occurs sufficiently frequently for many, including myself, to offer this as a screening investigation when taking blood for other purposes. The prognosis for prostatic cancer has always been rather better than that of other cancers, but it is crucial for critical illness policies that a robust definition be accepted. If any presence of neoplastic cells in the prostate is accepted for the diagnosis, then pricing will have to change appropriately but a more realistic definition might well be that the process must be locally invasive in order to trigger payment under a critical illness policy.

Obesity

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The management of OBESITY remains a major clinical problem. The cause is both genetic and environmental

The management of OBESITY remains a major clinical problem. The cause is both genetic and environmental and the latter is not often amenable to change. When obesity is secondary to depression, then the prognosis is reasonable provided the depression is treated vigorously. Two new drugs have recently been introduced which are proving of value. Orlistat acts by blocking absorption of fat from the small intestine by the inhibition of the enzyme which normally digests fat. It is useful in those who are able to keep to a low fat diet. Sibutramine acts in the brain by altering serotonin levels and this can in some cases turn off the feeling of hunger and desire to eat. The long term place of both these drugs in practice remains to be determined.

Depression

As everyone in UnumProvident knows, claims for psychological problems exceed those from any other single cause. DEPRESSION is the most common underlying disorder and it is indeed very common in the general population, both insured and non-insured. Pharmaceutical companies have been busy in this area and there are a whole number of new antidepressant drugs available. Claims assessors, I am sure, will have noticed the discouraging frequency with which claims for depression are submitted where the individual is either on no antidepressant medication or only on a relatively sub-therapeutic dose. Depression is a real challenge for a clinician and the right dose is as important as the choice of the drug in the treatment of the condition. The increasing complexity of drug regimes means that specialist psychiatric help should be sought with the more difficult cases, but in clinical practice, patients are often not referred soon enough or indeed not at all and it is probable that this is leading to much needless suffering. The diagnosis of depression is sometimes a cover for a breakdown in work relationships and claims assessors have become adept in sorting out the real failure for return to work.

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depression is a real challenge for the physician

Neurology

The most important advance in NEUROLOGY in recent years has been the development of high quality scanning procedures for the central nervous system. It is frustrating that scan appearances often do not correlate with the clinical condition but diagnosis of cerebral vascular disease, multiple sclerosis and brain tumours has been immeasurably advanced by these new scanning methods. The treatment of neurological disease remains disappointing, although some patients with multiple sclerosis can be helped by beta-interferon and newer drugs for Parkinson's disease and epilepsy will help the majority of sufferers who are severely affected. There is tantalising research into the growth of nerve cells which, if clinically available, could revolutionise so much neurological treatment but such treatment is probably several years away.

This article has attempted to address a few of the discussion points in modern medicine, but cannot hope to be comprehensive. Much can be learned about medical advances by reading what is written week by week in the broadsheet press. Many doctors, as well as their patients keep up to date in this way!

ref: 059874

Much can be learned about medical advances by reading what is written week by week in the broadsheet press. Many doctors, as well as their patients keep up to date in this way!

Charles Pumphrey

Charles Pumphrey is Consultant Cardiologist at St George's Hospital, Tooting, and Honary Senior Lecturer at St George's Hospital Medical School. He is director of the Cardiothoracic Unit at St George's Hospital. He trained in cardiology in London and Edinburgh and has been a British-American Travelling Research Fellow at the Mayo Clinic, USA. He has published extensively on a variety of issues in cardiology, but particularly in connection with ischaemic and valvular heart disease. He is a member of the British Cardiac Society, the British Pacing and Electrophysiology Group and the British Cardiovascular Intervention Group.

Recent Developments in Cardiology

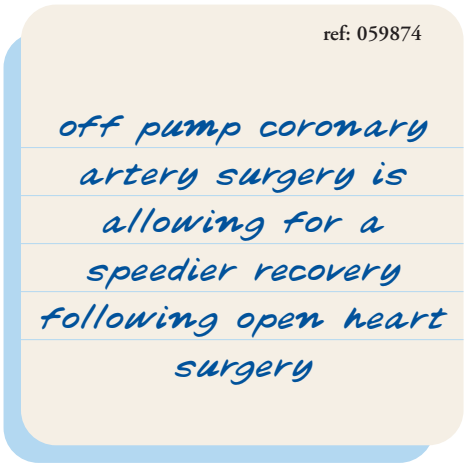
Charles W Pumphrey DM FRCP, Consultant Cardiologist, St George's Hospital, London

This report is devoted to identifying those developments in cardiology which are likely to reflect on the life assurance industry with particular reference to improving prognosis in various cardiovascular conditions and diagnosis.

Ischaemic Heart Disease

Myocardial Infarction

Diagnosis of myocardial infarction. With the development of troponin T as a sensitive measure of evidence of myocardial damage, the diagnosis of myocardial infarction has now been redefined. Patients who have cardiac pain in association with an identifiable level of troponin T in the blood are considered to have had a myocardial infarct. No change in the creatinine phosphate kinase or other conventional cardiac enzymes are necessary any longer. An elevated troponin T without elevation of conventional cardiac enzymes is thought to arise due to micro-emboli from an active coronary plaque causing infarction in the micro-circulation.



When a patient presents with chest pain and identifiable troponin T without a rise in cardiac enzymes, they are known to be at particular risk of developing a substantial infarct due to occlusion of an epicardial vessel. As a result patients presenting with unstable angina are now risk stratified according to their troponin T levels (as well as on going ECG changes) and early investigation by angiography with a view to revascularisation is offered to these patients.

The consequence of the development of troponin T assay as a marker for myocardial damage is that there will be an increase in the number of patients that can be defined as having experienced a myocardial infarct. Once revascularisation has been undertaken, however, the prognosis will be as if they have not had a conventional infarct (in the old sense of the word) since their heart muscle function will probably appear normal on echocardiography and angiography. The prognosis in coronary artery disease is, to a large extent, defined by left ventricular function and therefore not all patients defined as having an infarct by tropinin T will have the same adverse prognosis as is associated with patients who had a myocardial infarction diagnosed by the old criteria.

Coronary Revascularisation

The techniques in coronary surgery are developing: off pump coronary artery surgery is allowing for a speedier recovery following open heart surgery with a reduction in the cerebrovascular complications associated with coronary surgery.

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The techniques in coronary surgery are developing: off pump coronary artery surgery is allowing for a speedier recovery following open heart surgery

Minimally invasive coronary artery surgery (midcab) is also developing in specifically defined types of coronary lesion. However, the majority of coronary operations still involve a sternotomy and the use of a cardiopulmonary bypass pump. Surgeons are favouring the process of full arterial revascularisation which is having a measurable impact on the longevity of a successful outcome. Although associated with greater technical problems at the time of surgery, the use of the radial artery, right internal mammary artery (as well as left internal mammary artery) result in the patients being symptom-free for longer than was expected with the use of saphenous vein grafts. In the latter context, 50% of patients would have a need for further revascularisation at 10 years following surgery. Patients now remain symptom free for longer. The consequence of this is that patients who return to work following coronary artery surgery are likely to remain in work for a longer period than they would have done had they had saphenous vein grafts, since it is the experience that the relapse of symptoms following successful coronary surgery is the time that most patients seek to retire from their employment on medical grounds.

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Percutaneous coronary intervention (PCI) has now overtaken coronary artery bypass surgery in terms of the number of procedures undertaken

Percutaneous Coronary Intervention

Percutaneous coronary intervention (PCI) has now overtaken coronary artery bypass surgery in terms of the number of procedures undertaken per million of the population per year with a ratio of 60-40 in most centres. The introduction of stents and the development of the glycoprotein IIbIIIa platelet inhibitors has made the technique very much safer and as a consequence the procedure is being undertaken in centres which do not have on site surgery. This will develop more and more in the years to come and it is reasonable to anticipate that PCI will be the preferred treatment of choice in patients presenting with angina rather than relying on anti-anginal medication.

The great pitfall of in stent re-stenosis, which has dogged the long term success rate following PCI is likely to become much less of a problem with the introduction of drug eluting stents using either rapamycin or paclitaxel. These stents are to be introduced next year and clinical trials are yet to be undertaken in large volumes to indicate whether their initial promise will be sustained. Furthermore, as technology improves the ability to deal with complex narrowings increases. The challenge remains of managing stenoses involving major side branches and whether any technology can be developed to deal with chronic occlusions.

Management of Risk Factors

The role of lipid lowering therapy is now well established in the management of chronic ischaemic heart disease. It is also emerging that unstable coronary syndromes have a more favourable outcome if lipid lowering therapy is introduced aggressively. (It seems that statins pacify unstable plaques). The prevailing view at the moment is that the lower the cholesterol can be maintained, the better the outcome in patients with established coronary artery disease or in those patients who have additional risk factors (especially a positive family history) for coronary artery disease.

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The role of stress in the development of coronary artery disease remains controversial

The importance of controlling high blood pressure, particularly in the context of diabetes mellitus, has long been established with target levels now being 140/85 or less in non-diabetic patients and 140/80 or less in diabetic patients.

The role of stress in the development of coronary artery disease remains controversial. The conventional view that stress unmasks symptoms from pre-existing coronary artery stenosis still prevails. The consequence of this, is that many patients seek early retirement or redeployment in their working life in order to avoid stress and therefore symptoms of angina.

Heart Failure

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The prognosis in heart failure has been improved

The diagnosis of heart failure may improve with the introduction of assays such as ANP and BNP levels. Conventionally symptoms associated with an abnormal echocardiogram have led to the diagnosis. However, it still remains the case that people are diagnosed with heart failure, usually in a primary care setting, when they present with breathlessness and/or swelling of the ankles and yet neither symptom ultimately proves to be due to heart muscle disease.

The prognosis in heart failure has been improved. The introduction of aggressive vasodilation usually with ACE inhibitors is well known to improve prognosis. Similarly the use of beta blockers, particularly in patients with a resting tachycardia also improves prognosis as well as symptoms. In advanced cases of heart failure, some patients benefit from the introduction of biventricular pacing which helps to reduce the degree of functional mitral regurgitation. Similarly, in heart failure patients with unstable cardiac rhythms, the use of implantable cardiac defibrillators unequivocally improves prognosis over that achieved by conventional anti-arrhythmic therapy (usually amiodarone).

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Marfan's Syndrome

It is now recognised that in asymptomatic patients with Marfan's syndrome, that the prognosis is improved by undertaking elective aortic root replacement when the aortic root diameter is 5.0 cm or more. The lower risks of the operation have justified proceeding to surgery earlier than has hitherto been the case.

Arrhythmias

The importance of anticoagulation in atrial fibrillation has now been well recognised and conventionally patients over the age of 65 who have atrial fibrillation, or patients who have a very enlarged left atrial with paroxysmal atrial fibrillation are advised to have Warfarin as this significantly reduces the risk of stroke.

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Warfarin .... significantly reduces the risk of stroke

Other tachycardias are now being treated by interventional techniques. Ablation for reciprocating tachycardias has been well established. Radiofrequency ablation for atrial flutter is now also well established. The challenge is developing radiofrequency ablation techniques for atrial fibrillation and also for ventricular arrhythmias.

The indications for the implantation of cardiac defibrillators has been recognised by the national institute of clinical excellence and therefore, there has been a marked increase in their use. Whereas before the use of an ICD was for patients whose prognosis was severely compromised, now the use of an ICD may not indicate that the prognosis is as adverse as was recently the case.

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In advanced cases of heart failure, some patients benefit from the introduction of biventricular pacing

Mansel Aylward

Professor Mansel Aylward is Chief Medical Adviser and Medical Director to the new Department of Work and Pensions (DWP).

He is a physician and specialist in rheumatology and rehabilitation, therapeutics and clinical pharmacology and is an Expert Agrée Professor. Entering the Civil Service in 1985 he was appointed Chief Medical Adviser in 1996.

He played a key role in development and evaluation of the medical assessment for incapacity (the All Work Test), and recently has been heavily involved in developing the Personal Capability Assessment (PCA). He leads the Corporate Medical Group on the Government's Welfare Reform initiatives and made a major contribution in establishing the new postgraduate diploma for doctors in Disability Assessment Medicine. His interests are in rheumatology and rehabilitation, stress-related illnesses, chronic fatigue syndromes and back pain disability.

Health and Welfare Government Initiatives and Strategy, and Developing Trends in Incapacity-Related Benefits.

Mansel Aylward, BSc MD FFOM FFPM Chief Medical Adviser & Medical Director, The Department for Work and Pensions, London

From the perspective of the Government's commitment to reform the welfare system for sick and disabled people this paper addresses some of the existing and planned initiatives in the areas of Health and Welfare. Additionally, the paper reports the characteristics and trends among recipients of incapacity-related state benefits which demonstrate in recent years striking shifts in the diagnostic characteristics of disabled people who populate the case load of and inflows to, these benefits.

Health Services and Rehabilitation

The NHS Plan

In coming years the NHS will shape its services around the needs and preferences of individuals patients, their families and carers. The emphasis of an NHS of the 21st Century must be its responsiveness to the needs of groups and individual within society, and its challenging discrimination on the grounds of age, gender, religion, disability and sexuality. Services will be centred on patients' needs and society will have a greater say in the NHS.

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delivering improvements in public services remains a Government priority

Delivering improvements in public services remains a Government priority. An additional £1 billion will be made available in 2002-03. The main debate stimulated by the 2001 Pre-Budget Report concerned the future of the NHS and how expansion and improvement were to be managed and funded. This stems from the Chancellor's announcement of the findings from an interim report from the Wanless Review on long-term health trends in the UK. That interim report, endorsed by the Chancellor, concluded that there was no reason why a publicly funded NHS could not be the most efficient solution to the UK's long-term health needs. Although the Chancellor has ruled out any increases in income tax in this Parliament, he has raised the possibility that expansion and improvements in the NHS could be funded by higher taxes.*

*At the time of writing the report, the recent changes to National Insurance contributions in the April 2002 budget had not been announced.

In the NHS Plan, the Government has also set a target to increase by 50% the number of people who will benefit from Modernising Community Equipment Services by 2004. Over the next 3 years the

NHS is expected to spend an additional £105 million to improve disability equipment services with an expected integration of these services across health and social services and monitoring of compliance.

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strategic objectives are to identify and address health needs and to modernise services, and to increase effectiveness, efficiency and responsiveness

NHS Plus

Under the recently launched NHS Plus initiative the NHS will be encouraged to provide occupational health services in order to improve the health of the work force and to generate income.

Among the expected outcomes by 2010 are targets for substantial reductions in incidence of work-related ill-health and in numbers of days lost due to work-related ill health. This initiative will build on occupational health interventions and vocational rehabilitation developed by NHS Trusts. It provides a potential vehicle for the commercial provision of integrated health and employment interventions to help people at risk of losing their job because of ill health or disability; and to enhance and increase the provision of rehabilitation services to aid a return to work of those displaced from the labour market because of work-limiting factors or longer term disabilities.

Health Action Zones (HAZs)

26 HAZs have been established covering 13 million people in 34 Health Authorities and in some of the most deprived areas of the country. Their strategic objectives are to identify and address health needs and to modernise services, and to increase effectiveness, efficiency and responsiveness. HAZs represent a novel way of working; should become the core business of Health Authorities, and the main instrument of strategic partnerships with Local Authorities and other agencies. They will provide the link for health, regeneration, employment, educational, housing and anti-poverty initiatives.

Joint Investment Plans on Welfare to Work for Disabled People

These plans are to provide for effective and joined-up services for disabled people who want to work, to stay in work, or move closer to the world of work. The core concept is of inter-agency working with a focus on the needs of the user.

Job Retention and Rehabilitation Pilots (JRRPs)

The JRRPs are a joint initiative between the Department of Health, the Department for Work and Pensions and the Department for Education and Skills to test the relative effectiveness of different healthcare and employment initiatives in enabling people at risk of losing their jobs

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there is a common interest across several Government Departments in measures which would reduce the prevalence and high costs of sickness absence

because of ill health or disability to remain in work. The first of 3 phases of the procurement exercise generated 29 outline proposals for delivering a service to clients. Nine preferred bidders have been selected to develop further and to test the feasibility of their proposals in a Feasibility Phase which commenced in October 2001, at the end of which successful bidders may be offered contracts to plan for, and deliver pilot services from Autumn 2002. Moreover, the practicality of a highly innovative 4 way random assignment model will be established during the Feasibility Phase.

Other Health and Work Issues

There is a common interest across several Government Departments in measures which would reduce the prevalence and high costs of sickness absence, and improve the quality and availability of vocational and employment rehabilitation.

Absence Management

Many employers do not manage workplace absence. This costs the country around £10.7 billion a year in lost production and leads to an avoidable drift in to longer-term incapacity. UnumProvident's own research in this area has added significantly to the knowledge of the Costs of Sickness Absence to employers. That, in itself, can lead to further health problems for individuals so affected and increasing inequalities between communities. The encouragement and promotion of good attendance management practices are an essential component of the Government's agenda.

Vocational Rehabilitation (VR)

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Many employers do not manage workplace absence. This costs the country around £10.7 billion a year in lost production

VR services aim to help people keep their jobs or stay connected with work or the job market, and have the potential to help more people move away from incapacity benefits and reconnect with work. The Government shares an interest with other organisations in the public, private and voluntary sectors which have a stake in the development and wider availability of more effective models of vocational rehabilitation and case management. Moreover, VR services could provide a framework to support and build on the work of the Job Retention and Rehabilitation Pilots. The Government is currently consulting with a wide range of organisations to appraise the role that VR services could play in the welfare system for sick and disabled people of working age.

Recipients of State Incapacity – Related Benefits

Characteristics and Trends

Analysis of the current caseload for working age recipients of incapacity – related benefits demonstrate the skew towards older age groups: 8 per cent of working age men and 6 per cent of working age women are receiving these benefits. The range is from around 3 per cent of those aged less than 30 years to approximately 25 per cent of men aged 60 to 64 years. The preponderance of male recipients is partly due to the higher state pension age but there are more men in receipt of the benefits at all ages. However, growth in receipt of benefits has been faster among women in recent years, even when controlled for age. For women these increases tend to be bigger among the older age groups. This may well represent the effects of phasing out the "married women's option" which began in 1977. During the 1980s and early 1990s the biggest increases in recipients were among working age men aged 50-64 years. Since 1995 there has been a small reduction in this age group which is likely to be due to the introduction of benefit reforms in that year. For men aged up to 50 however, there have been increases in those receiving these benefits for all age groups.

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there are more men in receipt of the benefits at all ages. However, growth in receipt of benefits has been faster among women in recent years

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Characteristics by Diagnostic Grouping

Mental and behavioural disorders account for 33% of recipients of incapacity – related benefits. Almost half of these are recorded as having a "depressive episode". Musculoskeletal and connective tissue diseases are reported in 21% of recipients. Diseases of the circulatory and respiratory systems account for 8 per cent and 3 per cent of recipients respectively. Mental health and behavioural disorders (29%) and musculoskeletal and connective tissue diseases (16%) dominate diagnostic categories among those people flowing on to incapacity- related benefits. Not unexpectedly, those flowing on to these benefits classed under the consequences of external factors such as injury, etc, are greater among inflows (15%) than in the stock of recipients (6%).

Differences between inflows and stock for circulatory and respiratory system diseases are only marginal. Moreover, growth in benefit recipients due to mental and behavioural

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disorders has been rapid during the past five years and are much more evenly spread across the age range than other diagnostic groups. Notably, the proportion of the population in receipt of these benefits as a result of mental and behavioural disorders has shown substantial increases for all age groups of both genders. Within every age group for men since 1995 the proportion of the population receiving these benefits for reasons other than mental and behavioural disorders has fallen. For women however, this overall proportion has remained relatively stable in stark contrast to the substantial increases in the proportion reporting mental and behavioural disorders since 1995. Better contribution records among women and the married women's opt out have probably contributed to some of the growth.

These analyses point to growth in mental and behavioural disorders as the main drivers. Indeed without this growth, there would have been a reduction in the caseload. Another interpretation, however, might be a migration in the diagnostic label from other medical conditions to "mental health problems" for reasons which as yet need further research. The growing ascendancy of mental health problems in the caseload can be attributed to two principal courses: (1) inflows have risen slowly and steadily since 1995 in the face of decreasing inflows into all the other diagnostic categories; (2) people reporting mental health problems remain longer on benefit than those with other diagnoses. On the whole people with mental health problems remain on benefit much longer than those with other chronic conditions which would be expected to have a prognosis of similar duration to, and in many instances greater than, that of the commonly encountered mental health disorders which populate this latter category. This reflects the observation that people with mental health problems are significantly less likely to be in employment than the disabled population as a whole: respective employment rates for people with a mental illness and the total population of those with chronic disabilities are 18% and 47% [Labour force survey].

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people reporting mental health problems remain longer on benefit than those with other diagnoses

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people with mental health problems are significantly less likely to be in employment than the disabled population as a whole

1 Working age recipients of Incapacity Benefit (IB), Severe Disablement Allowance (SDA) and National Insurance Credits (NICs)

2 Recipients may meet eligibility requirements by virtue of more than one medical condition. Nearly 8% of cases are unclassifiable on the basis of available information

Attachment to the Labour Market

Analysis of the IB claimants stock since November 1996 reveals that only 40% of these were in paid work prior to their claim, while almost a quarter had been in receipt of Job Seeker's Allowance (JSA) in the 3 months before claiming IB. Although some 40% of new claimants return to work within the first 6 months, those in receipt of benefit at 6 months have a very strong likelihood of remaining on benefit for years. Of those beginning a claim in 2000 around 30% will be in receipt of benefit for at least 4 years.

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Moreover, the low outflow rates from IB means that a high proportion will spend several years away from the labour market. More than two-thirds of IB/IVB claimants have been on benefit for more than 2 years and more than 33% have been in receipt of benefit since before the 1995 reforms. Furthermore, a high proportion of IB leavers move on to JSA rather than moving directly into work. The importance of the strength of the local labour market is revealed by the positive correlation between the proportions of a local population in receipt of benefits and men aged less than 50 years receiving unemployment benefits. However, in some areas (eg. South Wales, East Lancashire and the Clyde Valley) disability benefit receipt is high relative to unemployment. In London and some coastal towns the levels of benefits receipt is low relative to unemployment.

Productivity and Employment: A Dual Impact on the Nation's Well-Being

The Government is controlling social security spending by cutting the cost of social and economic failure through better work opportunities, getting benefit entitlement right and cutting back fraud. This permits more spending on the Government's priorities – poorer pensioners, and children and families. Social security is the largest single area of government spending. In 1991/92 spending on social security benefits in Great Britain represented 26.5% of total government expenditure.

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Social security is the largest single area of government spending.

By 1993/94 it had risen to around 29% and remained at that level up to 1999/2000. In 2000/01 and 2001/02 benefit expenditure is forecast to be 28.5% of total government expenditure when expenditure on Working Family's Tax Credit (WFTC) and Disabled Person's Tax Credit (DPTC) are also taken in to account. A detailed analysis of trends in social security spending is given in "The Changing Welfare State – Social Security Spending" (February 2000).

The Government's twin objectives of raising productivity and achieving full employment aim to increase the wealth-creating potential of the economy, thus raising prosperity for all. Reduction in public spending on benefit payments is a distinct advantage arising out of the full employment objective. The bringing together of labour market policy and the benefits system into a single Government Department – the Department for Work and Pensions – is underpinned by this rationale. Substantial progress has already been made and continues, particularly with the advent of Job Centre Plus, the single new agency for all benefit clients. Furthermore, the various initiatives described in this paper also demonstrate the commitment to working across departments and joined-up government which focus on an integration of health, social, employment and welfare policies and practices in achieving the Government's Welfare Reform agenda.

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Registered in England 983768.
Registered office: Milton Court, Dorking, Surrey RH4 3LZ.
Tel: 01306 887766 Fax: 01306 881394
Textphone: 01306 887784 www.unumprovident.co.uk

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