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Personal and Societal Impact of Low Back Pain

The Groningen Spine Cohort

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André P. Wolff, MD, PhD,

Study Design. Cross-sectional study.
Objective. The aim of this study was to study the personal and societal impact of low back pain (LBP) in patients admitted to a multidisciplinary spine center.
Summary of Background Data. The socioeconomic burden of LBP is very high. A minority of patients visit secondary or tertiary care because of severe and long-lasting complaints. This subgroup may account for a major part of disability and costs, yet could potentially gain most from treatment. Currently, little is known about the personal and societal burden in patients with chronic LBP visiting secondary/tertiary care.
Methods. Baseline data were acquired through patient-reported questionnaires and health insurance claims. Primary outcomes were LBP impact (Impact Stratification, range 8–50), functioning (Pain Disability Index, PDI; 0–70), quality of life (EuroQol-5D, EQSD; −0.33 to 1.00), work ability (Work Ability Score, WAS; 0–10), work participation, productivity costs (Productivity Cost Questionnaire), and healthcare costs 1 year before baseline. Healthcare costs were compared with matched primary and secondary care LBP samples. Descriptive and inferential statistics were applied.
Results. In total, 1502 patients (age 46.3 ± 12.8 years, 57% female) were included. Impact Stratification was 35.2 ± 7.5 with severe impact (≥35) for 58% of patients. PDI was 38.2 ± 14.1, EQSD 0.39 (interquartile range, IQR: 0.17–0.72); WAS 4.0 (IQR: 1.0–6.0) and 17% were permanently work-disabled. Mean total health care costs (€4875, 95% confidence interval [CI]: €409–5498) were higher compared to the matched primary care sample (n = 4995) (€2365, 95% CI: 2219–2526, P < 0.001), and similar to the matched secondary care sample (n = 4993) (€4379, 95% CI: 4180–4590). Productivity loss was estimated at €4315 per patient (95% CI: 3898–4688) during 6 months.
Conclusion. In patients seeking multidisciplinary spine care, the personal and societal impact of LBP is very high. Specifically, quality of life and work ability are poor and health care costs are twice as high compared to patients seeking primary LBP care.

Key words: chronic pain, multidisciplinary care, tertiary care, questionnaire, self-report, functioning, disability, quality of life, work ability, productivity loss, healthcare costs, health economics.

Level of Evidence: 3
Spine 2019;44:E1443–E1451
A minority of patients with LBP account for the majority of disability and it may be assumed that they account for the majority of costs as well. Less than 28% of LBP cases fall in severe categories, but are responsible for 77% of all years lived with disabilities.7 This subgroup of patients with persistent disabling LBP has potentially most to gain from effective treatment. Current guidelines recommend multidisciplinary biopsychosocial treatment programs for patients with LBP who have not responded to first-line treatment.8–10 However, for both multidisciplinary pain treatment and more invasive approaches, such as spinal surgery, there is only low to moderate level of evidence that intervention treatments are effective in the short and medium term. Furthermore, effect sizes are small to moderate and very little is known about the effectiveness of LBP treatments in the longer term.11–14

In 2015, the Groningen Spine Cohort (GSC) was initiated to gain a better understanding of the course and prognosis of pain, disability, quality of life, work participation, and medical consumption, as well as the quality and effectiveness of care in patients with LBP seeking multidisciplinary secondary or tertiary care. Data on short-, medium-, and long-term outcomes of LBP are collected using medical records, health insurance data, and patient self-report. The GSC will serve as basis for multiple future studies.

In this first article, we present an extensive overview of all baseline patient characteristics. We also present healthcare costs and productivity costs to answer the following question: what is the personal and societal impact of LBP in patients presenting in multidisciplinary secondary and tertiary spine care?

MATERIALS AND METHODS

Study Design
The GSC study is a 10-year prospective cohort study of patients with LBP referred to a university-based multidisciplinary secondary (patient referred by general practitioner, GP) and tertiary (patient referred by medical specialist, MS) care spine center, the Groningen Spine Center, in the north of the Netherlands. Inclusion of patients ran from July 2015 to July 2018. Baseline and follow-up data are acquired through digital questionnaires and health insurance claims. Before first consultation, all patients digitally filled out a comprehensive set of baseline questionnaires (±45 min). The present study reports results of the baseline questionnaires and presents an overview of health insurance 1 year before baseline and costs of productivity loss 6 months before baseline. The Medical Ethical Committee of the University Medical Center Groningen, the Netherlands provided a waiver (M15.169472) for this study with respect to medical ethical permission. Handling of the data was done in accordance with the guidelines for Good Research Practice.15

Patients and Setting
Patients referred to the Groningen Spine Center, between 18 and 65 years’ old, with LBP and/or leg pain were eligible for inclusion. All patients were informed on the purpose of the study and signed an informed consent for the use of their health and insurance data based on anonymity. Patients who did not understand Dutch language or had no Internet access were excluded. All patients received care as usual, and inclusion or exclusion did not change content of the treatment. Treatment could consist of minimal intervention only (reassurance, pain education and information), or could be combined with surgery, multidisciplinary rehabilitation, pain anesthesiology treatment, and/or other if needed (for example referral and treatment by a rheumatologist). Optimal triaging and treatment modalities of patients were discussed in a weekly multispecialist meeting with neurosurgeons, neurologists, rehabilitation physicians, radiologists, orthopedic surgeons, anesthesiologists, and physician assistants.

Measures

Questionnaires

National Institutes of Health Minimal Dataset
The National Institutes of Health (NIH) minimal dataset includes 40 items on patient characteristics, medical history, and self-reported symptoms and functioning.16 Nine of these items (Numerical Rating Scale, NRS, pain, range: 0–10; four items on pain interference, range: 1–5; and four items on physical function, range: 1–5) were used to create an outcome score, the Impact Stratification. The total score on the Impact Stratification ranges from 8 (least impact) to 50 (most impact) and is classified by the NIH Research Task Force as mild (8–27 points), moderate (28–35 points), or severe impact (≥35 points).16 The Impact Stratification strongly correlates with measures such as the Roland Morris Disability Questionnaire and the Oswestry Disability Index.16

Disability
The Pain Disability Index (PDI) measures self-reported disability for seven categories of daily life activities: family/home responsibilities, recreation, social activity, occupation, sexual behavior, self-care, and life support activity. Each item is constructed on a numeric rating scale with 0 indicating no disability and 10 indicating maximum disability revealing total scores from 0 to 70. The Dutch version of the PDI is responsive and 2-week test–retest reliability is good.17,18

Quality of Life
Quality of life was measured with the three-level version of the Euroqol-5D (EQ5D) questionnaire.19 Five dimensions (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) are measured on three levels each (no problems, some problems, extreme problems). Using a validated algorithm,20 the EQ5D scores can be converted into a utility value (ranging from −0.33 to 1). Validity, reliability, and responsiveness of the EuroQol-5D are sufficient.21,22
addition, patient-reported health status is measured on a visual analogue scale (EQ-VAS, range 0–100, worst to best health status).

Work Ability
The Work Ability Score (WAS) measures the self-reported current work ability compared to lifetime best. Scores range from 0 to 10, classified as excellent (10 points), good (8–9 points), moderate (6–7 points), and poor (0–5 points) work ability. The WAS has been demonstrated to be a good alternative for the Work Ability Index (WAI) for assessing work ability in occupational and primary health care. Convergent validity between the WAS and WAI is acceptable.

Psychosocial Work Environment
Psychosocial work environment was measured with a customized version of the short Copenhagen Psychosocial Questionnaire (COPSOQ II). Twenty-five items on a five-point Likert scale cover domains such as (mental) work demands, work organization and job contents, interpersonal relationship and leadership, and the work-individual interface. Test–retest reliability is adequate to good for the selected items of the customized version.

Productivity Loss
Health-related productivity losses were measured with the Institute for Medical Technology Assessment Productivity Cost Questionnaire (iPCQ). The iPCQ has a recall period of 4 weeks. Two modules measure productivity losses of paid work because of absenteeism and presenteeism. For the present study, the module on absenteeism was expanded with items specifying whether the absence of work was because of LBP. The items on absenteeism and presenteeism have been validated.

Additional Items
Additionally, at baseline, patients answered medical and job-related questions about previous hospital visits and imaging for their current LBP (hospital, year, specialty, imaging type), LBP red flags (previous history of cancer, unexplained weight loss, pain worse at night, systemically unwell, prolonged use of corticosteroids, morning stiffness > 1 hour, recent trauma, predominant leg pain), use of pain medication (paracetamol, nonsteroidal anti-inflammatory drugs, opioids, other), and job characteristics (weekly hours, responsibilities, physical demands, adjustments owing to health concerns, and so on).

Health Insurance Claims
Medical costs were obtained from patients who were insured with one of the main Dutch health insurance companies. We expected about 40% of GSC patients to be insured by this company. The Dutch health insurance system is based on managed competition and Dutch citizens are required to obtain a basic insurance package from a health insurer of their choice. Out-of-pocket medical costs were not collected. Health insurance claims were collected 1 year retrospectively before inclusion. A 14-month delay in retrieving cost data was permitted to ensure that all claims were collected.

Data Analyses

Health Insurance Costs
Both total health insurance costs and LBP-related costs were calculated. LBP-related costs were acquired by taking the sum of all health insurance claims that were likely to be related to LBP, for example, claims for pain medication, physiotherapy, medical specialist consults, back related surgery, or other interventions. Health insurance costs of GSC patients were compared to health insurance costs of patients with LBP who did not seek tertiary LBP care. The health insurance company provided 1-year total health insurance costs for two matched (age/sex) samples of patients seeking primary (n = 4993) or secondary care (n = 4993) for LBP.

Costs of Productivity Loss
For the absenteeism module of the iPCQ, patients reported the number of sick days in the past 4 weeks. If a patient was on sick leave since before the 4-week recall period they also filled out the date the sick leave started. The number of sick days in the 4-week recall period were extrapolated to 6 months (26 weeks) before baseline by multiplying it by 6.5. Absenteeism costs were then calculated by multiplying the total number of sick days by mean daily working hours and by costs of production loss per hour (2015; €31.80 for women, €38.10 for men). Absenteeism costs were calculated using the friction cost method (FCM), which assumes that after a period of 85 days another worker has fully replaced the absent patient. This implies that patients who are disabled for work do not incur productivity costs anymore, as they have been out of the productive process for > 85 days. Costs of productivity loss owing to presenteeism, that is, working while sick, were calculated using the number of affected work hours, an efficiency score (numerical rating scale, 0–10) that patients ascribed to their ability to work during those hours, and by the costs of production loss per hour. The sum of costs owing to absenteeism and presenteeism represents the total costs of productivity loss for paid work. Missing data on weekly work hours (in 14% of employed patients) and weekly work days (in 7% of employed patients) were handled with multiple imputation. Constraints were set on the minimum and maximum number of work hours (between 2 and 40 hours) and work days (between 1 and 5) per week.

Statistical Analyses
Descriptive statistics were applied to present baseline patient characteristics. Continuous data are reported as means and standard deviations or medians and interquartile range (IQR), depending on the distribution of the data. Categorical data are presented as frequencies with percentages. Cost data are presented as means with 95%
bootstrapped confidence intervals. Additionally, results on clinical and work-related primary outcome measures and health insurance data are presented separately for patients who were referred to the Groningen Spine Center by their GP or by an MS. Between-group differences for the two referral subgroups were tested with an independent *t* test, Mann–Whitney *U*, or Pearson *χ*² depending on level of measurement and distribution of data. SPSS software (version 23.0, IBM Corp., Armonk, NY) was used for data analysis. A *p* value of ≤0.05 was considered statistically significant.

RESULTS
A total of 1502 patients from the Groningen Spine Cohort were included in this study (Figure 1 and Table 1). An extensive overview of patient characteristics and clinical baseline results per item can be found in Appendix 1, http://links.lww.com/BRS/B448. Patients had an average age of 46.3 ± 12.8 years and the majority (57%) were female. Apart from 41 patients, all patients had developed chronic (>3 months) LBP. Exercise therapy was the most common type of treatment used (at any point in time) for LBP (88%), followed by opioids (53%), and LBP operation(s) (26%). The majority of patients (58%) had a score ≥35 as measured with the Impact Stratification (severely impacted by the LBP). Quality of life was low with a median EQ5D utility score of 0.39 (IQR: 0.17–0.72) and a health state (EQ-VAS) score of 52.9 ± 19.7 of 100. Patients scored their work ability a 4.0 (IQR: 1.0–6.0) of 10 and 17% of patients were permanently work-disabled (i.e., absenteeism exceeds 2 years). Compared to patients who were referred

![Flow chart of patient inclusion.](Figure 1.)
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total (n = 1502)</th>
<th>Referred by GP (n = 853)</th>
<th>Referred by MS (n = 649)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y, mean ± SD</td>
<td>46.3 ± 12.8</td>
<td>45.3 ± 12.9*</td>
<td>47.5 ± 12.7*</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>857 (57)</td>
<td>474 (56)</td>
<td>383 (59)</td>
</tr>
<tr>
<td>Education level, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>29 (2)</td>
<td>19 (2)*</td>
<td>10 (2)*</td>
</tr>
<tr>
<td>Low</td>
<td>522 (35)</td>
<td>266 (31)*</td>
<td>256 (39)*</td>
</tr>
<tr>
<td>Middle</td>
<td>487 (32)</td>
<td>283 (33)*</td>
<td>204 (31)*</td>
</tr>
<tr>
<td>High</td>
<td>343 (23)</td>
<td>224 (26)*</td>
<td>119 (18)*</td>
</tr>
<tr>
<td>Other</td>
<td>121 (8)</td>
<td>71 (7)*</td>
<td>60 (9)*</td>
</tr>
<tr>
<td>Medical history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration LBP, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;3 mo</td>
<td>40 (3)</td>
<td>30 (4)</td>
<td>10 (2)</td>
</tr>
<tr>
<td>3 mo–1 y</td>
<td>240 (16)</td>
<td>139 (16)</td>
<td>101 (16)</td>
</tr>
<tr>
<td>1–5 y</td>
<td>527 (35)</td>
<td>278 (33)</td>
<td>249 (38)</td>
</tr>
<tr>
<td>&gt;5 y</td>
<td>695 (46)</td>
<td>406 (48)</td>
<td>289 (45)</td>
</tr>
<tr>
<td>Previous medical imaging for current LBP, n (%)</td>
<td>1328 (88)</td>
<td>696 (82)*</td>
<td>632 (96)*</td>
</tr>
<tr>
<td>Visited medical specialist for current LBP, n (%)</td>
<td>822 (55)*</td>
<td>398 (47)*</td>
<td>424 (66)*</td>
</tr>
<tr>
<td>Previous low-back operation(s), n (%)</td>
<td>387 (26)</td>
<td>181 (21)*</td>
<td>206 (32)*</td>
</tr>
<tr>
<td>Treatment(s) used for LBP, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioids</td>
<td>803 (53)</td>
<td>418 (49)*</td>
<td>385 (59)*</td>
</tr>
<tr>
<td>Injections</td>
<td>328 (22)</td>
<td>147 (17)*</td>
<td>181 (28)*</td>
</tr>
<tr>
<td>Exercise therapy</td>
<td>1316 (88)</td>
<td>785 (89)</td>
<td>558 (86)</td>
</tr>
<tr>
<td>Psychological counseling</td>
<td>222 (15)</td>
<td>128 (15)</td>
<td>94 (15)</td>
</tr>
<tr>
<td>Pain and functioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRS score back pain (0–10), median (IQR)</td>
<td>7.0 (6.0–8.0)</td>
<td>7.0 (6.0–8.0)</td>
<td>7.0 (6.0–8.0)</td>
</tr>
<tr>
<td>PDI total (0–70), mean ± SD</td>
<td>38.2 ± 14.1</td>
<td>37.0 ± 14.1*</td>
<td>39.8 ± 13.8*</td>
</tr>
<tr>
<td>NIH minimal dataset Impact Stratification (8–50),</td>
<td>35.2 ± 7.5</td>
<td>34.7 ± 7.5*</td>
<td>36.0 ± 7.3*</td>
</tr>
<tr>
<td>mean ± SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild (8–27), n (%)</td>
<td>232 (16)</td>
<td>144 (17)*</td>
<td>88 (14)*</td>
</tr>
<tr>
<td>Moderate (28–34), n (%)</td>
<td>402 (26)</td>
<td>242 (28)*</td>
<td>160 (25)*</td>
</tr>
<tr>
<td>Severe (≥35), n (%)</td>
<td>868 (58)</td>
<td>467 (55)*</td>
<td>401 (62)*</td>
</tr>
<tr>
<td>Quality of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EQ5D: health state (0–100), mean ± SD</td>
<td>52.9 ± 19.7*</td>
<td>54.4 ± 19.8**</td>
<td>51.1 ± 19.4**</td>
</tr>
<tr>
<td>EQ5D: utility value (0.33 to 1.00), median (IQR)</td>
<td>0.39 (0.17–0.72)</td>
<td>0.57 (0.19–0.73)*</td>
<td>0.30 (0.17–0.69)*</td>
</tr>
<tr>
<td>Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work ability (0–10), median (IQR)</td>
<td>4.0 (1.0–6.0)</td>
<td>5.0 (1.0–6.0)*</td>
<td>3.0 (1.0–6.0)*</td>
</tr>
<tr>
<td>Work status, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not working</td>
<td>601 (40)</td>
<td>296 (35)*</td>
<td>305 (47)*</td>
</tr>
<tr>
<td>Permanent work disability</td>
<td>253 (17)</td>
<td>125 (15)*</td>
<td>128 (20)*</td>
</tr>
<tr>
<td>Employed</td>
<td>901 (60)</td>
<td>557 (65)*</td>
<td>344 (53)*</td>
</tr>
<tr>
<td>Working</td>
<td>409 (27)</td>
<td>271 (32)*</td>
<td>138 (21)*</td>
</tr>
<tr>
<td>Partial sick leave</td>
<td>260 (17)</td>
<td>161 (19)*</td>
<td>99 (15)*</td>
</tr>
<tr>
<td>Sick leave</td>
<td>232 (15)</td>
<td>125 (15)*</td>
<td>107 (17)*</td>
</tr>
</tbody>
</table>

EQ5D indicates Euroqol-5D; GP, general practitioner; IQR, interquartile range; quartile 1 to quartile 3; LBP, low back pain; MS, medical specialist; N, number of patients; NIH, National Institutes of Health; NRS, numerical rating scale; PDI, pain disability index; SD, standard deviation.

*P < 0.05.

1Twenty-three missing.
11Thirteen missing.
1Ten missing.
1Eleven missing.
1Six missing.
1Five missing.
by their GP (57%), patients who were referred by an MS
(43%) were older, lower educated, had more often received
treatment in the form of surgery, opioids, or injections for
LBP, were more disabled, and more severely impacted by
their LBP, scored lower on quality of life, and were more
often unemployed or on permanent work disability.

Health insurance costs were available for 436 patients
(29%) (Table 2). Mean costs for the total GSC sample
(€4875; 95% confidence interval [CI]: 4309–5498) were
significantly higher than for the matched primary care
sample (€2365; 95% CI: 2219–2526; \( P < 0.001 \)) but did
differ significantly from the matched secondary care
sample (€4379; CI: 4180–4590; \( P = 0.23 \)). Almost half
(€2175; 95% CI: 1852–2547) of the total health insurance
costs of GSC patients in the year before visiting the
Groningen Spine Center were back pain-related. GSC
patients who were referred to the Groningen Spine Center
through their GP had significantly lower costs (€3458; 95%
CI: 2898–4077) than those who were referred by an MS
(€6851; 95% CI: 5648;8017; \( P < 0.001 \)).

A total of 387 of 901 employed patients in the GSC
reported sick days in the 6 months before visiting the
Groningen Spine Center, which resulted in mean (friction)
costs of €1615 (95% CI: 1392–1882) per GSC patient
(Table 3). For 85% of patients, LBP was the cause of their
sick day(s) (€1380; 95% CI: 1181–1598). A total of 566
patients were affected by reduced productivity while at
work, resulting in mean costs of €2700 (95% CI: 2442–
2969) per GSC patient. Costs for absenteeism, absenteeism
owing to LBP, presenteeism, and total productivity loss were

### TABLE 2. Health Insurance Costs in Euros 1 Year Before Receiving LBP Care

<table>
<thead>
<tr>
<th>Sample</th>
<th>N</th>
<th>Mean Costs (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groningen Spine Cohort (secondary/tertiary care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients</td>
<td>436</td>
<td>4875 (4309–5498)</td>
</tr>
<tr>
<td>Patients referred by GP</td>
<td>254</td>
<td>3459 (2898–4077)</td>
</tr>
<tr>
<td>Patients referred by MS</td>
<td>182</td>
<td>6852 (5648–8017)</td>
</tr>
<tr>
<td>Matched controls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>4995</td>
<td>2365 (2219–2526)</td>
</tr>
<tr>
<td>Secondary care</td>
<td>4993</td>
<td>4379 (4180–4590)</td>
</tr>
</tbody>
</table>

CI indicates bootstrapped 95% confidence interval for mean: lower bound to upper bound; GP, general practitioner; LBP, low back pain; MS, medical specialist; N, number of patients.

### TABLE 3. Costs Owing to Productivity Loss in Euros 6 Months Before Baseline (Friction Cost Approach)

<table>
<thead>
<tr>
<th>Groningen Spine Cohort</th>
<th>N</th>
<th>Mean Costs Per Affected Patient (CI)</th>
<th>Mean Costs Per GSC Patient, n = 1502 (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All employed patients (n = 901)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absenteeism Total</td>
<td>387</td>
<td>6546 (5773–7305)</td>
<td>1615 (1392–1882)</td>
</tr>
<tr>
<td>LBP-related</td>
<td>328</td>
<td>6560 (5814–7269)</td>
<td>1380 (1181–1598)</td>
</tr>
<tr>
<td>Presenteeism Total</td>
<td>566</td>
<td>7165 (6683–7683)</td>
<td>2700 (2442–2969)</td>
</tr>
<tr>
<td>Total productivity loss Total</td>
<td>751</td>
<td>8773 (8190–9400)</td>
<td>4315 (3898–4688)</td>
</tr>
<tr>
<td>Patients referred by GP (n = 557)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absenteeism Total</td>
<td>231</td>
<td>7540 (6633–8469)</td>
<td>1982 (1655–2328)</td>
</tr>
<tr>
<td>LBP-related</td>
<td>196</td>
<td>7675 (6641–8823)</td>
<td>1704 (1395–2065)</td>
</tr>
<tr>
<td>Presenteeism Total</td>
<td>357</td>
<td>7130 (6513–7807)</td>
<td>2984 (2650–3312)</td>
</tr>
<tr>
<td>Total productivity loss Total</td>
<td>461</td>
<td>9300 (8423–10242)</td>
<td>4966 (4435–5585)</td>
</tr>
<tr>
<td>Patients referred by MS (n = 344)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absenteeism Total</td>
<td>156</td>
<td>5074 (4156–6017)</td>
<td>1132 (866–1416)</td>
</tr>
<tr>
<td>LBP-related</td>
<td>132</td>
<td>4903 (3859–5912)</td>
<td>954 (710–1238)</td>
</tr>
<tr>
<td>Presenteeism Total</td>
<td>209</td>
<td>7225 (6388–8103)</td>
<td>2327 (1968–2726)</td>
</tr>
<tr>
<td>Total productivity loss Total</td>
<td>290</td>
<td>7936 (6952–8985)</td>
<td>3459 (2908–4059)</td>
</tr>
</tbody>
</table>

CI indicates bootstrapped 95% confidence interval for mean: lower bound to upper bound; GP, general practitioner; LBP, low back pain; MS, medical specialist; N, number of patients.

*Amount of patients who reported sick leave. Some patients still had zero costs as a result of their sick leave when using the friction cost method, which takes into account the replacement of absent workers after 85 days.*
lower for patients referred by an MS than by their GP (presenteeism: $P < 0.05$, absenteeism and total productivity loss: $P < 0.001$).

**DISCUSSION**

The objective of this study was to assess the personal and societal impact of LBP in patients seeking multidisciplinary secondary and tertiary spine care. We found that patients had an extensive medical history related to their LBP and presented with very low functioning and quality of life. One-third of patients were either on sick leave or were permanently work-disabled. Health insurance costs were twice as high compared to patients seeking primary LBP care and most employed patients reported productivity loss. Patients who were referred to the Groningen Spine Center by an MS were more severely impacted by their LBP than those referred by their GP.

Almost all patients referred to the Groningen Spine Center presented with chronic (>3 months) LBP. A wide variety of interacting biopsychosocial factors have been recognized to contribute to chronic disabling LBP and could have potentially played a role in the recurrence and complexity of LBP in our patient sample. Most notable in our cohort were the presence of leg pain, multisite pain, catastrophizing, and feelings of depression and/or anxiety (Appendix 1, http://links.lww.com/BRS/B448). Still, many factors and underlying mechanisms associated with the transition to persistent disabling LBP are yet unknown.

Two-thirds of patients reported severe pain (NRS pain >7), which aligns with other Dutch LBP and chronic pain samples in primary, secondary, and tertiary care. Disability scores, as measured with the PDI, were also similar to those of Dutch chronic pain patients in secondary care. Quality of life, however, was very low among GSC patients. The EQ5D utility score for the general Dutch adult population is approximately 0.91. Patients with LBP in primary care scored on average between 0.61 and 0.67. Higher scores were also observed in cancer studies, where the median utility score was 0.75. Although other studies have reported on one or few characteristics, this is the first study we know of that reported on multiple characteristics, all showing high personal impact, thus physical, psychological, social, and economic consequences of LBP for the individual patient. In addition, this study adds health insurance and productivity data, demonstrating high societal impact, as well.

Patients’ health insurance costs in the year before visiting the Groningen Spine Center were slightly higher compared to patients with LBP seeking secondary care, but twice as high compared to patients seeking primary LBP care. Healthcare consumption for the general Dutch population aged 20 to 65 years is lower at approximately €2100 per year (source: www.vektis.nl/streams/open-data). Almost half of the insurance costs in our sample could be contributed to LBP-related care. Higher LBP-related costs (€4015) were reported in patients with discogenic LBP referred to specialized pain care. However, that study also included direct nonmedical costs such as travel costs. Overall, in the year leading up to seeking multidisciplinary LBP care, GSC patients were likely to have already spent >€2000 on back pain-related care.

The work ability of patients in the GSC was poor (median WAS: 4.0). Seventeen percent of patients were on permanent work disability, whereas on average 6% of the working age population in the Netherlands rely on disability benefits. Return to work is associated with significant improvements in health, but unfortunately the probability of returning to work for patients on permanent work disability is low. Work ability was higher, but still poor, for employed patients (median WAS: 5.0) and moderate for employed patients who were working fully (median WAS: 7.0). The average WAS score for nonsicklisted workers from a variety of work fields is 8.0 (SD: 1.1).

Productivity loss costs owing to absenteeism were €1615 per patient during 6 months. The majority (85%) of patients reporting sick leave did so because of back pain. Cost-of-illness studies are notoriously difficult to compare because of little standardization across studies and international variations in health economic guidelines. In the Netherlands, we have endorsed the FCM, which typically produces smaller estimates of productivity losses compared to the human capital method (ranging from twice to 19 times less costs). Using the FCM, a German study on patients with chronic LBP in primary care found significantly lower absenteeism costs of €577 during 6 months. Assuming relatively constant productivity costs in the year before visiting a spine center, a Dutch study on patients in specialized LBP care, using the FCM, reported higher absenteeism costs (€3778) during a period of 12 months.

This study demonstrates that in higher levels of care there is a higher burden of LBP for patients. The impact on quality of life, work ability, and medical consumption is highest for patients seeking tertiary care (referred by MS), followed by secondary (referred by GP), and primary LBP care. Results on societal costs, however, show that patients referred by their GP accrued higher costs than patients referred by an MS, as a result of productivity loss in the 6 months before baseline. This may seem counterintuitive, but can be partly explained by the fact that among the patients referred by their MS, the percentage not working and disabled was higher than in patients referred by the GP. Productivity costs can only be incurred by those currently having a paid job. Furthermore, a higher percentage of employed patients in the MS group compared to the GP group (28% vs. 13%) were on sick leave for >267 days (6 months before baseline plus the 85 days friction period), which also lead to zero productivity costs within the applied FCM.

There are some limitations and considerations to this study. First, as the majority of data were collected through patient questionnaires, a potential self-reporting bias could have occurred. Second, the calculated health consumption is an approximation of total medical costs because we did not include direct nonmedical costs or out-of-pocket medical costs. Also, LBP-related health care costs were probably slightly overestimated. All claims with a high probability of
being LBP-related were labeled as such but could still be utilized for different reasons (e.g., pain medication). Nevertheless, a strength of our approach was the use of objective cost data instead of self-report, which excludes recall bias. Productivity loss data could be subjected to recall bias and extrapolating from a 4-week period to 6 months could under- or overestimate productivity loss costs. However, almost all patients reported chronic LBP, so we have reason to believe that productivity loss would not vary greatly during the 6 months before baseline.

CONCLUSION

In patients seeking multidisciplinary secondary and tertiary spine care, the personal and societal impact of LBP is very high. Despite having exhausted a wide variety of health care resources, as demonstrated by an extensive medical history and high health care costs, functioning, quality of life, and work ability are still very poor. Multidisciplinary spine care should target those patients that are most likely to respond to treatment to reduce the personal burden of LBP and to prevent further accumulation of health care costs and productivity loss.

Key Points

- Patients presenting in multidisciplinary secondary and tertiary spine care were severely impacted by their LBP. Specifically, quality of life and work ability were poor.
- Health care costs were twice as high compared to patients seeking primary LBP care.
- Productivity costs were on average €4315 per patient, with 43% of employed patients reporting sick leave in the last 6 months.
- Patients referred to multidisciplinary spine care by a medical specialist were more severely impacted than those referred by their GP.

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References


