Work is important to the economics of countries and households. In modern health care, cost-effectiveness is required to justify the use of new treatments, and nothing has greater economic impact than to keep people working, off state benefits and paying taxes. People with arthritis who are at work, value that work [1], and it is likely that doctors, who often define themselves by their career, would value it even more:

As a primary care physician, onset of the classic symptoms and signs of rheumatoid arthritis did not present any particular diagnostic challenge. I had after all, seen them in my patients numerous times over the years in my clinical practice. What I was not prepared for, or even had really considered, was the impact this illness would have on all areas of my life and in particular my work. I remember reading somewhere, shortly after my diagnosis, that ‘within 5 years of diagnosis over 50% of patients had to give up work’. This was a particularly depressing thought, as not only was work an important part of my life, but I had a wife and 5 young children to support. During the early part of my illness, disease activity was difficult to control; as a consequence of this, I had significant joint pain and stiffness. I found simple tasks like fastening buttons and pumping up a sphygmomanometer difficult. With the support of my colleagues and family, I managed to continue working full time in a busy practice, although in retrospect, I am not quite sure how I kept going. Several years after my disease had gone into remission, a patient of mine, during a consultation, told me that she thought I had cancer and looked like I was going to die! At the height of my illness, in order to be sufficiently mobile to get to work, I needed to set my alarm clock an hour earlier, so that the anti-inflammatories could take effect and the morning stiffness start to subside. Due to the profound fatigue I also experienced, at the end of a working day I felt physically drained and was unable to do anything else, which had a considerable impact on family life, with my wife and children bearing the brunt of my frustrations. After being on several different DMARDs with only limited clinical response, I started anti-TNF therapy. I remember it well, the response I can only describe as truly spectacular. Within a fortnight I had stopped all analgesia and anti-inflammatories. My pain and stiffness had ‘melted away’, the synovitis resolved and my haemoglobin and energy levels rose back to pre-illness levels. My work at the practice was re-invigorated with a new found enthusiasm, much to the relief of my colleagues! Most importantly my family and personal life returned to chaotic normality. Six years on, I remain in remission and every fortnight, at injection time, I reflect on how different life could have been.

This personal account highlights the impact of rheumatic diseases on a fundamental aspect of our lives, work. Moreover, it reinforces the message that we now, at last, have the tools to control inflammatory disease to a point where work is not only manageable, but even enjoyable. This account also highlights several key concepts relevant to pharmacoeconomic assessment of rheumatic diseases. It would be difficult to argue in a case such as this, where the ability to work was restored as a direct result of effective treatment, that the costs of the therapy need to be balanced against the return to productive work. Using the human capital approach, such treatment would probably be judged cost effective. Unfortunately, rheumatic diseases can be politically silent and disproportionately affect people not in the work force, including older people, making pharmacoeconomic assessments more difficult. This case also clearly illustrates a concept gaining traction—presenteeism. It is clear enough how to account for a person whose arthritis prevents them from attending work, but how do you account for markedly decreased productivity by someone affected by arthritis who is present at their job? This issue of Rheumatology has a special focus on musculoskeletal diseases and work.

There can be no doubt that rheumatic diseases interfere with the ability to work. In this issue, we publish papers documenting such work disability in diseases ranging from the inflammatory arthritides (RA, PsA and AS) [2–7] to multisystem diseases (SLE, SSc and SS) [8–11].

The impact in terms of societal costs, productivity and political thinking are also covered [12]. The light at the end of the tunnel is revealed by studies showing that controlling the disease results in less lost work [13, 14] and that sympathetic work practices may help in conditions with less satisfactory treatment, such as fibromyalgia [15, 16].

The complexity of motivation to work is shown by the continued debate about what relevant information to measure, and how to measure it, in relation to work [17]. Continuing to work productively depends on the need to work, the type of job and the attitude of the employer, as well as features of the disease. Then there is the economic modelling and the fiddle factors used to produce a cost...
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per quality adjusted life year (QALY). What should NICE and other funding bodies take into account [18]? However, it is justified in that our ability to use these new, expensive and effective drugs certainly improves the quality of our jobs.

And let us not forget that some musculoskeletal conditions have been considered to be caused by certain jobs. The ongoing debate about the interaction between lateral epicondyliitis and occupation continues [19].

So what does all this mean for physicians today? Understanding the large impact of musculoskeletal diseases on work also brings with it a wake-up call. Are we taking ability to work as seriously in our patients as we do a DAS-28 score or a high ESR? Do we have appropriate methodologies to understand what impact rheumatic diseases are having on our economy? How can we measure the effect of disease on unpaid work? Can we rise to the challenge from Dame Carol Black [12] to take a more proactive approach in liaising with occupational health services to allow our patients to remain as productive as possible at work and at home? Are we being the most powerful advocates we can be for our patients, so that arthritis treatments are accorded fairly compared with treatments for other diseases, given the growing health-care costs and worsening economies? It is up to us to show that we are able to rise to this important challenge and provide the leadership that our patients need.

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