Osteopathy and the NHS

Published studies have documented that access to osteopathic treatment occurs through a variety of locations in addition to private practices including NHS hospital outpatient departments, General Practices (GPs) and clinics attached to osteopathic education institutions\textsuperscript{1,2,3}.

Osteopathy has now featured in a range of clinical recommendations, notably for back pain\textsuperscript{4,5}. This began with the Clinical Standards Advisory Group (CSAG) guidelines\textsuperscript{4}, was followed by the European back pain guidelines (www.backpaineurope.org)\textsuperscript{6,7}, and has most recently been evident in guidelines published by the National Institute for Health and Clinical Excellence (NICE) in May 2009. The latter reviewed evidence looking at the acute management of chronic non-specific low back pain; this looked specifically at back pain that lasting longer than six weeks but not more than thirteen months\textsuperscript{8}. The guidelines produced information concerning a variety of different treatments and approaches for patients with non-specific low back pain. This includes up to 9 sessions of manual therapy treatment which includes osteopathy.

The inclusion of osteopathy in national and international guidelines has facilitated the work of osteopaths in the NHS. A new website has been developed which looks specifically at osteopathy in the NHS and can be found at http://nhsosteopathy.co.uk. This article will look at a small selection of more recently published studies related to osteopathic practise in the NHS.

In 2003, medically-qualified osteopath, Nefyn Williams undertook a pragmatic trial for spinal pain in primary care for patients experiencing back pain from between 2 and 12 weeks\textsuperscript{9}. The study concluded that a primary care osteopathy clinic improved short-term physical and longer term psychological outcomes, at little extra cost to normal GP care. Rigorous multicentre studies are now indicated to assess the generalisability of this approach. A cost-utility analysis was undertaken for this study concluding that a primary care osteopathy clinic may be a cost-effective addition to usual general practice (GP) care\textsuperscript{10}. A relative improvement in the mean quality-adjusted life-years (QALYs) for the osteopathy treatment
group versus usual GP practice care was noted. This was associated with a small increase in mean health service costs. However, a larger scale study will be required to further investigate the economic benefits.

In 2004, funding was awarded by the Medical Research Council for the United Kingdom Back Pain, Exercise and Manipulation (UK BEAM) randomised trial. This looked at how a package of care involving one or a combination of treatment approaches could improve low back pain in patients. The study concluded that the combination of spinal manipulation (delivered by osteopaths, physiotherapists or chiropractors) and exercise was more beneficial than when the treatments were used in isolation, and when compared to “best care” offered through general practice. An economic evaluation was made for this study and this concluded that adding spinal manipulation to “best care” was a cost effective way to manage back pain in general practice. Further analysis of the UK BEAM trial data was undertaken by Froud et al, 2009 who examined the number needed to treat (NNT) from this randomised controlled trial (RCT). This work identified that in contrast to the small mean differences originally reported, NNTs were small and could be attractive to clinicians, patients, and purchasers.

Osteopaths Mike Hopkins and Charles Peers were involved in the study published by Gurry in 2004 which looked at a multidisciplinary setting within Plymouth Primary Care Trust (PCT). It found that the return to work time was quicker using this service, which included osteopaths, than GP and physiotherapy services alone. An audit of the service revealed that 84% of patients with low back pain can be managed without the need for hospital referral; this represents a considerable saving for the PCT. Charles Peers has described an NHS audit in detail in the NCOR Audit Handbook for Practising Osteopaths available via the O-zone.

Chown et al (2008) more recently attempted to investigate the difference in outcome between patients being treated with group exercise, physiotherapy or osteopathy in a hospital setting. The interventions offered in this prospective study were group exercises led by a physiotherapist, a one-to-one session with a (predominantly manipulative) physiotherapist, and a one-to-one session with an osteopath. Outcome data was collected at baseline, 6 weeks and 12 months post discharge using the Oswestry Disability Index (ODI) the EuroQol EQ-5D (including a simple health status visual analogue scale), a shuttle walk
test (SWT), and questions relating to life satisfaction and satisfaction with the intervention. Attendance levels were greatest for osteopathy (80%). The mean change in ODI score for osteopathy participants exceeded that of physiotherapy participants by 0.84 (95% CI -0.35 to 5.2). The drop-out rate at this stage of the study was found to be less among the osteopathy group; a number of reasons have been suggested for this including more flexible appointment schedule, patients’ preference for hands-on treatment, personal characteristics, or past experience within private practice.

The creation of the recent fellowship by the British Osteopathic Association has seen another osteopath become involved in the NHS through work at the Queen’s Medical Centre, Nottingham. Many of the osteopathic educational institutions have been involved also in NHS care for a number of years. The small, but growing band of osteopaths in the NHS will make osteopathic care increasingly more accessible to patients unable to attend private practice.

References


