THE NEW STATESMAN

The Report

Arthritis
Tackling the UK's burden of pain

Deborah Alsina Why musculoskeletal health demands public action

Symposium How can we transform arthritis care and patient wellbeing?

Sir Michael Marmot The unequal spread of chronic pain in Britain

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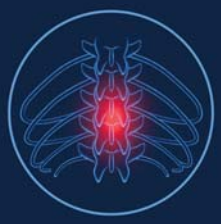
Arthritis UK

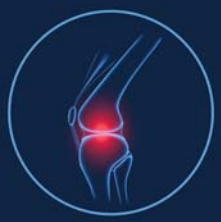
Arthritis UK
The state of musculoskeletal health

20.6m
adults live with MSK conditions in the UK.

615k
young people (under 20) live with arthritis in the UK.

6m women
with osteoarthritis compared to 4 million men.





HEALTH

1m+
cases are currently on a trauma and orthopaedic waiting list across the UK.

£13.2bn
the projected cost to NHS of treating arthritis in 2025.

Longer wait
for those who live in more deprived areas. Unfortunately those in deprived areas are more likely to benefit from a hip replacement, but are less likely to receive it.

MULTIMORBIDITY

50% increase
in likelihood of reporting a mental health condition for those with a long-term MSK condition compared to those without.



ECONOMY

1 in 2
people with arthritis said that their condition had impacted their ability to work in some way.

1 in 10
current UK employees have an MSK condition

27m
lost working days in the UK. MSK is one of the leading causes of absence due to sickness and one of the conditions most often reported by people who are economically inactive.

£3bn
projected cost of working days lost due to arthritis and other MSK conditions in 2024.





Source: Arthritis UK
Accessed September 2026

Comment



Deborah Alsina MBE
Chief executive, Arthritis UK

The government must stop turning its back on arthritis

For far too long, millions of people living with arthritis and other musculoskeletal (MSK) conditions have been dismissed and deprioritised: languishing in pain, stuck on the UK's longest waiting lists and unable to work. The UK government must stop turning its back on this growing public health crisis. Failure to act will undermine its own ambitions for economic growth and prosperity in every postcode.

Good MSK health underpins almost every aspect of life. It enables us to work, live independently, care for families and stay active, while reducing the risk of other long-term conditions. Like good mental health, it is a cornerstone of a healthy society.

Today, 20.8 million people in the UK, almost one in three, live with an MSK condition like arthritis – affecting muscles, bones, joints or connective tissues. These conditions can affect anyone, from children to working-age adults and older people.

Arthritis and other MSK conditions are the most common cause of disability and a leading cause of long-term pain and fatigue. They can strip people of independence, agency and dignity, while driving loneliness and isolation. Without timely support, people may be forced to depend on already-overstretched social care.

MSK conditions are also the second most common reason for sickness absence at work, and their treatment costs the NHS billions each year. People with arthritis also face higher risks of cardiovascular disease, diabetes and mental health conditions. Better MSK outcomes would therefore benefit individuals, society, the NHS and the economy.

The case for urgent action is compelling, yet progress has fallen short of the sustained, system-wide, cross-government response required in all UK nations. Millions still wait too long for diagnosis, treatment and support to live well.

The Burnham administration can set a new direction and deliver meaningful change for millions living with arthritis and other MSK conditions.

MSK conditions are more prevalent in communities experiencing poverty and deprivation – the places the Prime Minister has pledged not to leave behind. People in these areas may also develop such conditions 10 to 15 years earlier than people in wealthier communities. Tackling poor MSK health is therefore essential to reducing health inequalities.

We need a costed, time-bound, cross-government strategy for MSK health that recognises the impact of arthritis and related conditions on individuals, society, the NHS and the economy. Some progress is being made in Scotland and Wales on making MSK a priority but so far, nothing substantial is happening in England. This needs to change.

An MSK strategy should commit to improving primary and community care data, helping decision-makers better understand people's experiences and target support effectively. It must focus relentlessly on reducing waits for surgery and community care – the two largest NHS waiting lists.

It should also explain how people with MSK conditions will be supported through new neighbourhood health partnerships, making this a priority for every Integrated Care Board. Crucially, people with lived experience must help shape, deliver and evaluate the strategy, ensuring services respond to what matters most in daily life.

People with arthritis and MSK conditions have waited long enough. Without a change in direction, millions will continue to be let down.

Arthritis UK is the UK's leading charity supporting the 10 million adults, young people and children living with arthritis. We bring expertise, evidence and the voices of people with lived experience. We stand ready to work with the government, the NHS, regional and local government and partners to deliver lasting change. The opportunity is clear; now ministers must act with the urgency and ambition this public health crisis demands.

ARTHRITIS UK

What one policy change would most transform outcomes for people living with arthritis?

How prompt diagnosis, care and support can deliver better quality of life



Lesley Kay
National clinical director for musculoskeletal conditions

The term "arthritis" itself is part of the problem. It is an umbrella term covering over two hundred different conditions.

Most people will think of the common conditions such as osteoarthritis and back pain, where causes are not well understood and approaches to supporting people are medical, social and societal. At the other end are conditions where the person's immune system attacks the person's own tissues, such as rheumatoid arthritis and axial spondyloarthritis, where specific drug treatment can prevent progressive pain, permanent changes in the joints, and resulting disability, meaning that prompt access to proper assessment and medication is critical.

People with arthritis would have far better experiences and outcomes if our health and care services could recognise far more quickly what is most likely to help each person with arthritis to achieve the best possible quality of life and outcomes that matter to them.

Arthritis has rarely featured as a priority in healthcare, despite its personal and societal costs, partly because we do not routinely measure the factors that influence policy: the frequency of these conditions, the impacts they have and the outcomes of the available interventions.

The biggest policy change for impact would be to measure these effects of arthritis, particularly in primary and community care, and to have a full picture of the opportunities we are missing to improve participation in society and the economic detriments caused by failing to do so.



Joe Brunwin
Head of external affairs at the Royal College of Occupational Therapists

The one policy change that would most transform outcomes for people living with arthritis is a statutory right to rehabilitation.

Arthritis is one of the leading causes of disability in the UK, yet access to rehabilitation remains inconsistent and often comes too late. People should not have to wait until they have left work, lost independence or reached crisis point before receiving support that helps them manage their condition and participate fully in life.

For people living with arthritis, timely rehabilitation can make the difference between staying in work or leaving employment, living independently or relying on increasing levels of support, and managing a condition well or experiencing deterioration that might otherwise be avoided.

Occupational therapists help people manage pain and fatigue, adapt daily activities, remain productive and continue doing the things that matter most to them.

As the government seeks to improve healthy life expectancy, reduce pressure on hospitals and support more people to stay economically active, rehabilitation is one of the most effective tools available. A statutory right to rehabilitation, within a wider national MSK strategy, would help ensure people can access support based on clinical need, regardless of where they live. To make this a reality, it must be backed by a long-term workforce plan that ensures enough occupational therapists and rehabilitation professionals are available in the right places at the right time.



Ruth Wilkinson
Head of policy and public affairs at IOSH

One policy change that would best transform outcomes for people living with arthritis is better integration of work and health policy and pathways, underpinned by a stronger focus on prevention and good work design.

Too often, musculoskeletal conditions are caused or made worse by work. People may find their symptoms are cause or exacerbated by poorly designed work, unmanaged physical strain, and psychological pressures that could be addressed earlier.

A prevention-first approach would require employers, policymakers and health services to work together to identify and manage risks early, redesigning work where necessary through good job design and ensuring workplaces are adapted to people's needs and capabilities. IOSH believes that work should be good work: where people's needs are accommodated, work is ergonomically designed, with physical and psychosocial risks effectively managed, enabling employees to remain healthy, safe, productive and economically active for longer.

Prompt access to occupational health, workplace adjustments and rehabilitation can prevent conditions from worsening and help people to stay in or return to work. Prioritising prevention alongside treatment can reduce the number of people going on to develop avoidable work-related musculoskeletal harm and prevent existing conditions from getting worse, improving quality of life for millions of people.



Nidhi Sofat
Professor of rheumatology at the University of London

Earlier diagnosis for musculoskeletal conditions is key: clinicians need to see patients sooner and deliver effective care. The availability of disease-modifying and biologic drugs has transformed management of rheumatoid arthritis and other inflammatory disorders. However, the greatest burden comes from osteoarthritis, affecting more than ten million people in the UK, for which no disease-modifying therapies exist.

Many patients suffer in silence, with symptoms affecting their daily life, including self-care, work and social engagement. One policy that could transform outcomes for people living with osteoarthritis is an early diagnosis, coupled with effective advice for long-term care. Patients in my clinic repeatedly highlight the long waiting times to be seen by a clinician. Patients report pain symptom recognition and a personalised approach to their care as major unmet needs.

A whole-system approach is needed to improve care. NHS guidelines need to support earlier access to an osteoarthritis diagnosis, alongside the delivery of effective care. Positive messaging is essential, as is improved education for all clinicians. My team is working with Arthritis UK to develop an osteoarthritis toolkit, which will be disseminated to GPs, pharmacists, physiotherapists, clinicians and patients, to redefine what good care looks like. Our toolkit will have a joined-up approach, integrating purposeful tools and delivering high-quality advice about osteoarthritis management, thereby improving patient outcomes.

Rob Martinez
"I suffered with pain, mentally, physically and financially"



Rob Martinez developed osteoarthritis in his early 60s. Long waiting times and missed opportunities to treat his condition promptly caused him avoidable pain, mental distress and the loss of his job.

Martinez was working as an insurance consultant for a large civil engineering company in an office-based role which also involved travelling around the UK for meetings, particularly into London.

Before he was even placed on the waiting list, Martinez went through steroid injections, physiotherapy, X-rays, MRI scans and different consultants while his mobility and pain progressively worsened. Eventually, an MRI showed his knee was effectively "bone on bone" and he was told he needed two knee replacements.

He was placed on the waiting list around October 2019, just before the pandemic severely disrupted elective treatment. He describes being left in limbo while waiting, with very little communication, no meaningful follow-up and no real support to help manage his pain or deteriorating quality of life.

"There was no pain management whatsoever in place. There were no follow-ups... even just a call to say, 'How are you at the moment?' There was nothing like that," he said.

Martinez wanted to continue working and his employer wanted to retain him. They adapted his desk and chair, allowed him to work from home for some of the week and tried to reduce the impact of his condition.

But his arthritis became so severe that even getting to meetings became extremely difficult. After he nearly collapsed due the pain while travelling to a meeting, he knew he could not continue.

"There's only so much you can do in a workplace to keep a job going when you can't be there in the office, or work from home, or try to get to meetings," he said.

Despite his employer doing what it could, the combination of pain, travel and the demands of the job became impossible.

Deciding to temporarily leave work until his surgery happened, Martinez sought financial support, including PIP, but says he scored no points. He appealed and was rejected again.

"I had to dive into my pension pot early. Thankfully I had that, or else I don't know what would have happened," he said.

He was also so desperate for treatment that he investigated going private, but was quoted around £12,000 per knee, which was unaffordable.

"It was a dark time. It depressed me. It made me anxious. I didn't feel like I was getting anywhere," he said.

When he eventually received both knee replacements his recovery was very good and he says the operations transformed his quality of life. "The knee replacement was totally life-changing. I got my life back after that," he said. After treatment he did return to employment, taking a local part-time role helping at a primary school. His former employer also asked him to return, although by then he had reached retirement age and decided not to.

This is an important part of the story: the capacity and desire to work were still there. Earlier treatment could potentially have allowed Martinez to remain in his original career for longer.

Looking back on the experience, the waiting period for surgery affected him much more than his employment. He describes it as a dark time, with pain, financial worries, isolation during lockdown and uncertainty about when treatment would happen all affecting his mental wellbeing.

"I lost a good two years of my life. I'll never make up for that," he said. ●

ARTHRITIS UK

Comment



Sir Michael Marmot
Director of UCL's Institute of Health Equity

"We must address the social and economic impact of chronic pain"

The UK is unhealthy. It has shorter life expectancy than many other rich countries. Even more dramatically, our healthy life expectancy is shamefully low: among 21 rich countries, the UK ranks 20th. The only rich country that is worse than us is the USA, which has consistently ranked 21 out of 21.

Within England, Wales, Scotland and Northern Ireland, there is a steep gradient in life expectancy – the greater the deprivation of an area, the shorter the life expectancy. The gradient is even steeper for healthy life expectancy. Not only do people in more deprived communities have shorter lives, but they can expect to live more of those years in an unhealthy state.

Major contributors to these inequalities in ill-health are arthritis and other musculoskeletal (MSK) conditions. When we think of major diseases, we think of cancer, heart disease and stroke. Rightly so: these are the major causes of death. But arthritis contributes importantly to unhealthy lives. It affects about one in six adults in the UK; pain in joints, bones and muscles (MSK) impacts many more – at least one in three of us.

That suffering is unequally distributed. One study of people over 50 in England showed a complete mismatch between the need for hip replacement, based on arthritis of the hip, and the supply of NHS hip replacements. People living in the most deprived 20 per cent of areas had 3.8 times the need for a hip replacement of people living in the least deprived 20 per cent. It was a gradient: the greater the deprivation, the greater the need. But actual hip replacements went the other way: people in the least deprived quintile were marginally more likely to have benefited from an NHS hip replacement. To the injury of unequal occurrence of disease, we have added the insult of unequal access to treatment.

Two "why" questions: why is there so much arthritis, pain and suffering, and why is it unequally distributed? The answer to both questions is *not* the inevitable consequence of ageing. It is worth focusing on two remedial influences: weight and obesity, and work. In the UK, 6 in 10 adults are overweight or obese – the greater the deprivation, the greater the likelihood of being overweight or obese. If weight is a cause of inequalities in arthritis, we need to look at the cause of the cause. Assessment by the Food Foundation showed that for a household in the lowest quintile of household income to follow healthy eating guidance they would have to spend half their income on food. Eating healthily is simply out of reach. A result is weight gain and obesity. There are also clear social gradients in leisure-time physical activity.

Working conditions can be a potent contributor to musculoskeletal problems, because of physical effects on the body. In the US these inequalities in pain played out with disastrous consequences. Pain, from work or other causes, became the marketing object of the purveyors of opioids. The result has been an epidemic of overdose deaths. Happily, we have avoided this epidemic in the UK, but it is a stark illustration of the social and economic impact of chronic pain. We must address it.

UCL

Arthritis UK

No matter where you are on your arthritis journey, we're here.

At Arthritis UK, we're here to offer trusted information and support. So that every adult, young person and child can live well with arthritis today, with real hope of a cure in the future.

Visit our website

for resources such as gentle exercise and stretching routines.

Call our free Helpline

to talk to our friendly team on **0800 5200 520**.

Connect with others

in our welcoming and supportive online community.

Download My Arthritis

a self-management app that helps you take control.

Scan the QR code to learn more or visit

arthritis-uk.org

Arthritis UK is a registered charity in England and Wales (207711) and Scotland (SC041156).
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