

Editorial: estimating the costs of care in irritable bowel syndrome—a necessary step to enhance value-based care for a high-prevalence, low-cost condition

Irritable bowel syndrome (IBS) is one of the most common gastrointestinal disorders worldwide, with a global prevalence of over 10%.¹ Although the per-person costs for individuals diagnosed with IBS are lower than for those with other chronic conditions, rigorous quantification of current, disease-specific spending estimates are warranted to adequately allocate resources and to identify research priorities for which appropriate funding levels can be determined.

Goodyoory et al recently provided a contemporary estimate of the direct healthcare expenditures for IBS in the UK.² Although IBS costs have been reported previously, these estimates are largely outdated, completed outside of the UK, and/or rely on commercial insurance claims databases.^{3–5} In this study, the authors recruited individuals registered with ContactME-IBS, a national UK registry of 4280 members with self-reported IBS. Members who met Rome III and IV criteria were administered questionnaires on demographics, gastrointestinal/psychological symptoms, quality of life and healthcare utilisation. The mean per-person annual direct cost for IBS care for those meeting Rome III and IV criteria was between £474.16 and £ 556.65, respectively, resulting in an estimated total annual cost between £1.27 and £2.07 billion. The largest cost drivers were appointments with healthcare professionals (40.3%), investigations (28.3%), unplanned emergency service visits (18.3%), and medication (13.1%). Importantly, this is a significant deviation from the cost drivers for other high expenditure, low prevalence gastrointestinal conditions, such as inflammatory bowel disease and hepatitis C, where medications and unplanned emergency service utilisation make up the majority of costs.^{6,7}

Whereas IBS is a heterogenous condition with different clinical phenotypes and variable patient response to therapies, this study highlights the need to refocus efforts on making a prompt diagnosis according to established Rome criteria, thereby limiting unnecessary expensive exclusionary investigations, and on optimising appointments to ensure that clinically indicated care is provided at each visit. Given that IBS patients interact frequently with the healthcare system, the development of evidence-based pathways tailored to an individual's healthcare needs is necessary, with particular attention paid to high healthcare utilizers.^{8,9}

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The rapid dissemination of virtual care platforms due to the COVID-19 pandemic and the availability of digital therapeutics have created novel approaches to provide more convenient, effective and efficient care to IBS patients. It is becoming increasingly clear that IBS requires an integrative, multidisciplinary care team consisting of physicians, dietitians, behavioural therapists, social workers and, in some instances, health coaches and complementary alternative medicine providers.¹⁰ Previously, team-based interventions were often inaccessible beyond specialised academic centres, and a lack of access linked to overutilization of unnecessary diagnostic testing, use of expensive and often ineffective medications, and preventable emergency service utilisation. As virtual care and digital therapeutics allow for a 'hybrid' approach to multidisciplinary care delivery using in-person visits and home-based care, there is potential to expand access, enhance equity and improve patient centred-outcomes, while increasing spending efficiency. Future evaluations should rigorously examine the clinical and economic impact of these promising innovations that may transform the care of individuals with IBS.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

LINKED CONTENT

This article is linked to Goodyoory et al papers. To view these articles, visit <https://doi.org/10.1111/apt.16939> and <https://doi.org/10.1111/apt.16966>

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