

Carol Black's Review

Early in 2007 the Secretaries of State for Health and for Work and Pensions commissioned the National Director for Health and Work, Dame Carol Black, to undertake a review of the health of Britain's working age population

Dame Carol put out a call for evidence to inform her review and the Faculty of Occupational Medicine and the Society of Occupational Medicine agreed to make a joint submission

RESPONSE FROM

**THE FACULTY OF OCCUPATIONAL MEDICINE
AND THE SOCIETY OF OCCUPATIONAL MEDICINE**

MAIN RECOMMENDATIONS

1. Independent bodies such as FOM and SOM should take a lead in disseminating more widely the important message that work, if well organised, is beneficial for health.
2. The FOM and SOM should work further with the Royal College of General Practitioners to increase awareness among general practitioners of the benefits of work for health, of the positive contribution that work can make to recovery and rehabilitation from illness and injury, and of the potential for temporary job modifications to enable patients to return to work earlier. This should be both through input to GP training and assessment, and also through articles in journals and presentations at meetings.
3. Time and resource for activities related to health and work should be included in the GP contract.
4. NICE should include work outcomes in their guidelines.
5. A pilot exercise should be conducted to assess the cost-effectiveness of providing specialist occupational health advice to general practitioners through a consultant-led NHS service operating at a regional or sub-regional level. This service could also contract with local NHS trusts to provide care for their staff.
6. Evidence-based guidelines should be developed on return to work after common disease events and surgical procedures, and should be widely disseminated and implemented. To this end, the contract of the RCP/FOM Occupational Health Clinical Effectiveness Unit should be extended beyond its current term.
7. Before any recommendations are made for substantial further investment in strategies to control occupational stress and reduce physical activities that are associated with common musculoskeletal disorders, the impact of proposed interventions should be properly evaluated.
8. Where reviews identify important gaps in knowledge, primary research should be commissioned to generate the information required. To this end, Government should fund a primary research programme on Health and Work, incorporating rigorous scientific peer-review.
9. The FOM, working with other relevant professional bodies, and also with HSE and NHS Plus, should develop standards for organisations that provide occupational health services, which could then form a basis for a system of voluntary accreditation.

INTRODUCTION

This submission has been prepared jointly by the Faculty of Occupational Medicine (FOM) and the Society of Occupational Medicine (SOM).

We first present a broad overview of health-related incapacity for work and of the types of intervention by which it might be reduced. With this as a background, we then address the specific questions set out in the call for evidence. Finally, we make a number of additional observations that we suggest should be taken into account in drafting the National Director's report.

HEALTH-RELATED INCAPACITY FOR WORK

Impacts of health on work

In considering the relation between health and capacity to work, four main categories of impact should be considered – short-term sickness absence, long-term sickness absence, reduced productivity (“presenteeism”), and unemployment attributed to incapacity. It is helpful to distinguish between these categories because their causes and the strategies by which they should be approached may differ.

Short-term sickness absence

Short-term sickness absence tends to be more common in younger, female workers, and variations in its incidence are thought to be determined more by socio-cultural factors than by differences in rates of disease. Its control depends principally on good management, and techniques for addressing the problem are well established. The main contribution from occupational health professionals to the management of individual cases is in checking whether there is a long-term underlying health problem such as asthma or inflammatory bowel disease that might be expected to necessitate more frequent sickness absence than the average. However, such cases constitute only a small minority of the total.

Long-term sickness absence

In contrast, long-term sickness absence tends to be more of a problem at older ages and in men, and while it too may be strongly influenced by socio-cultural factors, especially when it is attributed to illnesses such as back pain and mental health disorders, there is often significant underlying disease. Here, input from health professionals can have a greater impact. In particular, it can help to ensure timely and effective treatment where this is required, and also to optimise arrangements for return to work, with temporary or permanent modification of duties as required. Medical input is also needed in decisions on ill-health retirement.

Reduced productivity

The impact of health on performance at work has been studied less than sickness absence, and is more challenging to manage because the outcome is less overt. Except where employees work at home or “hot desk”, it is easy to establish whether they are at work or absent. However, it may not be so obvious that an employee's performance is below par, and recognition of presenteeism depends on good management. Health problems are only one of many reasons why an employee may be under-performing at work, and it is the job of the manager to make an initial assessment of where the problems might lie. Input from health professionals may be useful, however, where illness is suspected of contributing. One health problem that often impairs performance at work is the abuse of alcohol or drugs, and the Faculty of Occupational Medicine has published guidelines on this difficult area of practice [1].

Unemployment attributed to incapacity

Unemployment attributed to incapacity differs from sickness absence and poor performance at work in that it is less obviously a problem for employers. They have an interest in avoiding the loss of skilled staff through ill-health retirement (because of the costs of recruiting and training replacements, and also to pension schemes), but once a disabled individual is unemployed, there is little incentive for employers to address the problem. Their main objective in recruiting new staff is to take on workers who can perform the required duties most effectively. Particularly in times of higher unemployment, when there is a large pool of applicants for jobs, they may be tempted to turn down those with a past history of job loss for health reasons as “higher risk”. Good employers endeavour to avoid unfair discrimination of this sort, and may seek independent advice on fitness for work from occupational health professionals. In addition, the Disability Discrimination Act provides more general protection against serious injustice in selection for employment. However, in trying to reduce long-term unemployment because of incapacity, it may be easier to enlist the support of employers in preventive strategies (i.e. those aimed at preventing workers with health problems from losing their jobs) than in interventions aimed at getting people back into work once they have become unemployed through illness.

Economic impact

Short-term sickness absence tends to be more disruptive for employers than long-term sickness absence, but the latter accounts for a larger total number of days lost from work, and therefore is more important economically. The costs of presenteeism are much harder to quantify, and this is an area that merits research. The main direct costs of unemployment attributed to incapacity arise from social security payments, but there may also be demands on employers’ pension schemes. In addition, indirect costs may occur from secondary effects of prolonged unemployment on the health of the affected worker and his or her family.

Interventions to reduce incapacity for work

Interventions to reduce incapacity for work may be divided into those directed at workers who are in active employment and performing satisfactorily (primary prevention), and those targeted at individuals who are already underperforming, absent from work or unemployed because of a health problem (secondary prevention). Primary prevention may be attempted through general measures that apply to all of a working population, or it may be targeted at selected individuals who are thought to be at higher risk of future incapacity. For example, a recent randomised controlled trial in the Netherlands explored the benefits of “preventive coaching” for workers who were identified through a screening questionnaire as being at higher risk of prolonged sickness absence [2]. Secondary prevention is pursued most obviously through individual case management of the sort that is widely practised by occupational physicians and nurses, but it is also importantly influenced by more generic factors such as social security provisions and terms and conditions of employment.

The types of intervention that may influence incapacity for work can operate at a national, organisational or individual level.

Interventions at a national level

At a national level, incapacity for work can be influenced both by regulation and by fiscal measures.

Regulation

An example of the former is the Disability Discrimination Act, which has obliged employers to think more carefully about whether a disability really does impair capacity to undertake a job, and also about the scope for modifications to work so that it can be carried out by someone who has a health limitation.

Another example is a regulation in the Netherlands, which required employers to give sick workers more support and attention. It is thought that this may have contributed to a decline in sickness absence in that country [3]. Subsequently, a new law was introduced making employers liable to pay sick leave up to at least 70% of the last wage during the first two years of sick leave, and placing joint responsibility on employers and workers to take steps towards resumption of work as early as possible [4].

Fiscal measures

Fiscal measures include changes to social security provisions for work incapacity, either by restricting the availability or level of benefits to individuals, or by shifting more of the responsibility for financial support during sickness absence to the employer (as in the above example) and thereby increasing the incentive to employers to manage the problem more effectively.

It should be noted that reducing the availability of benefits to individuals not only encourages some people with marginal disabilities to remain at work where they would not otherwise have done so, but may even reduce the occurrence of illness in the working population. Support for this theory comes from the major epidemic of upper limb disorders that occurred among office workers in Australia in the early 1980s [5]. The epidemic was not paralleled in other countries that were using the same technology, and is now thought to have been triggered by an unusually generous compensation scheme. Subsequently, the rules on eligibility for compensation were tightened, and the epidemic subsided.

On the other hand, restricting benefits for incapacity will inevitably disadvantage some individuals with intractable disability, who have no choice but to be off work (e.g. a worker undergoing aggressive chemotherapy for cancer). In making fiscal arrangements, therefore, gains to productivity and to the health of some individuals must be balanced against increased hardship for others.

Public education

Changes in regulation and fiscal arrangements may indirectly modify public attitudes to health and work. Separate from this, however, there is scope to influence people's thinking and behaviour more directly, by promoting a better understanding of common illnesses and of the ways in which they can be managed, and also of the benefits to health from work. Thus, for example, a public educational campaign on back pain in Victoria, Australia led to a reduction in incapacity for work attributed to back disorders that was not paralleled in neighbouring New South Wales [6]. More recently, however, a similar campaign in the West of Scotland, although producing demonstrable changes in beliefs about the need for back pain sufferers to remain active, had no discernable impact on the sickness absence rates of a major employer (Royal Mail) or on new awards of social security benefit for back pain [7].

Education of employers and health professionals

As well as the public at large, it is important to influence the attitudes and behaviours of employers and general practitioners. General practitioners have a pivotal role in the management of longer term incapacity for work, especially for the majority of workers who do not have access to an occupational health service. They need a greater awareness of the benefits of work for health, of the positive contribution that work can make to recovery and rehabilitation from illness and injury, and of the potential for temporary job modifications to enable patients to return to work earlier. The FOM and SOM are keen to work further with the Royal College of General Practitioners in addressing this problem, through input to GP training (and formative or summative assessment), through articles in journals and presentations at meetings, and through continuing primary care based research such as THOR-GP.

In general, educational campaigns of the type described will come better from independent bodies such as Royal Colleges than directly from Government, who may be perceived as interested only in reducing costs to the Treasury from benefit payments. However, they will only work if general practitioners have the time and resource that is needed to implement desired changes in behaviour. Issues of time and resource for health and work therefore need to be considered in the context of the GP contract. In the longer term, there could be a case for auditing general practitioners' sickness certificates, in the same way as their prescriptions. However, general practitioners can only be expected to push for early return to work insofar as they recognise it as beneficial for the patient concerned.

Provision of specialist advice for general practitioners

As is recognised in the Department of Health's Commissioning Framework for Health and Wellbeing [8], general practitioners need access to specialist advice when managing the occupational health problems of some patients. We are aware that consideration has been given to the appointment of specialist GPs within primary care trusts as a source of advice and support for other general practitioners. While this model could be worth testing in a pilot study, we suggest that the alternative of providing advice through a service overseen by a specialist NHS occupational physician should also be explored. Referral services of this sort are currently or have in the past been provided on a limited scale by NHS occupational health departments in, for example, Manchester, Nottingham and Bristol. We develop this idea further in our response to specific questions.

Interventions at an organisational level

Control of occupational hazards and safety culture

One obvious way in which employers can contribute to promotion of a healthy workforce is through the control of health hazards in the workplace. By application of a now well-established paradigm involving the identification and characterisation of hazards, assessment of associated risks, implementation where appropriate of controls to remove or reduce hazardous exposures, and checks to ensure that controls have had the desired effect, occupational health practitioners have largely eliminated some of the most serious occupational diseases in the British workforce, and substantially reduced the frequency of occupational injuries. This trend to safer workplaces has been assisted considerably by changes in industrial activity, with a reduction in the numbers working in more hazardous manufacturing and production processes, and a growth in less dangerous service industries. Nevertheless, it is a commendable achievement, and may have contributed to the adoption of safer practices outside the workplace (e.g. in the garden and when carrying out DIY activities). Significant numbers of occupational injuries and cases of occupational diseases such as asthma, dermatitis and noise-induced hearing loss, do still occur, and remain a target for preventive activity. However, because they are now less common, the potential impact on the overall health of the workforce is limited.

Numerically and economically much more important nowadays are work-related illnesses such as back pain, arm pain, and mental health problems attributed to occupational stress. Because these disorders appear to depend importantly on beliefs and expectations as well as on harmful external physical and psychological stresses, they may not be so amenable to management by the traditional paradigm for control of occupational health hazards. For example, if carried out in the wrong way, attempts by employers to identify and control sources of stress in the workplace may inadvertently modify employees' expectations, paradoxically rendering them more susceptible to stress-related illness. It is therefore important that before recommending substantial further investment in strategies to control occupational stress and reduce physical activities that are associated with common musculoskeletal disorders, the impact of proposed interventions be properly evaluated. It may be that measures to reduce psychological stress in the workplace are more successful if implemented as part of a programme aimed at optimising the positive psychological benefits of work, rather than being presented as an attempt to minimise the effects of an adverse environment.

Terms and conditions of employment and management structures

Another way in which employers can influence incapacity for work is through their terms and conditions of the employment. For example, an over-generous scheme for ill-health retirement may encourage workers to leave employment unnecessarily, and perhaps even to develop illness and disabilities that would not otherwise have occurred.

Barriers to maximum employment may also arise inadvertently through internal management structures or bonus schemes. For example, when a hospital devolved responsibility for the placement of staff to the individual departments in which they were employed, it became much more difficult to arrange temporary redeployment of nurses recovering from back disorders who worked in departments that did not have less strenuous jobs. And at a company which paid a manager and his employees a bonus according to the productivity of their department per person-hour worked, there was a strong disincentive to keeping staff with health problems at work or helping them to rehabilitate when they were not considered capable of working at a normal rate. Instead, therefore, partially incapacitated employees were encouraged to take or remain on sick leave, receiving full pay, at a net overall cost to the employer.

Employers should be encouraged to review their management structures and terms and conditions of employment to ensure that they do not cause unintended adverse effects of this sort.

Management practices and support from colleagues

Perhaps even more telling, is the support and encouragement that employees receive from their managers and colleagues. Anecdotally, it is common to encounter two occupational groups (e.g. two wards in a hospital or two shifts in a company) carrying out similar tasks, one of which functions much more effectively, and with less sickness absence, than the other. Often the explanation appears to lie in the style of management and the make-up of the work team. Employees naturally benefit if they feel supported and valued by their manager and colleagues. Conversely, if nobody appears to care whether or not they are present, or if they are made to feel unhappy or excluded by their colleagues, they are likely to be less productive and more inclined to absent themselves from work. A review of common mental health problems by the British Occupational Health Research Foundation (BOHRF) found evidence that contact with supervisors at least every fortnight was an effective intervention in getting individuals back to work [9].

Promotion of good management practice and encouragement of effective teamwork should be a goal for all employers. Naturally, a balance has to be drawn when dealing with unsatisfactory employees, and there may be occasions when a manager has to take a tough line. However, macho management should not be the norm. Care is needed, therefore, in the appointment of managers, in their training, and in the criteria by which their performance is assessed. Proper credit should be given to managers who help to optimise the performance of employees with health problems.

General health promotion

Many larger employers in the UK have initiated programmes of general health promotion addressing aspects of lifestyle such as diet, smoking and exercise. The workplace has special advantages for this sort of initiative. The target audience is relatively captive in that they can be approached during working time. Furthermore, messages can be backed up by provisions to enable and reinforce desired changes in behaviour. For example, canteens can provide healthier choices of food, and showers and changing facilities can be made available for employees who cycle to work.

Ultimately, health promotion of this sort is aimed at preventing serious chronic disease such as cancer and coronary heart disease, but the short-term impact on such disorders is likely to be small. A more immediate benefit is likely to come from changes in perceived health and well-being, leading to reduced incapacity for work.

Approaches to health promotion and the creation of healthier workplaces are discussed in a more detail in a report published jointly by the Faculty of Public Health and FOM in 2006 [10].

Interventions at the individual level

As already indicated, individual case management can contribute usefully to the management of sickness absence and health-related impairment of work performance. A problem at present, however, is the restricted access of workers to occupational health advice, which is largely limited to bigger employers, and the insufficient understanding of occupational health by general practitioners and hospital doctors. Ways of making occupational health advice more widely available are discussed later in our response to the specific question on this topic.

The importance of the general economic environment

While interventions of the type described may improve capacity for work, their impact will depend importantly on, and perhaps be outweighed by, effects of the general economic environment. If the national economy is in recession and unemployment is high, employees may be less inclined to take sickness absence for fear of losing their jobs. On the other hand, employers may be more inclined to allow ill-health retirement if they need to downsize because of economic pressures (especially if ill-health retirement is cheaper for them than redundancy).

ANSWERS TO SPECIFIC QUESTIONS

1. How can we keep working age people healthy and how can the workplace be used to promote health?

As indicated above, actions should include:

- a) Wide dissemination of the important message that work, if well organised, is beneficial for health. This will come better from independent bodies outside government such as FOM and SOM.
- b) Encouragement of good management practices to promote a supportive environment in the workplace and enhance the psychological benefits of work.
- c) Application of established methods to ensure that risks of occupational injury and disease are satisfactorily controlled.
- d) Evaluation of interventions aimed at the prevention of work-related illnesses such as back pain and common mental health problems, and implementation of those that are effective.
- e) Improved case management for workers with health problems that impair their capacity for work (see 2 below).
- f) Encouragement of general health promotion in the workplace at both an organisational and an individual level as an adjunct to health promotion for the public more widely. Health promotion interventions should be evaluated to establish which are most effective.

Further guidance on the promotion of health at work is available in the Faculty of Public Health/FOM publication "Creating a healthy workplace" [10].

2. How can people best be helped to remain in or quickly return to work when they develop health conditions including chronic disease or disabilities?

- a) People need to feel valued at work.

- b) Workers who develop illness that impairs their capacity to work need rapid access to diagnostic services and to effective treatment. Our impression is that in England this has improved in recent years (although possibly not in Wales).
- c) Doctors, and particularly general practitioners need to be more aware of the health benefits of employment, and to view satisfactory maintenance of, or return to, employment as an important criterion of success in the management of illness. This will be helped if NICE includes work outcomes in its guidelines.
- d) Doctors, and particularly general practitioners, need to be more aware of the scope for maintenance of, or early return to, work through modification of duties or hours of work; to discuss the possibility of such modifications with their patients where it is appropriate; and to liaise with employers or their occupational health services about implementation of modified work where it is considered desirable.
- e) General practitioners may be assisted in developing their practice in this area if they have access to a specialist referral service. However, such a service could only be justified if it were cost effective. Pilot services should therefore be trialled with proper evaluation of their impact and costs. One possible model of delivery would be through one or more general practitioners with a special interest, and another through a regionally organised, consultant-led NHS occupational health service.
- f) Employers should seek advice from an occupational health service where they have access to one, and should liaise constructively with external health services when they do not. In particular, they should be flexible, where possible, in arranging temporary modification of duties or working hours, if this is recommended.
- g) Employers should ensure that their terms and conditions of service, including bonus schemes, do not inadvertently discourage continued work or timely return to work of employees who are limited by health problems.
- h) There is a need for evidence-based guidelines on return to work after common disease events and surgical procedures, which should then be widely disseminated and implemented. The RCP/FOM Occupational Health Clinical Effectiveness Unit is already active in this area, and could usefully continue this work beyond the term of its current contract. Where reviews identify important gaps in knowledge, primary research should be commissioned to generate the information required.
- i) In some cases return to work is likely to be importantly influenced also by financial considerations. Generous sick pay schemes may be an encouragement for some workers to remain off work, and may even cause illness to persist when it would not otherwise do so. However, any tightening of such benefits would impact adversely on other workers with intractable incapacity from serious disease.

3. How does the age of the person affect the support that is needed?

- a) The principles are the same at all ages, but many chronic diseases such as osteoarthritis and coronary heart disease are more common at older ages, and therefore, older workers may require modified work more frequently than younger workers [11].
- b) The design of pension schemes may encourage some older workers to seek ill-health retirement when they have a disability, where they would not do so at younger ages.

4. How can we encourage action to improve employee health?

- a) In general, employers are unlikely to adopt interventions unless they perceive a net benefit. Thus, to sell a policy to employers, it will be necessary to accumulate convincing evidence that financial gain is likely, or at least that it will be cost neutral but with benefits for the well-being of their workforce.
- b) Knowledge and attitudes about work and health among general practitioners could be improved by inclusion of the topic in their training curriculum and assessments, by articles in journals and periodicals read by general practitioners, and by presentations at meetings. FOM and SOM would be pleased to work with RCGP in developing this.

5. What underlies the apparent growth in mental health problems in the working age population and how can this be addressed?

- a) Good evidence on the causes of the rising trend in incapacity attributed to mental health problems is lacking, and this is a priority area for research.
- b) One contributor may be the rapid changes in the world of work over the last two decades, with much less security of employment than previously, particularly in organisations such as the NHS and civil service that historically have offered a job for life. In addition there has been a growth in the monitoring of personal performance with pressures to meet challenging deadlines and targets.
- c) Another contributor may be the decline in family life, with more workers living alone or in single parent families, and receiving less social support outside work.
- d) Probably much more important, however, is a reduction in the stigma that was previously associated with mental illness, such that a worker who is stressed at work is now seen as a victim deserving sympathy rather than as being weak and unable to cope. This has been accompanied by increased public awareness of occupational stress as a hazard, possibly leading to altered expectations of what is tolerable.
- e) Addressing mental health problems attributed to work is not as straightforward as the management of traditional occupational hazards such as asbestos. This is because the illness depends as much on individual expectations as on external stressors. The best approach may be as part of programmes to promote the positive psychological benefits of work, but this needs to be evaluated through well-conducted intervention studies.

6. What constitutes effective occupational health provision and how can it be made available to all?

- a) In broad terms, occupational health is about ensuring that individuals with health problems are appropriately employed (i.e. that they are not placed in jobs to which they are unsuited, but at the same time are not restricted unnecessarily), and ensuring that people are not injured or made ill by the work that they do. The level of provision that is needed will depend on the nature of the work undertaken. Some jobs require unusually high standards of fitness (e.g. professional diving, airline pilots), and others are unusually hazardous. For jobs such as these, specialist occupational health input is essential (and in some cases is a specified legal requirement). However, many jobs in the UK nowadays are relatively non-hazardous and do not require special standards of fitness. Work of this type does not need such intensive occupational health input, but providers must still be properly trained in the principles of occupational health. They must be familiar with the demands of jobs that their clients undertake and any associated risks to health, competent in assessing fitness for this work, and have a good understanding of their ethical obligations to both employee and employer. Where appropriate, they should be guided by relevant clinical guidelines such as those published by the FOM and by the RCP/FOM Occupational Health Clinical Effectiveness Unit.
- b) The FOM sets professional standards for doctors undertaking this sort of work, either as specialists or as non-specialists with a particular interest in occupational medicine, and it monitors their continuing professional development (CPD). Both FOM and SOM contribute to CPD for occupational physicians and other medical practitioners by provision of scientific meetings and workshops. Other bodies such as the Royal College of Nursing set standards for other occupational health professionals.
- c) In addition to professional standards for individual practitioners, we believe there is a need to develop standards for organisations that provide occupational health services. This is a concept that the FOM proposes to explore further in the near future, working with other relevant professional bodies, and also with HSE and NHS Plus. Such standards could form a basis for a system of voluntary accreditation.
- d) Going beyond this, consideration should be given to revoking the current exemption of occupational health services from the Private and Voluntary Health Care Regulations (Regulation 5).

- e) A major obstacle to the provision of effective occupational health services for all is the historical exclusion of occupational health from the remit of the NHS. NHS occupational health departments do provide services to external employers in both the public and private sectors, but their primary role is to serve the hospital trusts in which they are located, and the extent of their external activities is limited by the requirement for trusts to balance their books, often with only a short-term perspective. Thus, because of trust-wide policies to cut immediate costs, a department may be forced to lose posts that become vacant, and as a consequence lose external contracts. Moreover, some trusts are now considering outsourcing their occupational health services to private providers. For these reasons, we do not think that NHS occupational health services as currently constituted can satisfactorily fill the gap in occupational health cover for the national workforce as a whole.
- f) A further constraint on broadening occupational health provision is the shortage of trained specialists in occupational medicine. The FOM is developing strategies to encourage recruitment into the specialty, but even if this bears fruit, it will not be for some years. However, a broader occupational health service for the general population would not necessarily require a large number of trained specialists. One approach would be to develop a service at regional or sub-regional level that was consultant-led, but provided by a multi-disciplinary team including part-time occupational physicians (mostly general practitioners) holding the FOM Diploma in Occupational Medicine, occupational health nurses and others. This service could contract with local NHS trusts (including primary care trusts) to provide care for their staff, and carry out work on contract for other local employers. In addition, it could receive referrals from general practitioners regarding fitness for work and suspected occupational illness, particularly where there was no occupational health service at the patient's place of employment. And by feeding back information to the referring doctors on how cases were managed, the service could help to increase knowledge about occupational health in the general practice community.
- g) A service of this sort could be delivered by a private provider, but might better be organised under the aegis of a strategic health authority. The arrangement would have the advantage of protecting the service from uncertain fluctuations in the finances and management goals of individual Trusts. A first step in developing such a service, whether through a private or NHS provider, would be a pilot exercise in one or more areas.

7. What would be the impact on poverty and social inclusion of a healthier working age population?

We know that unemployment can lead to poverty and social exclusion, and a reduction in these adverse outcomes would therefore be expected from fuller employment of people with impaired capacity to work. However, it is difficult to quantify the benefits that might be expected.

8. What are the costs of working age ill-health to business and what are the benefits to companies of investing in the health of their staff?

For an employer, the costs of ill-health include production losses, costs of rehabilitation, recruitment and training, legal sanctions, reduced competitiveness and flexibility, loss of quality and damage to reputation in the view of current and potential customers, shareholders, workforce and suppliers. Sickness absence has been estimated to cost UK employers around £12.2 billion per year [10].

OTHER OBSERVATIONS

Disease, illness and disability

The call for evidence refers at various points to “health”, “healthy”, “ill-health”, “disease” and “disability”. In drafting the report, it will be important to define and use these terms precisely. In common parlance the words “disease” and “illness” are often used interchangeably, but technically there is a distinction. Disease refers to a disordered state of an organ or physiological system, whereas illness is a subjective lack of well-being. Disease often gives rise to illness, but the two phenomena do not always coincide. Thus, a woman with undiagnosed, asymptomatic early breast cancer may have no illness despite her disease. On the other hand, a patient with no underlying disease may be unwell with multiple symptoms and associated disability that arise through psychological mechanisms. The term “healthy” is often used to embrace not only well-being and a lack of symptoms, but also characteristics or behaviours that lead to a lower risk of future disease. For example, smoking, poor diet and lack of exercise are considered unhealthy even when they do not cause immediate illness.

From the terms of reference, we understand that this review will focus principally on health-related factors that influence capacity to work, and that unhealthy characteristics or behaviours which predispose to later disease are therefore mainly of interest insofar as any resultant illness might impact on ability to work. However, it should be recognised that the benefits from health promotion in employment will normally extend, and may be greatest, well beyond retirement.

When considering influences on capacity to work in the UK, particular attention must be given to illness that occurs in the absence of demonstrable underlying pathology. Many of the disorders to which incapacity for work is most frequently attributed (e.g. non-specific back, neck and arm complaints and common mental health problems) are illnesses but not diseases. As such, they are not a simple response to injurious exposures, but depend importantly on individual psychology, and also on culturally determined beliefs and expectations. And even for well-defined diseases such as osteoarthritis and coronary heart disease, the impact on patients’ capacity to work may vary substantially according to their attitudes, expectations and economic circumstances. Thus, for example, rates of health-related job loss are markedly higher in occupations such as teaching and the police force, which have generous pension schemes, than in others such as agricultural workers, who do not enjoy this benefit [12].

The need for background data

As a background to the review, it will be helpful to review the descriptive epidemiology of sickness absence, incapacity for work and unemployment in the UK. We know, for example, that there have been enormous changes over time in incapacity for work attributed to musculoskeletal disorders (principally back pain) and to mental health problems. It would be useful to establish whether these trends evolved uniformly across the country, or whether changes started in some regions before others (Professors David Coggon and Mansel Aylward are currently exploring this question in collaboration with DWP statisticians). Regional differences in timing might suggest that the trends were driven more by cultural changes than by changes in the workplace.

Understanding may be assisted also by analysis of data on geographical variation and time trends in sickness absence from employers such as the Civil Service and Royal Mail with large workforces widely dispersed across the country. Again this could give pointers to the relative contributions of the occupational environment, non-occupational causes of disease and socio-cultural influences.

The international context

Several other European countries have also been attempting recently to improve their management of incapacity for work, including the Netherlands, Finland and Denmark. There may be opportunities to learn from analyses of the problem and experience of interventions that have already been carried out elsewhere. Thus, it would be worth

contacting relevant individuals or organisations in these countries with a view to sharing information. If required, FOM/SOM can help in identifying appropriate contacts.

Assessing the impact of intervention strategies

For the purposes of this review, the most important criteria by which to assess the value of an intervention are its cost-effectiveness and the proportional impact that it can make on the overall problem of incapacity for work. Even if an intervention has established efficacy (i.e. it is proven to reduce incapacity), it will only be worth pursuing if the benefits outweigh the costs of its implementation. In particular, employers cannot be expected voluntarily to pursue policies that are not expected to produce a return on investment (ROI) in excess of one.

Interventions that are cost-effective can be recommended, but some may have a bigger impact than others. Thus, in prioritising recommendations for action, it will be important to assess also the extent to which each might contribute to reducing the overall problem of incapacity for work.

In practice, evaluating interventions to reduce incapacity is not easy. Many are implemented at a national or organisational level, and therefore do not lend themselves to investigation by randomised controlled trials (RCTs). Instead, it is necessary to fall back on observational investigations, the strongest of which will normally be controlled, non-randomised intervention studies. Studies of this type can still be very informative, but unlike large RCTs, they are vulnerable to possible confounding effects, which must be taken into account in their interpretation.

Further complications arise when assessing the economics of interventions because financial benefits will vary from one country to another, depending on their organisation of health care. For example, the ROI from an intervention aimed at prevention of illness may be greater for an employer who pays for the health care of employees (e.g. through health insurance premiums) than for another whose employees receive their care through a “free” national health service.

Evidence on effectiveness of interventions

In the time available to prepare this response it has not been feasible for us to review systematically the evidence that is available on the cost-effectiveness and potential impact of different interventions aimed at reducing incapacity for work, but clearly such a review is needed.

We are aware of limited evidence from other countries that interventions such as employee assistance programmes [13] can be cost-effective in reducing absenteeism, and improving retention and productivity, but as explained above, care is needed in extrapolating economic benefits to the UK.

Here in the UK, there is preliminary evidence from the Pathways to Work pilot exercise that active case management of people with health-related unemployment can reduce the burden of incapacity benefit [14], but this requires more thorough evaluation. Other interventions such as the Job Retention and Rehabilitation project have been rather uninformative [15], underlining the need for careful scientific review of such studies before they are funded.

We also know of initiatives on work and health by individual employers such as BT that have produced encouraging results and are perceived as cost-effective, although they have not been subject to rigorous evaluation.

We think it likely that formal systematic review of the type that is currently being undertaken by NICE in the guidance that it is developing for primary care services and employers on the management of long-term sickness and incapacity will reveal a dearth of good quality evidence on the efficacy and cost-effectiveness of improved case

management and of interventions by employers aimed at reducing incapacity for work. If so, there will be a need to address this gap in information by future research. However, even where such initiatives are cost effective, their impact may well be small in comparison with the effects of cultural, fiscal and regulatory influences.

REFERENCES

1. Faculty of Occupational Medicine. Guidance on alcohol and drug misuse in the workplace. London: Faculty of Occupational Medicine, 2006.
2. Duijts SFA, Kant IJ, van den Brandt PA, Swaen GMH. Effectiveness of a preventive coaching intervention for employees at risk for sickness absence due to psychosocial health complaints; results of a randomised controlled trial. Paper presented at EPICOH conference, Banff, October 2007.
3. <http://www.cbs.nl/en-GB/menu/themas/arbeid-sociale-zekerheid/publicaties/artikelen/archief/2004/2004-1433-wm.htm?Languageswitch=on>
4. http://internationalezaken.szw.nl/index.cfm?fuseaction=dsp_document&link_id=80599
5. Gun RT. The incidence and distribution of RSI in South Australia 1980-81 and 1986-87. *Med J Aust* 1990;153:376-80.
6. Buchbinder R, Jolley D, Wyatt M. Population based intervention to change back pain beliefs and disability: three part evaluation. *Br Med J* 2001;322:1516-20.
7. Waddell G, O'Connor M, Boorman S, Torsney B. Working backs Scotland: a public and professional health education campaign for back pain. *Spine* 2007;32:2139-43.
8. Department of Health. Commissioning Framework for Health and Wellbeing. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604
9. BOHRF. Workplace interventions for people with common mental health problems: evidence review and recommendations. http://www.bohrf.org.uk/downloads/cmh_rev.pdf
10. Faculty of Public health and Faculty of Occupational Medicine. Creating a healthy workplace. London; Faculty of Public Health, 2006. http://www.fphm.org.uk/resources/AtoZ/I_healthy_workplaces.pdf
11. Faculty of Occupational Medicine. Position Paper on Age and Employment. London; Faculty of Occupational Medicine 2004. <http://www.facocmed.ac.uk/library/docs/ppageemp.pdf>
12. Solomon C, Poole J, Palmer KT, Coggon D. Health-related job loss: findings from a community-based survey. *Occup Environ Med* 2007;64:144-149.
13. McDonnell Douglas Corporation. McDonnell Douglas Corporation employee assistance program financial offset study 1985-1989. St Louis, MO: McDonnell Douglas Corporation, 1990.
14. Blyth B. Incapacity benefit reforms – pathways to work pilots performance and analysis. London: DWP, 2006. <http://www.dwp.gov.uk/asd/asd5/wp26.pdf>

15. Purdon S, Stratford N, Taylor R, Natarajan L, Bell S, Wittenburg D. Impacts of the Job Retention and Rehabilitation Pilot. London: DWP, 2006.
<http://www.dwp.gov.uk/asd/asd5/rports2005-2006/rrep342.pdf>

Dr David Snashall
President
Faculty of Occupational Medicine

Dr Gordon Parker
President
Society of Occupational Medicine

30 November 2007