

Making Europe Fit for Work

Key findings of the Fit for Work Europe report on musculoskeletal disorders and work

Fit for Work Europe is an EU initiative that aims to improve the quality of working life for people with musculoskeletal disorders. Stephen Bevan, Robin McGee and Tatiana Quadrello present the main findings of research carried out as part of the initiative to establish what needs to be done at the European and national level to improve job retention and work re-introduction for people who develop such conditions.

This article was printed in the Dec 09/Jan 10 issue of *Occupational Health [at oWork]*, which is published by The At Work Partnership. For more information about this journal, please visit www.atworkpartnership.co.uk

A healthy workforce means a healthy economy. Yet conventional measures to improve productivity, from investment in skills, technology and innovation to labour market deregulation, fail to take account of one of the most serious barriers to growing prosperity: poor workforce health. Over 44 million (one in six) members of the European Union (EU) workforce have a long-standing health problem or disability that affects their ability to work¹, and musculoskeletal disorders (MSDs) account for a higher proportion of sickness absence from work than any other health condition. *Fit for Work Europe* studied the social and economic impact of MSDs across 25 countries. The research was conducted by reviewing recent academic and practitioner literature on the relationship between four types of MSDs and labour market participation and by conducting interviews with over 100 experts. The project investigated the impact of low back pain and work-related upper limb disorders (WRULDs) – two groups of conditions which are usually characterised by short but intense episodes of pain and incapacity – and rheumatoid arthritis and spondyloarthritis, two inflammatory conditions that are often progressive and increasingly incapacitating.

The *Fit for Work Europe* report examines the causes, effects and costs of MSDs in the European workforce and assesses what more can be done to help alleviate the often damaging economic and social consequences of this widespread, but frequently hidden, problem.

EXTENT, CONSEQUENCES AND CAUSES

The quality and quantity of data on the definition, prevalence, impact and costs of MSDs vary considerably between countries. Even at the most basic level, great differences exist across European countries in the variety of MSDs included on occupational disease lists. Nonetheless, chronic musculoskeletal pain affects 100 million people in Europe, and it is widespread among the working age population – although undiagnosed in over 40% of cases². They represent an estimated cost to European society of up to 2% of gross domestic product³.

► **Back pain** is common, episodic, often recurrent and generally self-limiting. Multiple factors, including work,

contribute to and cause back pain. Even though the factors are not solely work-related, regardless of the cause the same outcome of work disability occurs. Back pain is estimated to cost more than £12 billion; much of this due to lost productivity⁴. The majority of the cost related to back pain is associated with a small percentage of individuals who are away from work for long periods. About 85% of people with back pain take less than seven days off work, yet this accounts for only half of the working days lost by back pain. The rest is accounted for by the 15% who are absent for over a month⁵.

► Almost a quarter of European workers report that they have experienced muscular pain in their neck, shoulders and upper limbs⁶. **WRULDs** can be caused, or exacerbated, by work that involves repetitive movements, prolonged keyboard use, heavy lifting, poor posture or other forms of work-related physical strain. Ergonomic design and the psychological health of individual workers can have a decisive impact both on the degree of work disability and the ease with which a successful return to work can be achieved. These disorders can also be costly – in the Netherlands, for example, repetitive strain injury (RSI) at work costs €2.1 billion each year⁷.

► **Rheumatoid arthritis** is an example of a specific, progressive and inflammatory MSD. Over 2.9 million people in Europe have rheumatoid arthritis – many of working age⁸. Its features include pain, stiffness in joints and tiredness, particularly in the morning. Individuals often have ‘flares’ of intense pain. Managing these flares in employment requires close communication and understanding between employees and employers. The effects of the disease can make it difficult to complete everyday tasks and up to 40% leave work completely within five years of diagnosis⁹. In the UK the National Audit Office calculated that a 10% increase in people with rheumatoid arthritis being treated within three months of diagnosis could result in productivity gains of £31 million for the economy due to reduced sick leave and lost employment¹⁰.

► **Spondyloarthropathies** represent a family of chronic inflammatory conditions, with a prevalence rate similar to rheumatoid arthritis¹¹. People with conditions such as ankylosing spondylitis – a progressive and chronic

rheumatic disorder that mainly affects the spine, but can also affect other joints, tendons and ligaments – are three-times as likely to be out of work as the general population¹². These diseases often affect younger people and if they are not treated early, they can be lost to the labour market and be claiming benefits for decades. The total annual costs of ankylosing spondylitis per patient in 2003 were around \$11,843 with 72% of these costs attributable to indirect costs such as lost productivity¹³.

MSDs place a significant burden on European society. Of the four categories, both WRULDs and low back pain affect large numbers of workers and are frequently caused by work. The second two, rheumatoid arthritis and spondyloarthropathy, while affecting smaller numbers of workers, are not caused by work, but can be made worse by work. However, work can be both a cause and a cure. In all cases there is clear evidence that well-designed work environments and flexible working arrangements can support job retention and phased return to work. Work – especially if it is good work – can be good for health, wellbeing and recovery.

Psychological and organisational factors can combine with physical factors to influence the probability that someone with an MSD leaves work prematurely. For example, physically demanding work, a lack of autonomy, higher levels of pain, lower functional status and lower educational levels are predictors that individuals with rheumatoid arthritis will leave work early¹⁴. Workers with these conditions are also likely to experience prolonged work disability and find return to work after a period of absence more difficult if their psychological wellbeing is also poor. Ergonomic changes to the work environment, while important, cannot be the only pillar of successful job retention and vocational rehabilitation strategies. Aspects of psychosocial health must also be addressed. These aspects include job design that promotes control, task discretion, flexibility and employee involvement, which are all associated with good work.

EARLY INTERVENTIONS MAKE A DIFFERENCE

If the negative effects of MSDs on both quality of life and work disability are to be minimised then early interventions can often be critical. These interventions take place in a number of domains, such as the workplace, welfare and healthcare systems. In each domain, stronger cooperation with OH professionals is desirable and likely to impact greatly workers with MSDs. Early action in a multidisciplinary team approach that applies the biopsychosocial model of care can help those with MSDs keep their jobs and achieve a balance between the need for respite and the need to work.

► Workplace interventions identified include reasonable adjustments to job design or working time to allow early

or partial return to work, and requiring employers and employees to undertake return-to-work interviews. Others, such as providing screening in the workplace through the use of standardised questionnaires can assist in the early identification of MSDs.

► Where individuals enter the welfare system and begin receiving sickness or incapacity benefits, initiatives that allow for partial work and partial benefit, claim and work with employers to implement early return-to-work plans, can assist in encouraging workers back to work gradually. OH professionals in some countries work with the welfare system to identify adjustments needed to support return to work.

► The healthcare system can also play a proactive role in assisting individuals with MSDs by encouraging early referral to physical therapy, providing early access to effective drug therapies for workers with inflammatory conditions and offering early access to cognitive behavioural therapy (CBT).

Policymakers recognise the importance of health and wellbeing in the workplace and most countries have legislation or programmes in place to prevent accidents at work. However, the issues workers with MSDs are faced with are much wider than OH and safety. One of the most important characteristics of functioning labour market policy is the existence of programmes serving as a buffer for vulnerable workers so that they do not become detached from the labour market. Finding ways of improving job retention for these workers is vital because we know that their chances of finding meaningful work again are severely damaged.

Through the *Fit for Work Europe* research, a number of examples of early interventions for MSDs across Europe were identified. These ranged from early access to physical therapy for workers with low back pain, through to drug treatments that put those with inflammatory conditions into remission, to CBT for those with persistent wrist, neck or shoulder strain. However, in many countries studied, awareness, resources and political will are not yet at a stage where coordinated and effective early intervention is deliverable. The consequences of this lack of readiness may be far-reaching for workers with MSDs who want or need to retain contact with the labour market.

Successful early interventions require healthcare professionals, employers and the healthcare and social welfare systems to work together. Through qualitative research and exploratory econometric analysis, the study has found that there may be quantifiable evidence of an economic return to early interventions aimed at keeping people with MSDs in work. Indeed, there is likely to be an early intervention ‘premium’, which is linked both to levels of sickness absence from work and to a reduction in premature exit from the labour market due to ill-health.

CONCLUSIONS

- **Musculoskeletal** disorders (MSDs) affect a large portion of the European population and comprise a group of conditions that may, or may not, be caused by work, but may nonetheless lead to work disability
- **Psychological** wellbeing, or mental health, influences outcomes for workers with MSDs; applying the biopsychosocial model of care can help those with MSDs
- **Work**, especially good work, can promote health, wellbeing and recovery
- **Early** interventions can ease the burden of MSDs
- **Coordination** among all the stakeholders will ensure progress is made in reducing the burden of MSDs to European society and economy

RECOMMENDATIONS

The *Fit for Work Europe* study has a number of recommendations for stakeholders including:

- ▶ **Collect better data on MSDs.** Both the European Commission and national governments need to collect and analyse better quality and consistent data on the prevalence, incidence and (especially early) costs of MSDs.
- ▶ **Provide active labour market policy that allows workers with MSDs to stay in work.** This means finding the resources and implementing strategies to maximise job retention and early return to work. Core to this must be flexibility in welfare benefits which allow those with partial work disability to earn income and claim benefits.
- ▶ **Promote and enforce legislation requiring reasonable workplace accommodations for workers with MSDs.** Most countries have such legislation, but it is rarely fully enforced. Adjusting work demands – the physical work environment, working time, psychological support etc – can make a big difference to the reintegration of people with MSDs.
- ▶ **Disseminate examples of good workplace preventative practice.** Too many MSDs caused by work are preventable by better work organisation, job design and through ergonomic interventions.

OH professionals have an important role to play in encouraging the use of appropriate interventions and assisting patients, employers and others to find ways for individuals with MSDs to stay in, or return to, work as soon as practicable. To support achieving these aims OH professionals should seek to increase co-operation with other health professionals and stakeholders. Additionally, improved training in OH across Europe is required. Importantly, focusing on capacity rather than incapacity could greatly assist workers with MSDs. Work, if properly designed, can assist in recovery.

The current burden of MSDs in Europe is considerable. Looking ahead, the intensification of work, an ageing population and rising rates of obesity are all risk factors for MSDs in the working age population for at least the next 20 years. Failure to make improvements to

workplace practices, clinical interventions and social welfare provision, as well as to important aspects of health and employment policy will risk condemning another generation of European workers to vulnerable employment prospects, worklessness and poor quality of life. Timely, coordinated and focused action now can ensure that the future generation of workers in Europe are Fit for Work. ■

Stephen Bevan is managing director of The Work Foundation. Robin McGee is a researcher and Tatiana Quadrello is a senior researcher at The Work Foundation.

Notes

- 1 Dupré D, Karjalainen A. *Employment of disabled people in Europe in 2002. Statistics in Focus: Population and Social Conditions. Theme 3 – 26/2003. Luxembourg: Eurostat, 2003.*
- 2 Veale A, Woolf A, Carr A. *Influence of modified work on recurrence of sick leave due to musculoskeletal complaints. Journal of Rehabilitation Medicine 2008; 40: 576–581.*
- 3 Cammarota A. *The Commission's initiative on MSDs: Recent developments in social partner consultation at the European level. Presentation to conference on MSDs: A challenge for the telecommunications industry. Lisbon, 20–21 October 2003.*
- 4 Dagenais S, Caro J, Haldeman S. *A systematic review of low back pain cost of illness studies in the United States and internationally. Spine Journal 2008; 8(1): 8–20.*
- 5 Bekkering G, Hendriks HJM et al. *Dutch physiotherapy guidelines for low back pain. Physiotherapy 2003; 89(2): 82–96.*
- 6 Parent-Thirion A, Fernández Macías E et al. *Fourth European Survey on Working Conditions. Dublin: European Foundation for the Improvement of Living Standards, 2007.*
- 7 Blatter B, Houtman I et al. *Gezondheidsschade en kosten door RSI en psychosociale arbeidsbelasting. Den Haag: Ministerie van Sociale Zaken en Werkgelegenheid, 2006.*
- 8 Lundkvist J, Kastäng F, Kobelt G. *The burden of rheumatoid arthritis and access to treatment: Health burden and cost. European Journal of Health Economics 2008; 8 (Supplement 2): 49–60.*
- 9 Young A, Dixey J. *Which patients stop working because of rheumatoid arthritis? Results of five years' follow up in 732 patients from the Early RA Study (ERAS). Annals of the Rheumatic Diseases 2002; 61: 335–340.*
- 10 National Audit Office. *Services for people with rheumatoid arthritis. London: NAO, 2009.*
- 11 Akkoc N. *Are spondyloarthropathies as common as rheumatoid arthritis worldwide? A review. Current Rheumatology Reports 2008; 10: 371–378.*
- 12 Boonen A, Chorus A et al. *Withdrawal from labour force due to work disability in patients with ankylosing spondylitis. Annals of the Rheumatic Diseases 2001; 60: 1033–1039.*
- 13 Boonen A. *A review of work-participation, cost-of-illness and cost-effectiveness studies in ankylosing spondylitis. Nature Clinical Practice Rheumatology 2006; 10(2): 546–553.*
- 14 Sokka T, Pincus T. *Markers for work disability in rheumatoid arthritis. Journal of Rheumatology 2001; 28: 1718–1722.*