

Fit for Work Executive Summary

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. Despite relative prosperity in Europe, we must face up to the fact that the European workforce may not be healthy enough to drive the improvements in productivity required to ensure that Europe can compete with the USA and China. Indeed, in a post-recession Europe, poor worker well-being may represent a serious impediment to economic growth and competitiveness.

Having a significant proportion of Europe's working age population either temporarily or permanently unable to work through ill-health – even in a favourable economic climate – can reduce the aggregate level of labour productivity in an economy and damage the competitiveness and effectiveness of private and public sector organisations. In depressed labour markets, there is a heightened risk that those with long-term or chronic health conditions will find themselves detached from the workplace for long periods, with little prospect of returning quickly.

Fit for Work Europe – a focus on musculoskeletal disorders (MSDs)

Over 44 million (one in six) members of the European Union (EU) workforce now have a long-standing health problem or disability that affects their ability to work, and musculoskeletal disorders (MSDs) – conditions affecting bones, joints and connective tissue – account for a higher proportion of sickness absence from work than any other health condition. Indeed, over 40 million workers in Europe are affected by MSDs attributable to their work.

This report is the product of a major study – ***Fit for Work Europe*** – conducted by The Work Foundation across 23 European countries (www.fitforworkeurope.eu). The study has looked in some detail at:

- the impact that MSDs have on the working lives of thousands of European workers, the adequacy of the treatment and support they receive
- their experiences in and out of work
- the effect of their condition on their family and colleagues
- the human and financial costs involved.

Specifically, we have looked at 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 (RA) and spondyloarthritis (SpA), two inflammatory conditions that are often progressive and increasingly incapacitating.

We undertook a review of the recent academic and practitioner research on the relationship between these MSDs and labour market participation, and conducted interviews with over 100 acknowledged experts in this field from around Europe. The report examines the causes, effects and costs of MSDs in the European workforce and assesses what more can be done by policymakers, health care systems, social welfare regimes, clinicians, employers and by workers themselves to help alleviate the often damaging economic and social consequences of this widespread, but often hidden, problem.

Extent, causes and consequences of MSDs

The quality and quantity of data on the definition, prevalence, impact and costs of MSDs vary considerably between countries. Nonetheless, we know enough to conclude that chronic musculoskeletal pain affects 100 million people in Europe and that it is widespread in Europe's working age population – although undiagnosed in over 40 per cent of cases. Despite the growth of stress-related illness among European workers, MSDs remain the single biggest cause of absence from work. It is estimated that up to 2 per cent of European gross domestic product (GDP) is accounted for by the direct costs of MSDs each year.

Of the four categories of MSDs that the *Fit for Work* research concentrates on both WRULDs and low back pain affect large numbers of workers and are frequently caused by work – either through physical strain, repetitive movement or poor posture. The second two, RA and SpA, 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, or aggravator, 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 and that work – especially if it is good work – can be good for health, well-being and recovery.

So, what is the extent of the problem across Europe?

- Almost **a quarter** of European workers report that they have experienced muscular pain in their neck, shoulders and upper limbs. The symptoms of WRULDs can present in the tendons, muscles, joints, blood vessels and/or the nerves and may include pain, discomfort, numbness and tingling sensations in the affected area. These conditions can be caused, or exacerbated, by work which involves repetitive movements, prolonged keyboard use, heavy lifting, poor posture or other forms of work-related physical strain. They can also be costly – in the Netherlands, for example, repetitive strain injury (RSI) at work costs €2.1billion each year.
- It is estimated that **half of the European population will suffer back pain** at some time in their lives and in excess of a third of the European workforce suffer from low back pain. The costs of this back pain have been estimated to exceed €12billion. About 85 per cent of people with back pain take less than 7 days off, yet this accounts for only half of the number of working days lost by back pain. The rest is accounted for by the 15 per cent who are absent for over a month. Swedish back and neck patients on sick leave from work, for example, represent a total cost of about 7 per cent of the nation's expenditure on health services.

- Over 2.9 million people in Europe have RA, many of working age. **Every third person with RA becomes work disabled** and up to 40 per cent leave work completely within 5 years of diagnosis. Many people with RA want to stay in work but are unable to because their condition is not diagnosed or treated early enough. In the UK the National Audit Office has calculated that a 10 per cent increase in people with RA being treated within 3 months of diagnosis could result in productivity gains of £31million for the economy due to reduced sick leave and lost employment.
- People with SpA conditions such as ankylosing spondylitis (AS) are **three times as likely to be out of work** as the general population. 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 – often needlessly.

The **Fit for Work Europe** study has also investigated the links between the physical and psychosocial aspects of MSDs. It has highlighted that workers with these conditions are likely to experience more prolonged work disability and find return to work after a period of absence more difficult if their psychological well-being is also poor. Research we identified also suggests that ergonomic changes to the work environment, while important, cannot be the only pillar of successful job retention and vocational rehabilitation strategies unless aspects of psychosocial health are also addressed. These aspects include job design which promotes control, task discretion, flexibility and employee involvement.

It should be noted that though not all MSDs are caused by work, workers who live with MSDs that affect their ability to work remain almost invisible to national and EU policymakers.

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 diagnosis and treatment can often be critical. The **Fit for Work Europe** study has focused on the kinds of early interventions which can make the most difference to both health and labour market participation. These interventions can take place in a number of domains:

| Domain | What | When |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Workplace (Employers and employees) | Examples: <ul style="list-style-type: none"> – Reasonable accommodation to work organisation, working time or job design to allow early or partial return to work (RTW) – Employers required to undertake RTW interview in country – Screening in the workplace with standardised questionnaires looking for early signs or manifestations – Internal health care awareness programmes – Internal health care education systems | <ul style="list-style-type: none"> – For specified health conditions or disabilities – After 5 days of absence |

| Domain | What | When |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Welfare system | Examples: <ul style="list-style-type: none"> – Welfare system allows partial work and partial benefits claims – Functional capacity assessment by occupational health specialist – Employers required to implement an early return to work plan | <ul style="list-style-type: none"> – After 10 days of incapacity – After 10 days of incapacity – After 10 days of absence from work |
| Health care system | Examples: <ul style="list-style-type: none"> – Early referral to physical therapy – Early access to effective drug therapies for workers with inflammatory conditions (eg DMARDs, anti-TNFs) – Early access to cognitive behavioural therapy for selected back pain patients | <ul style="list-style-type: none"> – On diagnosis – In cases of insufficient response to initial treatment – After 8 weeks of work incapacity |

We found a number of imaginative examples of early interventions for MSDs across Europe ranging from early access to physical therapy for workers with low back pain, through to drug treatments which put those with inflammatory conditions into remission, to cognitive behavioural therapy (CBT) with persistent wrist, neck or shoulder strain. However, we also found that – in many of the countries we studied – awareness, resources and political will are not yet at a stage where coordinated and effective early intervention is currently 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 clinicians, employers and the health care and social welfare systems to work together. This is rarely the case, even to achieve positive clinical outcomes. It is even less common to find that job retention or return to work is the goal. And yet, through our qualitative research and our exploratory econometric analysis, the **Fit for Work Europe** study has found a growing body of evidence that there may be quantifiable evidence of an economic return to early interventions aimed at keeping people with MSDs in work. Indeed, we have identified that 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.

Recommendations

The Fit for Work Europe study has a number of recommendations for policymakers, employers, clinicians and other stakeholders:

1. 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.
2. Active labour market policy must allow 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.

3. Promote and enforce legislation requiring reasonable workplace accommodations for workers with MSDs. Most countries have such legislation, but it is rarely fully enforced. We know that adjusting work demands (the physical work environment, working time, psychological support etc) can make a big difference to the reintegration of people with MSDs.
4. Promote examples of good workplace preventative practice. Too many MSDs caused by work are preventable by better work organisation, job design and through ergonomic interventions. Many examples of good and effective practice exist. The European Commission and national governments should prioritise the active dissemination of good practice to support workplace prevention.
5. The EU MSD Directive should recognise pre-existing MSDs. Many workers have MSDs that are not caused by work. The forthcoming Directive should explicitly recognise that these conditions also have an effect on productivity and the quality of working life. It should also recognise that workplace interventions can support job retention, return to work and vocational rehabilitation. The Directive should also recognise the link between MSDs and mental health.
6. National governments should ensure that primary care physicians are supported in making decisions about work disability. If early intervention is to be initiated, and if return to work for people with MSDs is to be seen as a legitimate clinical outcome by family doctors, more specialist education and support is needed to ensure that opportunities to act early are not lost.
7. National governments should consider adopting a version of the UK 'Fit Note'. This would encourage clinicians and employers to focus on the capacity workers with MSDs have rather than their incapacity, and improve the flow of information between clinicians and employers. A shift in outlook is needed here if we are to change attitudes and behaviour to incapacity.
8. National governments should prioritise access to physical and psychological therapies for workers with MSDs. The evidence is clear – if people with MSDs can gain early access to treatments and therapies that help them to stay in, or return to, work then they should be made available. Timely interventions from physiotherapists and clinical psychologists can make a significant impact on return to work, and should be prioritised.
9. National governments should implement national care plans for people with MSDs. These frameworks should include measures to promote coordination and cooperation between health and social security institutions and employers. They should also include steps to intervene early and to prioritise early return to work.
10. Health Technology Assessments (HTAs) should be allowed to take account of the wider societal benefits of treatments and therapies for MSDs. While not without its technical and philosophical issues, it is clear that treatment or therapy which can prolong the working lives of workers with MSDs may also generate benefits which are likely to accrue to the individual, their family and carers, society at large and to the wider economy, and go far beyond narrow clinical criteria.

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, social welfare provision and to important aspects of employment, health and employment policy – both at EU-level and within member states

– will mean that we risk condemning another generation of European workers to vulnerable employment prospects, worklessness and a poor quality of life.

However, with timely, coordinated and focused action now we can ensure that many more of our future generation of workers in Europe are ***Fit for Work***.