Healthcare Conference – 2005

The Path to Inactivity:
What is it and what can we do about it ?

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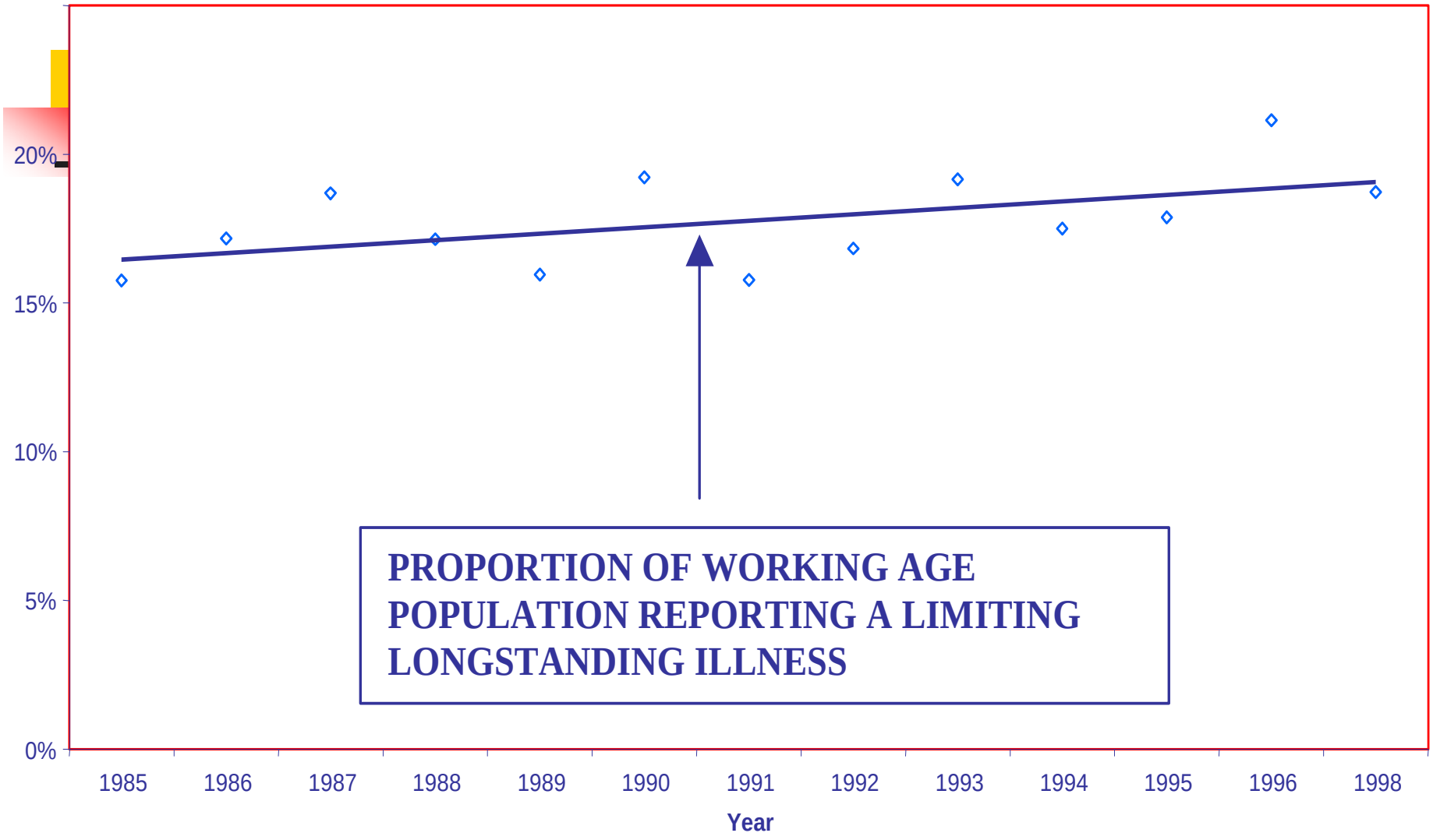
CORPORATE MEDICAL GROUP

United Kingdom Perspective

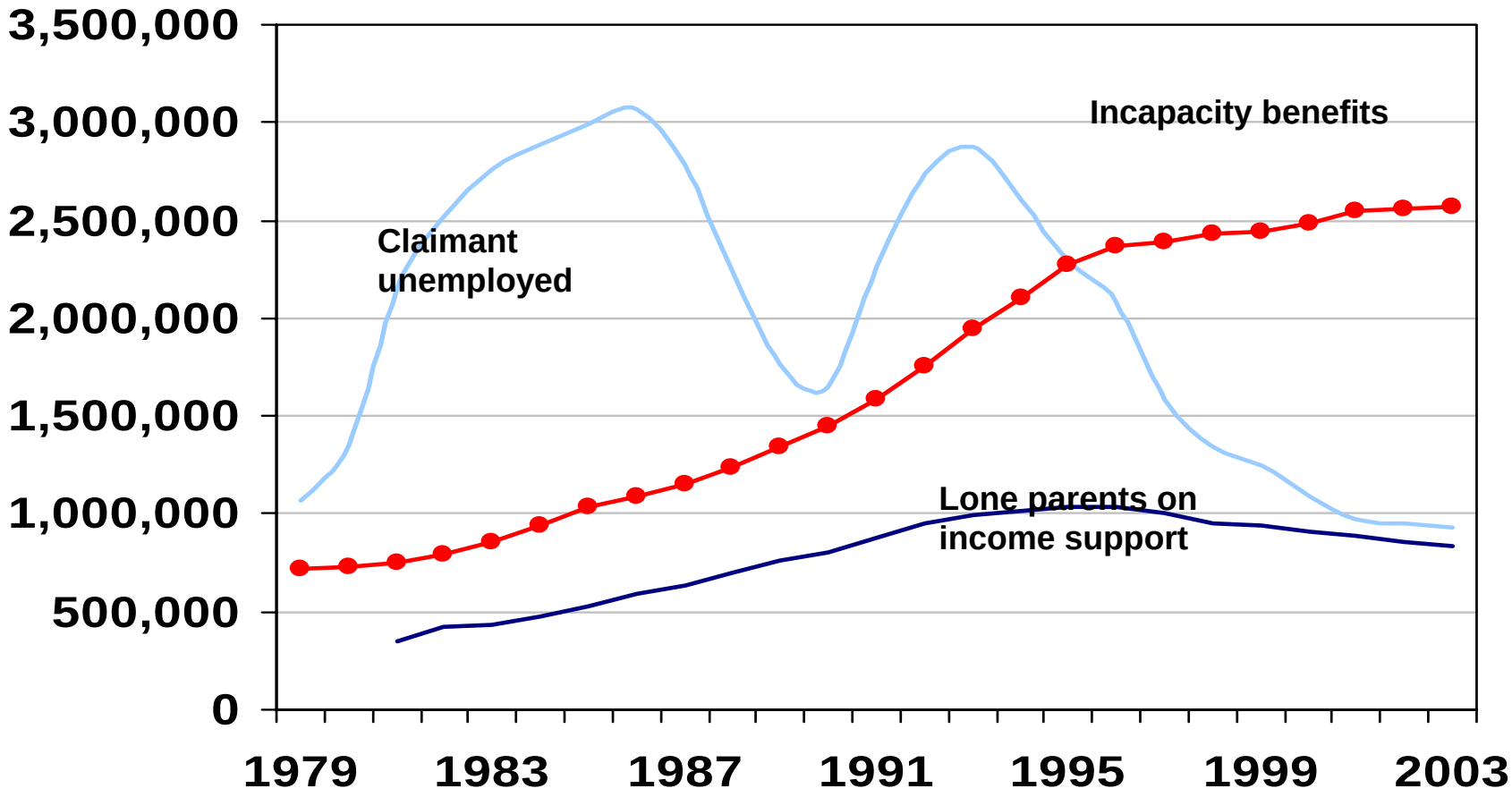
- An epidemic of disabling/incapacitating Common Health Problems?
- The burden on the State, Society and Industry
- When, how and why do subjective complaints (syn. symptoms) become disabling/incapacitating?
- What drives this dynamic process?
- Obstacles to Recovery and Barriers to Work
- Some solutions: Pathways to Work

Current context

- 1 million report sick each week; 3000 remain off work at 6 months and 80% of these will not work again in next 5 years
- 2.7 million people of working age on a state incapacity benefit [less than 1 million unemployed]
- Characteristics of benefit recipients:
  - major component of chronic pain
  - subjective health problems
  - mental health
- demographics not good; ageing population; IB load projected to rise further; regional dimension


20%
15%
10%
5%
0%
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1998
Year
PROPORTION OF WORKING AGE POPULATION REPORTING A LIMITING LONGSTANDING ILLNESS

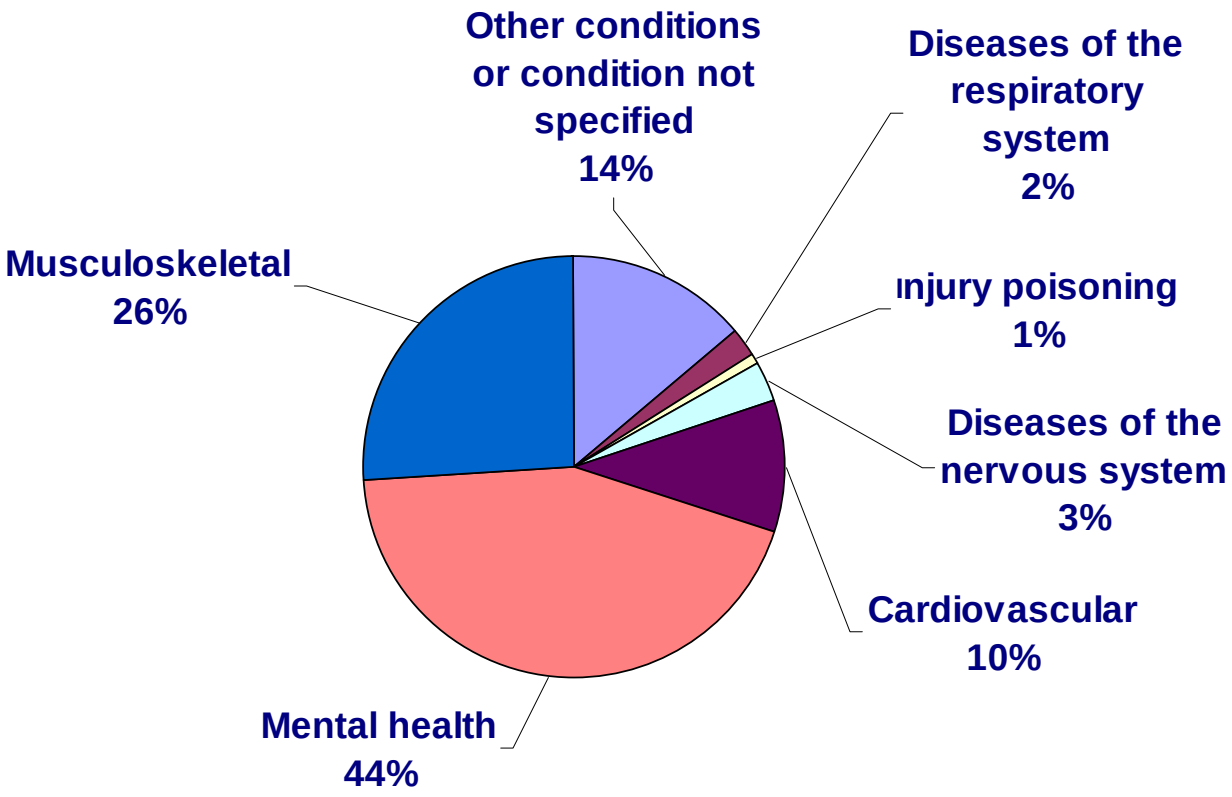
Recipients of key working age benefits



Source: DWP and ONS

IB Recipients - Diagnoses

Incapacity-related benefit recipients by diagnosis group, November 2003



UK Incapacity Benefit

- ‘Severe Medical Conditions’ <25%

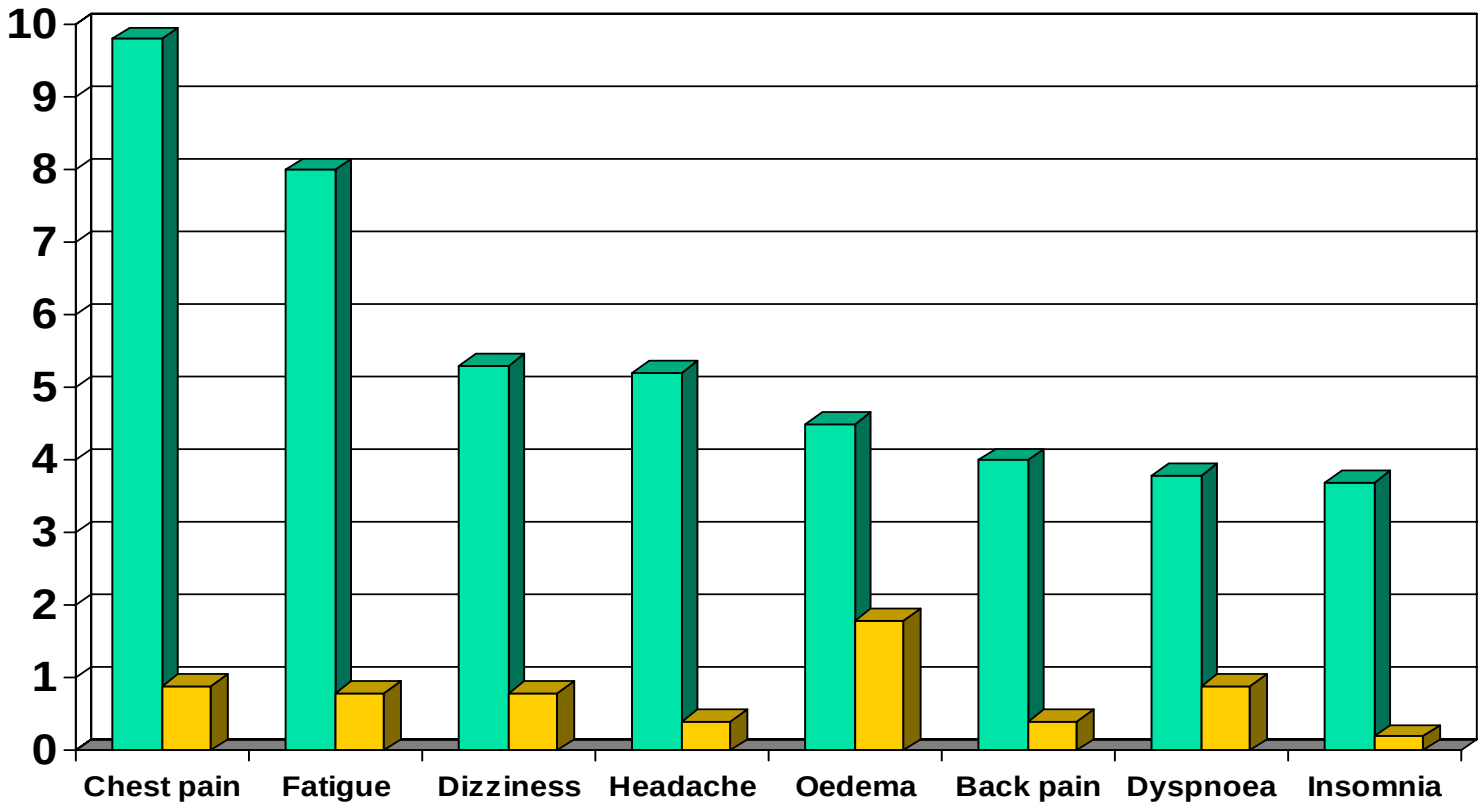
  (Conditions exempt from PCA 16%)

- ‘Common Health Problems’
  - Mental health problems 36%
  - Musculoskeletal conditions 20%
  - Cardio-respiratory conditions 10%

Severe Medical Conditions

- objective evidence of disease, pathology, with permanent physical or mental impairment
- e.g. blindness, severe or progressive neurological disease, psychoses

Three year incidence (%) of symptoms in general practice (Total and with organic cause) (Kroenke & Mangelsdorff 1989)



Prevalence of subjective health complaints in the last 30 days in Nordic adults (after, Eriksen et al, 1998

	Any complaints		Substantial complaints	
	Men	Women	Men	Women
Tiredness	46%	56%	17%	26%
Worry	38%	39%	13%	15%
Depressed	22%	28%	5%	10%
Headache	37%	51%	4%	9%
Neck pain	27%	41%	9%	17%
Arm/shoulder pain	28%	38%	12%	17%
Low back pain	32%	37%	13%	16%

>50% reported two or more symptoms

Edinburgh Neurology Study

	Not at all	Somewhat	Largely	Completely
Explained by disease	**11%**	**19%**	**27%**	**43%**
Physical Score	**75**	**85**	**85**	**80**
Anxiety or Depression	**70%**	**65%**	**48%**	**32%**

Incapacity for Work on Health Grounds:

- A growing problem in all western societies
- Despite improvements in most objective measures of health
- Non-specific and subjective health complaints predominate:
  - back pain and musculoskeletal disorders
  - common, non-specific bodily symptoms (that affect most people)
  - fatigue, worry, disturbed mood, headache, etc

SOME PERTINENT QUESTIONS:

- When, how, and why do symptoms become disabling?
- What are the relationships between illness, disability, and work incapacity?
- What drives this dynamic process?
  - Economic, financial (dis)incentives and risks?
  - Imposed by society organised for able-bodied living?
  - Political and social oppression?
  - Social and cultural attitudes?
  - Psychosocial influences?
  - Consciously motivated intent, volition and free will?

DISABILITY IS RESTRICTED ACTIVITY; IT MAY BE WHOLLY SUBJECTIVE

- Varies independently of IMPAIRMENT
- A measure of performance, influenced by:
  - a actual loss of function or restrictions on function
  - premature termination of activity
  - suboptimal performance
  - fatigue, pain
  - beliefs and attitude
  - environment and culture
  - deception

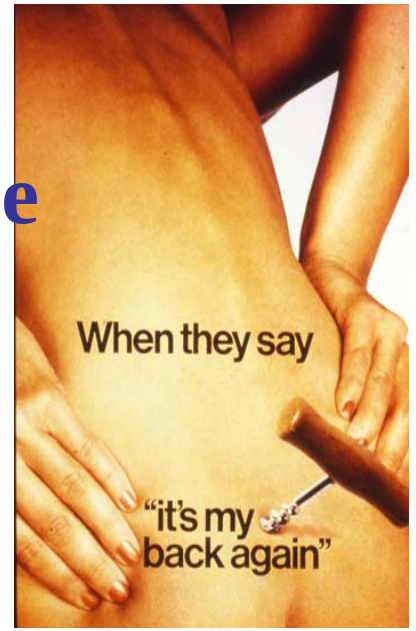
Common health problems

Less severe mental health, musculoskeletal and cardio-respiratory conditions

Limited objective evidence of disease

Largely subjective complaints

Often associated psychosocial issues



Long-term incapacity is not inevitable

- There is no permanent impairment
- High prevalence in normal population
- Most acute episodes settle quite quickly
- Most people remain at work or return to work quite quickly
- Essentially normal, healthy people
- Only about 1% go on to long-term incapacity

Why do some people not recover as expected?

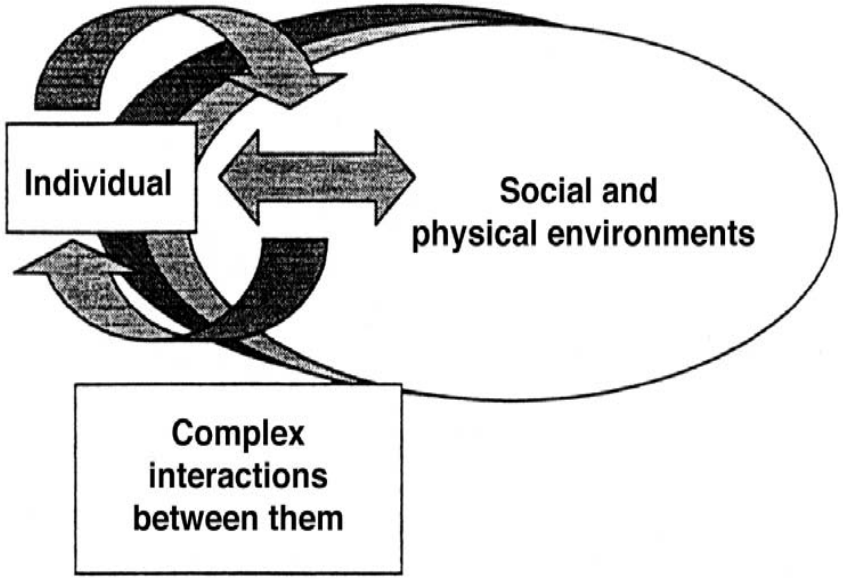
- Bio-psycho-social factors may aggravate and perpetuate disability
- They may also act as **obstacles to recovery & barriers to return to work**

Rehabilitation for common health problems should address obstacles to recovery and barriers to return to work

Elements to disability	Barriers to RTW	Rehabilitation interventions
BIO	Health condition Capy –v- demands	Clinical management Occupational management
PSYCHO	Personal perceptions Psychosocial aspects of work	Change perceptions, beliefs, behaviour
SOCIAL	Organisational Attitudinal	Modified work Systems, attitudes

Bio-psycho-social barriers to RTW

- Interactions
  - Person
  - Environment
- Perceptions
  - Person
  - Health professionals
  - Employer

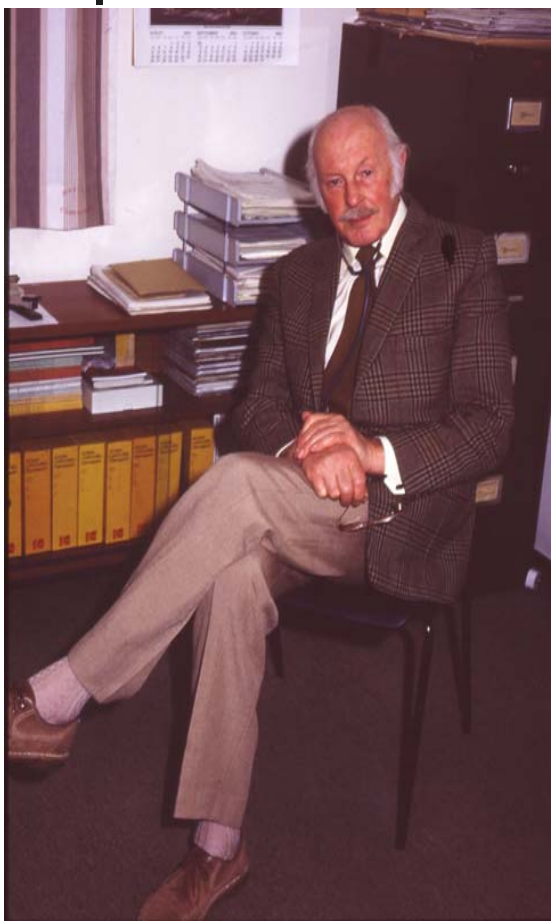


General Principles

- Rehabilitation cannot be a second stage after health care has failed.

- Principles of rehabilitation must be integrated into:
  - clinical management
  - occupational management

Health care for common health problems



Symptomatic relief **AND** restoration of function

‘Every health professional who treats common health problems should be interested in rehabilitation and occupational outcomes.’

Occupational management

- Common health problems are not a matter for health care alone.
- They are equally a matter of ‘occupational health’

Modified work
(Krause et al 1998)

- 29 empirical studies

- Halved the number of lost work days and

  Halved the number of injured workers who went on to chronic disability

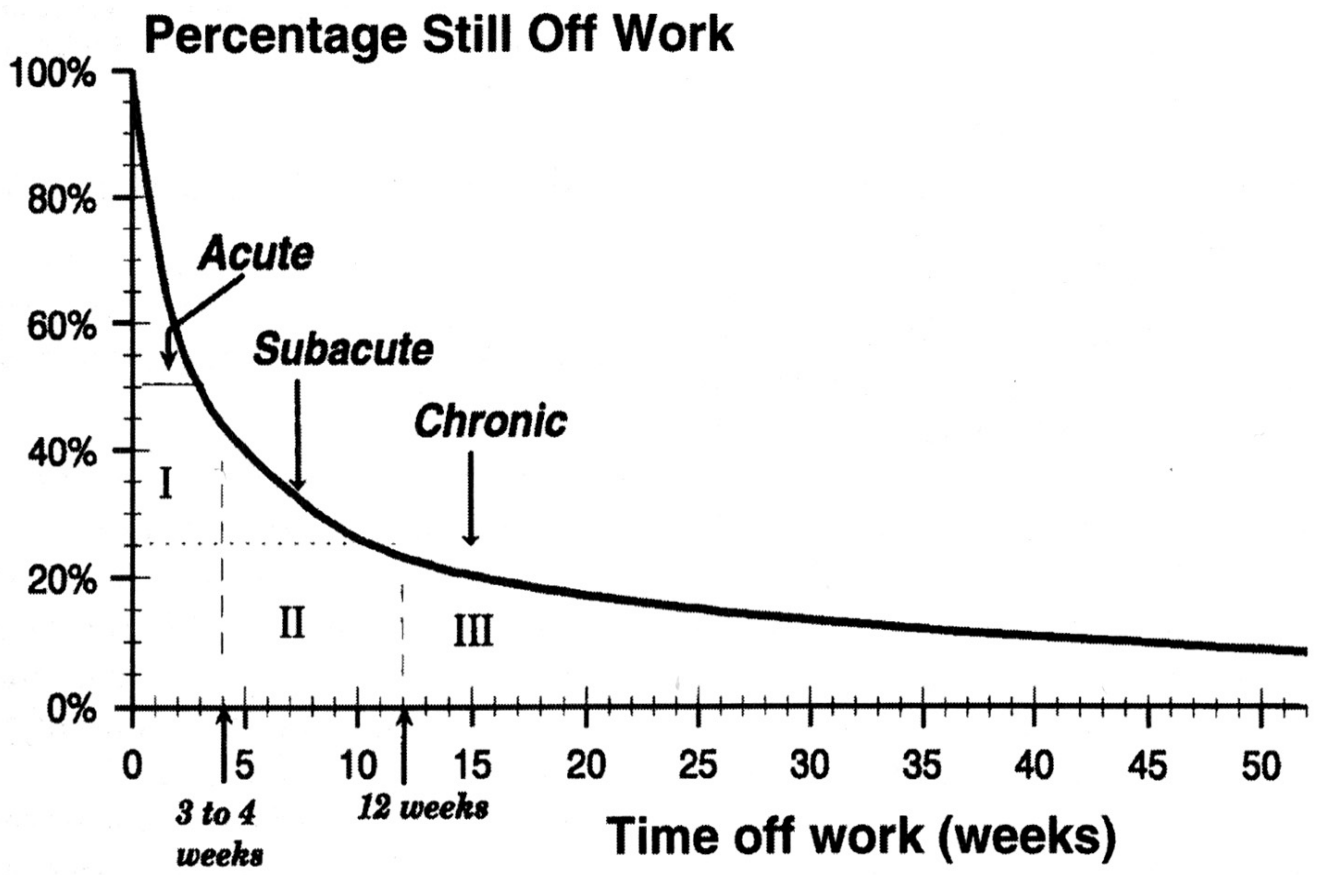
Health at work

- Health and work are intimately linked (+ve > -ve)
- The key idea is that work is healthy.
- The workplace offers an environment for promoting health and controlling ill health.
- ‘A ***Healthy working life*** is one that provides the opportunity, ability, support and encouragement to work in ways and in an environment that allows people to maintain and improve their health and well being’ (Scottish Executive 2004)

Health at work

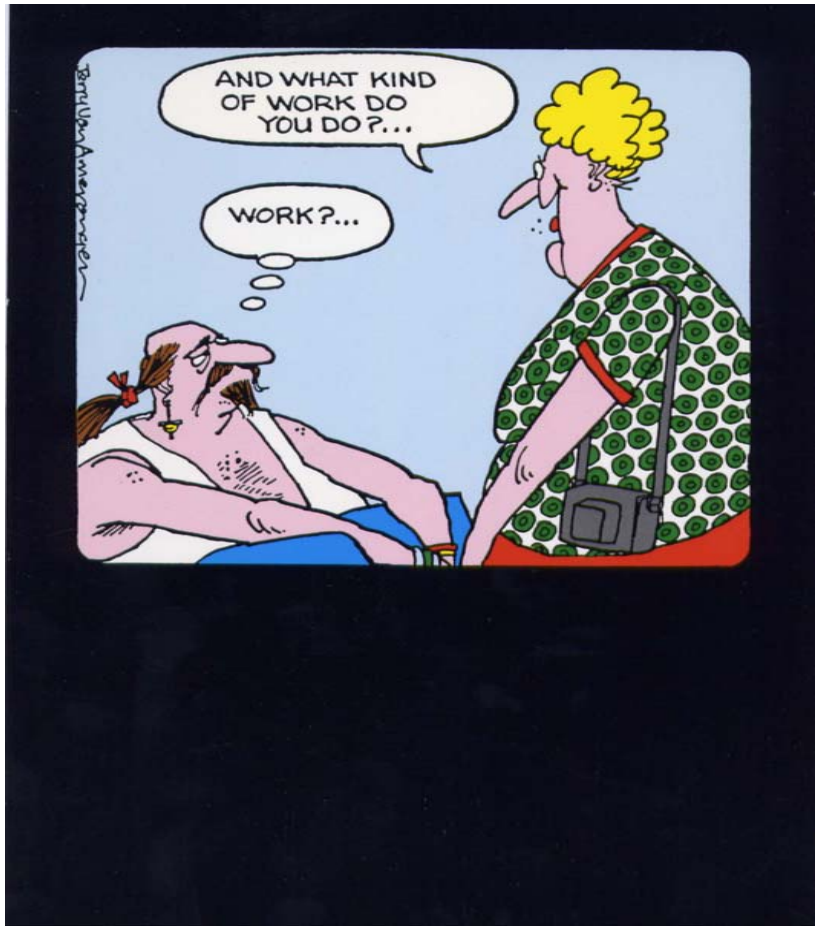
Company environment	Company & organisational characteristics. Management style & corporate culture
Management interventions	Health & safety policy & practice Sickness absence management
Outcomes	Incidence of work-related ill health Incidence of sickness absence Duration of sickness absence Overall outcomes & costs

Timing


Percentage Still Off Work
100%
80%
60%
40%
20%
0%
Acute
Subacute
Chronic
I
II
III
0
5
10
15
20
25
30
35
40
45
50
3 to 4 weeks
12 weeks
Time off work (weeks)

(Dis)incentives & control mechanisms

Culture



The collective attitudes, beliefs and behaviour that characterise a particular social group over time

The way ahead – First steps

Website: www.dwp.gov.uk/medical

Getting all stakeholders on side

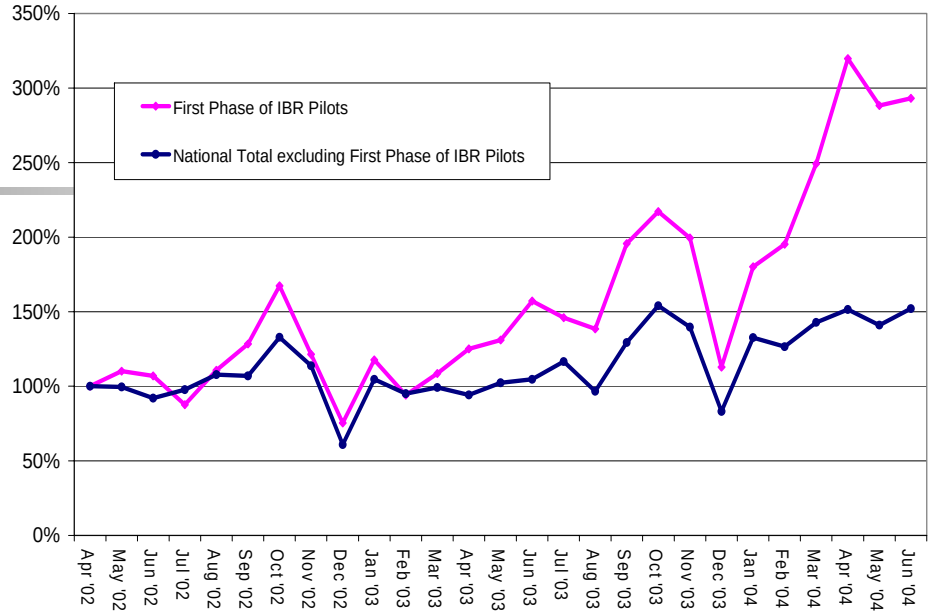
(Frank 1996, 1998)

- Workers
- Health professionals
- Employers
- DWP
- Communication
- Common understanding
- Common language
- Common goals

Pathways to Work:
A new approach to Vocational Rehabilitation

- Pilots – Local NHS PCTs and JobCentre Plus
- Multidisciplinary work-focused support
- Case Management (Personal Advisers)
- Mandatory Work-focused interviews
- Condition-Management Programmes:
  - musculoskeletal disorders
  - minor/moderate mental health problems
  - cardio respiratory diseases

Potential impact ?



NDDP job entries set as date of job entry not authorisation date
Job entries include those from "other inactives" to ensure consistency over time

Strong scientific evidence that we *could*:

- reduce sickness absence due to common health problems by 30-50%
- reduce number going on to chronic incapacity by 30-50%

In principle, by much more