

Management of Health Risks Special Report



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■ Work ill-health set to rise

Employers will need to put in place measures to deal with chronic diseases, the amount of which is expected to grow significantly in the next 20 years, according to a recent major report exploring the challenges and opportunities for managing and preventing ill health in the workplace.

The report, published by insurance company Bupa in partnership with the Work Foundation, the Oxford Health Alliance, and Rand Europe, predicts that the cost of sickness absence and other costs associated with working age ill health will rise, because of the aging workforce and an increase in the number of employees with long-term conditions that need managing over a sustained period. Workers are also likely to need to devote more time to caring for older people. For specific conditions it predicts:

- the number of workers with heart disease will rise by 13% by 2030
- the number of workers with diabetes or respiratory diseases will increase by at least 8% to 5.5 million
- a 9% increase in musculoskeletal disorders, affecting more than 7 million workers
- a 5% rise in the rate of mental illness in the workforce to affect 4.2 million employees.

The report goes on to suggest that the workplace could be a place to influence the health behaviour of people, particularly hard-to-reach groups and those at risk of disease. Workplace interventions have in the past been disregarded by employers because of a lack of perceived benefits to them and to avoid accusations of “nannying”.

It also says that employers can help reduce levels of mental illness, caused both in and outside work, by embedding workplace health in organisational culture. This will require companies to align investment in workplace health more closely with other aspects of human resources, such as skills and training, job design, and working practices.

A second report, due out later this year, will contain recommendations on how companies can help manage and improve the health of their employees.

A copy of the report can be viewed at www.bupa.co.uk/about/html/reports/health_at_work.html. ■

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■ News

New official work disease

The Department for Work and Pensions has announced that it has recognised osteoarthritis of the knee, commonly known as “Miners’ Knee”, as an official occupational disease in the UK.

The addition of Miners’ Knee to the Government’s list of prescribed diseases under industrial disease benefits rules means that miners who pass a disability threshold will be eligible for government payouts, through the Industrial Injuries Disablement Benefit.

It is thought that thousands of miners suffering from the condition will now be able to claim help from the Government.

Ministers decided to act on the recommendation from the Industrial Injuries Advisory Council (IIAC), that coal miners with the disease who have worked underground for 10 years or more should be able to claim Industrial Injuries Disablement Benefit. Symptoms of the disease include pain, swelling, stiffness and reduced mobility. The change is expected to come into force in the summer of 2009.

The IIAC report on osteoarthritis of the knee can be accessed at www.iiac.org.uk/pdf/command_papers/Cm7440.pdf.

Report slams cost of health and safety failures

A new report by a professor at Scotland’s Stirling University claims that deadly conditions are persisting in Britain’s workplaces because firms only pay a small fraction of the costs of occupational injuries and diseases. The report, entitled *Who Pays? You Do*, by Professor Rory O’Neill, of the University’s Occupational and Environmental Health Research Group, concludes that thousands of lives each year could be saved if businesses were prevented from “cost shifting” onto individuals and society the real bill for work-related ill health.

The report is highly critical of the British Chambers of Commerce (BCC) which recently published its 2009 Burdens Barometer, in which it targeted 10 workplace safety regulations covering working time, chemicals, asbestos, explosives, biocides, work at height, vibration and noise, as well as occupational exposure limits and the new corporate manslaughter legislation. Professor O’Neill said, “The British Chambers of Commerce objects to the cost of these crucial health and safety laws, which it says cost business £2.2 billion a year. But BCC’s calculation is undermined by a critical omission — the cash and human benefits of properly regulated workplace health and safety.”

The report *Who Pays? You Do* can be accessed online at www.hazards.org/deadlybusiness/whopays.htm.

The BCC 2009 Burdens Barometer is available at www.britishchambers.org.uk/6798219243887862847/burdens-barometer-2009.html.

Update on first aid

The Health and Safety Executive (HSE) has recently updated its website on first aid, with the provision of revised guidance on the subject.

The new guidance is entitled *First-aid Training and Qualifications for the Purposes of the Health and Safety (First-Aid) Regulations 1981: A Guide for Training Organisations* and the new edition became available in April 2009.

The publication will help first-aid training organisations prepare for introduction of the new training regime for first aiders in the workplace, the full implementation of which will take place from 1 October 2009.

The changes came out of the HSE’s consultation exercise on draft guidance for employers and first-aid training providers to support changes to first-aid training and approval arrangements.

The revised publication can be accessed at www.hse.gov.uk/pubns/web41.pdf. ■



■ Rehabilitation for backs

Back pain remains a problem for all sectors of society. It is costly for industry in terms of lost work time, and for healthcare services in terms of investigations and treatment — and those costs are huge. It is, of course, also a pain for the individual concerned. But who is that individual? Well, it is most of us in fact — at some time. Professor Kim Burton discusses the issues.

The problem of back pain

Something certainly needs to be done about back pain, but is that to prevent, cure or manage? It has proved a difficult question to answer: the health and safety community said it could be prevented, while the healthcare community suggested it could be cured. Despite valiant efforts in both areas, neither approach has made any substantial difference to the amount of back pain or its effects on the community. The fundamental problem is that back pain is not what it seems. There are various paradoxes, which means people must change how they think about back trouble and what can be done about it.

People have come to see back pain as an injury caused most often by some physical exposure at work. That view has come to dominate thinking about how to manage the problem. However, there are a few key observations that challenge that proposition. Across the developed nations, the second part of the 20th century saw a dramatic and exponential increase in the extent of disability due to back pain. During that period, the physical demands of work were decreasing, and delivery of healthcare was improving. Furthermore, the fact that over 50% of adolescents get notable back pain, and the fact that the experience does not disappear with retirement, is evidence that it is not simply a work-related problem.

Back pain is a symptom, not a disorder or an injury. For most people it is a recurring experience. More often than not, episodes come on for no particular reason, and even

when seemingly triggered by some physical exposure, there is very rarely any identifiable damage. For the majority of episodes people do not seek healthcare intervention, and most people stay at work while the symptoms settle. That is not to say there is not an occupational aspect to back pain — there is. Some postures and activities at work may provoke symptoms, and the severity can certainly fluctuate in response to some aspects of work, but that is quite different from the idea that work is the predominant cause of the symptom: only a small proportion of the overall back pain phenomenon will be due to a workplace injury.

Prevent or treat?

Understanding the underlying epidemiological pattern of back pain is crucial to establishing effective control. Because the underlying cause is generally unknown and the pathology cannot be determined, preventing back pain from happening seems an unrealistic goal. People are good at preventing occupational health problems when the cause and the effect are quite unambiguous, eg knowing that certain noxious chemicals cause skin complaints — the solution is to prevent the exposure. That model does not seem to work for back pain.

In 2004, a multidisciplinary multinational group produced the European guidelines for the management of low back pain (www.backpaineurope.org), which included a section on prevention. Following a detailed review of the scientific evidence, the group determined that the general nature and course of commonly experienced low back pain means that there is limited scope for preventing its incidence (first-time onset) — risk factor modification will not necessarily achieve prevention. However, it was considered feasible to prevent various consequences of back pain (sick leave, prolonged absence and recurrence). The interventions that were recommended in this respect focused on physical exercise and provision of biopsychosocial information (of

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which, more later); physical ergonomic workplace adaptations were only considered helpful for facilitating return to work. In essence, the evidence supported management of the problem rather than primary prevention.

The European guidelines had sections on the treatment of back pain. The recommended treatments were about providing appropriate (positive) information and advice, avoidance of bed rest, promotion of activity, and control of pain. In fact the list of treatments for which there was no supporting evidence far exceeded the treatments that have been shown to be effective. Furthermore, even those treatments that are effective have only a small overall effect.

The bottom line seems to be that prevention through risk control and ergonomic interventions alone does little to reduce sickness absence or the number of people experiencing back pain: more and better ergonomics is unlikely to offer a solution. Similarly, treatment alone has limited overall clinical benefits and does little to reduce sickness absence: more and better healthcare is unlikely to offer a solution. Arguably, too much of either will have a negative effect because it focuses on the wrong concepts and will offer mixed messages, leading to unfulfilled expectations.

The rehabilitation approach

Obstacles to recovery and return to work

Most people with back pain do not require sick leave; the majority of those that do take absence tend to return to their usual job in a timely fashion. There remains a minority, representing large numbers, who take prolonged or recurrent sick leave and can drift to long-term disability. The reason is not that they have a more serious “condition” — clinically they are indistinguishable. This, then, reverses the question — it is not so much a matter of what has gone wrong, but why some people do not recover as expected. What has happened is that they have come up against obstacles to recovery and obstacles to return to

work. This puts a very different complexion on the sort of interventions that might be helpful. People need to move away from seeing back pain as a disease to be prevented or cured, and view it as a complaint to be managed.

The person with back pain needs to be considered in a biopsychosocial framework. The term biopsychosocial is clumsy and can lead to confusion. Essentially, though, it is a straightforward idea that accepts there is a biological (medical) aspect underlying the symptoms, but acknowledges that this does not explain all that we observe. The idea goes on to recognise that the person with symptoms has a psychological makeup with attendant perceptions and behaviours, and they exist within a social context of systems and culture, all of which impacts on their health. The factors that act as obstacles to recovery and obstacles to return to work can be explained within this framework.

The obstacles have been characterised as “flags”. Flags represent a way of thinking about unfavourable outcomes in people with musculoskeletal problems and, at the same time, they indicate what needs to be done to improve those outcomes. Flags are features about the individual, their pain problem, and the world around them. The flags occur in three main domains and, for convenience, they are colour coded. The following examples characterise the flags and illustrate the obstacles.

Yellow flags are about the individual — they are largely psychological factors associated with unfavourable clinical outcomes and the transition to persistent pain and disability.

- Dysfunctional attitudes and beliefs about pain and disability.
- Anxiety, fear and avoidance.
- Distress, low mood.
- Negative coping strategies.
- Lack of motivation and effort — awaiting a “fix”.



■ Rehabilitation for backs (cont'd)

Blue flags are about the workplace — they stem largely from perceptions about the relationship between work and health, and are associated with reduced ability to work and prolonged absence.

- Job “stress”.
- Attribution to work.
- Doubting ability to work.
- Low job satisfaction.
- Perception of poor social support.

Black flags are about the context — they are largely to do with systems and policies that block interventions delivered through healthcare and the workplace.

- Social level
 - benefits systems
 - litigation
 - job availability
- Company level
 - intractable work organisation
 - unhelpful absence management
 - restrictive return to work policies.

Psychosocial factors affect most people most of the time. The trick is to seek out those that are acting as obstacles to symptom reduction and participation in activities (including work). Identifying flags depends on who you are and where you are — clinic or workplace. The different players have different reasons for identifying obstacles, and the way they spot them will be different. For instance, supervisors and clinicians have different skills and concerns: the one is better placed to identify blue flags through observation at the workplace, while the other is better placed to evaluate yellow flags using structured interviewing. But, because the various factors interact, it is essential that all the players are aware of flags across environments — this necessitates communication. Sam’s story neatly flags up a succession of obstacles that led to disaster.

Sam’s story

Last year I got a problem with my back that made my work a bit difficult. So my GP signed me off work and gave me tablets — but that did not make much difference. Then it took weeks to get some therapy — it helped a bit, but did not really cure it. They said my work probably caused the problem, so I could not go back till I was fully fit. The people at work did not call, so I could not discuss when or how I might be able to get back to work. By that stage I was getting really worried — and depressed. My union rep said I should make a claim, and sent me to a solicitor. My sick pay came to an end, I lost my job, and I went on to Incapacity Benefit. This whole saga has taken over my life, yet to begin with I thought I would soon get over it.

You will think it so, till you make it so

Many of the flags are underpinned by detrimental beliefs. Beliefs are central to what people do about back pain:

- about whether to rest
- about whether to seek treatment
- about whether to work
- about what it means for the future.

Importantly, beliefs about these fundamental questions are held by all the players — workers, clinicians and employers — and those beliefs influence how they all behave in response to an episode of absence due to back pain.

Detrimental beliefs stem largely from popular myths. There are a host of myths and misunderstandings about back pain, which are widely held across the population, both at the workplace and beyond. These misapprehensions have a significant influence on what we do when we get back pain, or when we encounter somebody with a back problem.

- Work caused the trouble.

■ Rehabilitation for backs (cont'd)

- Not true for most cases. Work may be difficult or painful because of a back problem, but that does not mean work caused the symptoms.
- The spine is damaged.
 - Rarely is there any underlying damage.
- Work will make it worse.
 - Usually not true: work may be uncomfortable for a time, but hurt does not mean harm.
- Sick leave is needed.
 - Most people with back pain do not need sick leave: for those that do, early return to work is beneficial.
- Must not return until 100% recovered.
 - This notion is unhelpful: work is part of rehabilitation — workers need to be helped back to work even when symptoms remain
- Permanent need for modified work.
 - Actually most people return to their usual work: modified work is a temporary arrangement that may be needed to help the transition back to work — it does not imply the work is detrimental.
- Life will just get worse.
 - Basically untrue: back pain often has ups and downs, but is not a progressive disease — getting gloomy about the future just impedes recovery.

We are surrounded by information and advice that perpetuates these and other myths. Family members are often overprotective; medical professionals can be inconsistent; cultural influences are inherently inaccurate; the media tend to sensationalise rather than impart useful information; legislation sends out mixed messages about health and safety; the Internet is awash with unreliable information. What is required is a cultural shift to dispel some of the myths surrounding back pain and work.

Rehabilitation

What can be done to help people with back pain? The answer is, a lot — if the right things

are done at the right time. It needs positive, consistent interventions across the three broad areas covered by the biopsychosocial pattern of the obstacles. Healthcare intervention needs to include timely delivery of whatever care is needed. That will usually entail symptomatic relief together with restoration of function — a can-do approach, avoiding negative messages and undue sick certification (fit notes make more sense than sick notes). Personal or psychological intervention may need to address unhelpful perceptions and beliefs about work and health, in order to encourage activity and participation. The social/occupational interventions will be focused around the workplace. The involvement of the employer is crucial — eg maintain contact between the absent worker and the workplace, availability of temporary modified work, a culture that embraces social support, positive absence management policies.

The key principle for helping people with back pain stay at, and return to, work is a combination of work-focused healthcare and an accommodating workplace. Both need to be addressed and co-ordinated. That requires all players onside and acting: effective communication is a must.

The timing of intervention, with all the players in concert, is especially important. Work-focused healthcare and an accommodating workplace should be available to all from the start of symptoms/absence: it is what good management of health at work is all about. That said, too much too soon is wasteful, but leaving it too late leads to entrenched obstacles. For a problem like back pain, a stepped care approach is best. It is an approach that guides care based on individual needs: in essence it delivers just what is needed when it is needed for the individual, while permitting allocation of resources to greatest effect on a population/company basis. In the first few weeks of symptoms or absence, most people with back pain can be helped to stay at, or return to, work by following some



■ Rehabilitation for backs (cont'd)

basic principles of healthcare and workplace management. This means identifying and addressing obstacles to recovery and work: in short, delivery of appropriate healthcare and information/advice along with facilitation at the workplace.

People who are struggling to recover or get back to work by about 4–6 weeks probably need a more structured form of rehabilitation, involving a combination of healthcare and workplace intervention. The principles are the same as the previous step, although they need to be delivered in a more structured, more intense manner. This too can be stepped-up with increasing time off work to tackle more complex obstacles. These structured rehabilitation interventions may include targeted healthcare based on cognitive behavioural principles, guided physical activity, multidisciplinary clinical interventions, and workplace case meetings. Devising appropriate individual plans requires considerable care and skill, and may require input from occupational health providers and case managers. The detailed content of structured rehabilitation approaches is beyond the scope of this article, but guidance on the first step is available: if implemented, this should prevent substantial numbers ever needing more structured rehabilitation.

Shifting the culture — informing the players

Dispelling the myths and shifting the culture is fundamental to better vocational rehabilitation for all common health problems, including back pain. A set of guidance leaflets has recently been produced to provide evidence-based information and guidance for the key players: workplace, healthcare and worker. Providing a consistent set of messages, each is written in language appropriate for its target group. The key messages revolve around the benefits of work for health, the importance of early return to work, the role played by the various players, and the ways in which they

should interact. They have widespread stakeholder support and endorsement, and the development process included end-user evaluation. The 8-page leaflets are published by The Stationery Office, and available in both electronic and print form (www.tsoshop.co.uk).

Work and Health: is for the various people in and around the workplace who are connected with health at work — senior management; line managers; human resources; small employers; union reps; health and safety advisers; occupational health; rehabilitation providers; claims handlers; lawyers. In addition to the key messages, there is a section on myths together with practical guidance on how people in the workplace should contribute to the return to work process.

Advising Patients About Work: is for health professionals — primarily GPs but equally appropriate for occupational health physicians, occupational health nurses, physiotherapists, occupational therapists, complimentary medicine practitioners, rehabilitation providers, case managers. It discusses the evidence on work and health, and gives practical advice on how to tackle this difficult topic, and stresses the importance of linking healthcare with the workplace.

Health and Work: is for workers/patients absent from work with a health problem. Written in readily accessible language, the focus is on reducing fear, myth busting, overcoming obstacles, and giving practical advice on how to co-operate with health professionals and the people at work to secure early return.

As far as back pain in particular is concerned, specific evidence-based information and advice for workers/patients is available in the form of *The Back Book* (www.tsoshop.co.uk), which is widely used in industry and healthcare. It aims to demedicalise the experience of back pain, and to support self-help and coping; it has been shown to shift beliefs about back pain in a more positive direction and can contribute to reduced sickness absence and an early return to work. Initially prepared as part of the UK clinical guidelines on back pain for GPs, the booklet

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has subsequently been incorporated into occupational health guidelines and is recommended by the Health and Safety Executive as a useful resource in the management of back pain at work.

Detailed guidance for clinicians concerning the management of work-relevant back pain is available from the Faculty of Occupational Medicine: *Occupational Health Guidelines for the Management of Back Pain at Work* (www.facocmed.ac.uk). The guidelines use a detailed evidence base to derive practical recommendations on how to tackle the occupational health aspects of the problem, and offers evidence-linked discussion of important background concepts, including the importance of an accommodating workplace. The guidance is entirely appropriate for all health professionals involved in the clinical management of workers with back pain.

The bottom line

Back pain is amenable to management rather than prevention or cure. Early return to work following absence due to back pain is both desirable and possible. Much can be achieved through healthcare and employers working together to provide work-focused treatment integrated with accommodating workplaces, and offers significant cost benefits.

Undoubtedly, some individuals will require more structured rehabilitation, but they will be a small minority: there remains a need to develop appropriate services and facilitate access for workers who need additional help, as discussed in Dame Carol Black's review,

Working for a Healthier Tomorrow (www.tsoshop.co.uk). Meanwhile, Banji's story illustrates the potential benefits of all the players acting together from the outset.

Banji's story

My back problem cropped up again a few weeks ago, but this time it seemed worse, so I asked the doc to check it out. Probably muscular he said, and it should settle OK with some painkillers — no need to stop doing anything. That made sense — my dad had a dodgy back that flared up now and then, but it never laid him up. Anyway, after a week it was not any better and I could not manage at work. So back to the doctor. He said I needed some therapy. As it happens the firm has this arrangement with a local physio, so we agreed I would try that. One of my friends tried to tell me it must have been caused at work. That just had to be rubbish — I know I have got a physical job but I have been doing it for years and nothing has changed. I reckoned that all I really needed was some treatment to get my back working again. The physio agreed, and when I told her that my job could be made easier for a while, she said going back could actually help. The doctor wrote to my boss about what I could manage, and when I went in to see the people at work they were really helpful. A few weeks later I was back at my usual job.