EDITORIALS

The north–south incapacity divide

We know that work—or lack of it—has a profound impact on our health. Well-managed work allows full participation in our society, leading to better health, particularly mental health [1]. Conversely, unemployment or long-term absence from work is associated with reduced psychological well-being, and is an important determinant of inequalities in health among adults of working age in the UK. Forty-six per cent of households in the 10% most deprived areas have no one with paid work, compared with 33% of households elsewhere [2].

There are many more people on Invalidity Benefit (IB) than registered unemployed people. IB rates are much higher in the north and Wales and geographical patterns of IB are similar to the well-established pattern of health inequalities across the country [3]. For example, in Manchester, boys can expect to live ~8 years fewer and girls ~7 years fewer than their contemporaries in Kensington, Chelsea and Westminster [2]. Cause and effect are always difficult to establish but in this case one might easily assume that the sicknesses that cause people to be on IB are the same ones that cause them to die younger. This may well have been the case in the past, but now the most common reasons for IB are mental and behavioural disorders and diseases of the musculoskeletal system and connective tissue [3]. Put simply—stress and backache.

Given that these diseases do not kill very many people, it could be that the causality is beginning to run the other way and that IB is a sure way of holding the recipient in poverty and this is what causes the pattern of mortality. Certainly, those on IB are likely to have their income fixed at a ceiling that denies them many choices. If the government increasingly sees choice as the way forward on public health issues, then tackling the underlying drivers behind IB becomes a crucial strategic task if we are ever to make progress on inequalities [4].

Focusing entirely on the diseases named on certificates will probably not lead us to long-term solutions. IB claims arise from a complex interaction between the kind of work that people do and the management regime and conditions within which they do it, the society and culture that they live in, the medical condition that they may be suffering from and the NHS, particularly the general practitioner’s (GP’s) response to that illness. As an example it might be thought possible to reduce the numbers of people claiming IB on grounds of backache because it tends to be self-limiting and it has been shown that taking analgesics and being on the move is effective [5]. While this might sound possible, it will not produce a long-term solution if work conditions continue to be poor or if the range of services available to GPs continue to be limited.

GP’s need to be able to offer practical support to their patients and patients need to view work as something that they like doing. If work is something that patients want to avoid and GPs only have sick notes to offer, then IB rates will not reduce.

Why the north–south divide? It would be easy to see why it exists if we were dealing with ‘old industrial diseases’ related to heavy industry but harder to see for depression and backache. Is work really a lot more fun in the south? Are employers more tolerant of poor performance in the south? Are coping skills more common in the south? Are communities more supportive in the south?

The data on the Department for Work and Pensions web site [3] show another interesting trend, the age curve for IB is shifting to the left. Compared with a decade ago, there are more people in younger age groups on IB. This may be the result of a shift in the age structure of the workforce as a whole, but it flies in the face of other data about health where both life expectancy and health expectancy are rising—illness as a whole is shifting to the right. If work-related illness is going in a different direction then we need to know why.

The cost of IB runs into many billions and the tragedy of so many people supposedly sick and out of work must be addressed. A number of innovative schemes are being tried where the equivalent of the new health trainers described in Choosing Health are reaching out to people on IB to try and make the best of what skills they have and help them back into work. In addition, a proactive and flexible approach to rehabilitation by employers can prevent long-term sickness absence [6]. Simple pragmatic measures such as these seem sensible but surely it would be good use of public money to support research to really find out what is driving this. Schemes to get people back in work are worth having but we need to concentrate our efforts on preventing the problem. Of course, a comedian would say that if you pay people to be sick and not work then it is not surprising that they do not—and the people up north are just quicker on the uptake. The real answer may be more complicated but we need to find it.

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References


