Attitudes and barriers to employment in HIV-positive patients

A. J. Rodger¹,²,³, N. Brecker⁴, S. Bhagani¹, T. Fernandez¹, M. Johnson¹, A. Tookman³ and A. Bartley³

¹Royal Free Centre for HIV Medicine, Royal Free Hampstead NHS Trust, London, UK, ²Research Department of Infection and Population Health, Division of Population Health, University College Medical School, Royal Free Hospital Campus, Rowland Hill Street, London NW3 2PF, UK, ³Department of Public Health, Royal Free Hampstead NHS Trust, London, UK, ⁴Health and Work Centre, Royal Free Hampstead NHS Trust, Pond Street, London NW3 2PF, UK.

Correspondence to: N. Brecker, Health and Work Centre, Royal Free Hampstead NHS Trust, Pond Street, London NW3 2PF, UK. Tel: +44 (0)20 7830 2509; fax: +44 (0)20 7830 2512; e-mail: naomi.brecker@royalfree.nhs.uk

Background
Unemployment in the human immunodeficiency virus (HIV) population remains a major issue. Recent changes in the benefits system have triggered concerns about (re)integration into work for adults with HIV.

Aims
To examine attitudes and barriers to employment in HIV patients.

Methods
We undertook a cross-sectional study in the Royal Free HIV outpatient department from December 2008 to February 2009. The questionnaire collected data on demographics, date of HIV diagnosis, combination antiretroviral therapy, CD4 count, employment status, attitudes to work, psychological health and perception of barriers to employment. Logistic regression analyses were used to assess factors associated with not working.

Results
Five hundred and forty-five HIV patients took part. Overall, 26% were not working and of these, half (53%) had been unemployed for >5 years. Associations with not working were having been diagnosed with HIV >10 years before, poor psychological health and poor attitudes to employment. There was no association between objective measures of health (CD4 count) and employment status. Those not working were less likely to agree with that ‘work is good for physical and mental health’ (90 versus 97%; \( P < 0.01 \)) and more likely to agree that ‘should only work if 100% fit and well’ (76 versus 51%; \( P < 0.001 \)) compared to workers. Those currently not working had negative perceptions of their abilities to gain employment and to remain in work.

Conclusions
There are opportunities for HIV services to provide psychological support around attitudes associated with unemployment and to help HIV-positive men in particular obtain and remain in work.

Key words
Employment; HIV; interventions; psychological health.

Introduction
Combination antiretroviral therapy (cART) has transformed human immunodeficiency virus (HIV) infection from a terminal illness into a manageable chronic condition with greatly improved health, quality of life and life expectancies for HIV-positive patients [1]. As HIV primarily affects individuals of working age, unemployment in the HIV population remains a major issue even a decade after introduction of cART [2–5].

Employment is known to be a key determinant of health and being employed has positive benefits for mental and physical health. Individuals who are unemployed tend to be socially isolated and suffer more anxiety and depression [6,7]. Employment also reduces health inequalities and improves life chances for people and their families. Obtaining and maintaining employment is a major challenge for any individual with a chronic illness. However, positive benefits of employment have been demonstrated in one study, with employed HIV patients reporting better quality of life, even controlling for HIV disease severity, than those who were unemployed [8].

Changes in the benefits system have seen HIV recently reclassified as a long-term condition. For many HIV patients, the reality is a reduction in income through benefits, with an expectation of engagement in work-focused activities for people whose health status allows this.
The aims of this survey were to identify attitudes and barriers to employment in HIV patients and to explore with them what might be useful in helping them remain in or return to employment. This information would be used to inform future service development.

Methods

The Royal Free HIV Department is one of the largest in the UK and carries a caseload of over 2700 HIV-positive patients.

We undertook a cross-sectional questionnaire study in the HIV outpatients department over a 3 month period from December 2008 to February 2009, which allowed collection of data from at least 20% of the total clinic population. A study-specific questionnaire was given to patients as they attended for outpatient review in random general HIV clinics and was completed in the waiting room. Clinic staff assisted patients who experienced difficulties with self-completion for a variety of reasons, in a consultation room if needed. The questionnaire contained no patient-identifying data and patients were asked to place the completed questionnaire in a sealed container in the reception area. The questionnaire was piloted with 100 patients to ensure it was understandable and acceptable and was approved by the Patient Participation Group.

The demographic profile of respondents was matched against all patients aged 20–50 years under active follow-up to ensure we had obtained a representative sample for the study.

Free text options were available for a number of questions. Qualitative data were transcribed verbatim and grouped into themes. Thematic analysis was used to identify key issues, undertaken by several team members to ensure validation.

We used the Office of National Statistics definition of employment (anyone who does at least one hour’s paid work in the previous week or has a job from which they are temporarily away or who do unpaid work in a family business or are on government-supported training schemes) [9]. Logistic regression analyses were used to assess factors associated with being employed. Missing data were excluded from the analysis. Statistical analyses were performed using STATA (StatCorp. 2001. Stata Statistical Software: Version 11.0; StataCorp, College Station, TX, USA). All reported P values are two sided.

This work was designed to gather patient views to help make services more appropriate and acceptable for patient need. Advice was sought from our Trust’s Department of Audit and Effectiveness who determined that, as a service improvement survey, it did not need specific ethical approval.

Results

Over 3 months, 545 HIV patients aged between 21 and 50 years took part in the survey (Table 1). Almost half were aged between 41 and 50 years (n = 264, 48%) and most were of white ethnicity (369, 69%). Participants were more likely to be male than female (82 versus 18%). Just over half (272, 51%) were born in the UK, and of those who had been born overseas, most (142/262, 56%) had lived in the UK for >10 years. Socio-demographic features of our sample reflected the socio-demographic features of our total HIV clinic population suggesting minimal sampling bias. One-third of the sample (189, 36%) had been diagnosed with HIV for >10 years.

The majority (438, 83%) were on cART, and 86% had been on therapy for >1 year. Most had well controlled HIV, over a third had CD4 counts >500 mm$^3$ and only 12% had a CD4 count <200 mm$^3$. There was no significant difference in self-reported health status by CD4 count; 52% of those with CD4 count >500 mm$^3$ rating their health as good or excellent compared to 51% of those with CD4 count <200 mm$^3$. Health status also appeared to be stable; only 12% of participants reported their health had deteriorated in the past 3 months and 88% stated their health was the same or better.

Overall, 401 were working (74%) and 144 were not working (27%). This was not significantly different by gender (78% men and 73% women working). Over half (52%) were on some form of state financial benefits. Of those classed as working, 51% (n = 276) were in full-time paid employment, 9% (n = 50) in full-time self-employment, 4% (n = 24) in part-time paid employment, 5% (n = 25) in part-time self-employment, 3% (n = 16) were in training and 1% (n = 7) were looking after family dependents. In those currently employed, 73% were in professional jobs or managerial and technical positions, 20% in manual work and 1% in unskilled work.

Of those classed as not working (n = 144), 9% (n = 48) were self-classified as permanently sick/disabled, 3% (n = 33) as temporarily sick/disabled, 11% (n = 58) as unemployed and 1% (n = 5) had retired. CD4 counts were not significantly different between those working and those not working. Over half (53%) of those not working had been unemployed for >5 years. Only 14% had been unemployed for <1 year. HIV was either totally or partly the reason given in 66% of cases for stopping work.

After adjustments in a multivariate analysis, factors significantly associated with not working were length of time diagnosed with HIV (OR: 2.19; 95% CI: 1.24–3.85) for those diagnosed >10 years compared to those diagnosed within 1–5 years and poor self-reported health status (OR: 16.66; 95% CI: 5.38–34.69) for those classing their
health status as poor or fair compared to those who classed their health as excellent. There was no association of objective measures of ill-health such as CD4 count with employment status or any association with cART status (Table 1).

Those not working had significantly poorer psychological health than those working (Table 2). Those working were more likely to feel full of life ‘most or all of the time’ compared to than those not working (61 versus 29%, \( P < 0.001 \)). They were also less likely to ‘feel nervous’ (19 versus 41%, \( P < 0.001 \)), ‘down in the dumps’ (11 versus 35%, \( P < 0.001 \)), ‘worn out’ (22 versus 49%, \( P < 0.001 \)) or feel low (12 versus 42%, \( P < 0.001 \)) and more likely to regard themselves as a ‘happy person’ (71 versus 37%, \( P < 0.001 \)).

Those working were significantly more likely to agree that work was good for physical and mental health than those not working (97 versus 90%, \( P < 0.01 \)). The working group were also more likely to agree that employers are legally required to make reasonable adjustments to jobs and workplaces to help someone with a longstanding health problem remain in or get back to work (98 versus 90% \( P < 0.001 \)).

In terms of physical health and employment, only half (51%) of those currently working agreed that an individual should be at work only if 100% fit and well

<table>
<thead>
<tr>
<th>Age group (years) ((N = 545))</th>
<th>All ((N = 545))</th>
<th>Not employed ((N = 144)), (n(%))</th>
<th>Employed ((N = 401)), (n(%))</th>
<th>Unadjusted analysis</th>
<th>Multivariate analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OR (95% CI) for not being employed</td>
<td>( P ) value (LRT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OR (95% CI) not being employed</td>
<td>( P ) value (LRT)</td>
</tr>
<tr>
<td>21–30</td>
<td>55</td>
<td>12 (22)</td>
<td>43 (78)</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>31–40</td>
<td>226</td>
<td>50 (22)</td>
<td>174 (78)</td>
<td>1.01 (0.49–2.08)</td>
<td>0.64 (0.78–3.1)</td>
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<tr>
<td>41–50</td>
<td>264</td>
<td>82 (30)</td>
<td>182 (69)</td>
<td>1.33 (0.78–2.25)</td>
<td></td>
</tr>
<tr>
<td>Gender ((N = 529))</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>97</td>
<td>118 (27)</td>
<td>314 (73)</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>Male</td>
<td>432</td>
<td>21 (22)</td>
<td>76 (78)</td>
<td>1.33 (0.78–2.25)</td>
<td></td>
</tr>
<tr>
<td>Ethnic group ((N = 537))</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>370</td>
<td>101 (27)</td>
<td>269 (73)</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>Black African</td>
<td>94</td>
<td>23 (25)</td>
<td>71 (76)</td>
<td>1.14 (0.56–2.30)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>73</td>
<td>19 (26)</td>
<td>54 (74)</td>
<td>1.13 (0.66–1.93)</td>
<td></td>
</tr>
<tr>
<td>Time since arrival in UK ((N = 533))</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>UK born</td>
<td>272</td>
<td>79 (29)</td>
<td>193 (71)</td>
<td>1.17 (0.79–1.74)</td>
<td></td>
</tr>
<tr>
<td>Non-UK born</td>
<td>261</td>
<td>62 (24)</td>
<td>199 (76)</td>
<td>1.17 (0.79–1.74)</td>
<td></td>
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<tr>
<td>Diagnosed HIV (years) ((N = 529))</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>42</td>
<td>7 (17)</td>
<td>35 (83)</td>
<td>0.81 (0.31–2.1) ***</td>
<td>0.68 (0.25–1.82) *</td>
</tr>
<tr>
<td>1–5</td>
<td>176</td>
<td>32 (18)</td>
<td>144 (82)</td>
<td>1.64 (0.98–2.93) 1.54 (0.83–2.85)</td>
<td></td>
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<tr>
<td>6–10</td>
<td>122</td>
<td>33 (27)</td>
<td>89 (73)</td>
<td>2.64 (1.6–4.04) 2.18 (1.24–3.85)</td>
<td></td>
</tr>
<tr>
<td>&gt;10</td>
<td>189</td>
<td>67 (36)</td>
<td>122 (64)</td>
<td>2.64 (1.6–4.04) 2.18 (1.24–3.85)</td>
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<tr>
<td>ART ((N = 528))</td>
<td></td>
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<tr>
<td>Not on ART</td>
<td>90</td>
<td>19 (21)</td>
<td>71 (79)</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>On ART</td>
<td>438</td>
<td>118 (27)</td>
<td>320 (73)</td>
<td>1.37 (0.78–2.41)</td>
<td></td>
</tr>
<tr>
<td>CD4 count (mm(^3)) ((N = 462))</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;200</td>
<td>55</td>
<td>13 (24)</td>
<td>42 (76)</td>
<td>0.82 (0.36–1.87) NS</td>
<td></td>
</tr>
<tr>
<td>200–350</td>
<td>75</td>
<td>22 (29)</td>
<td>53 (71)</td>
<td>1.78 (0.40–1.52)</td>
<td></td>
</tr>
<tr>
<td>350–500</td>
<td>141</td>
<td>35 (25)</td>
<td>106 (75)</td>
<td>0.77 (0.41–1.46)</td>
<td></td>
</tr>
<tr>
<td>&gt;500</td>
<td>191</td>
<td>46 (24)</td>
<td>145 (76)</td>
<td>0.77 (0.41–1.46)</td>
<td></td>
</tr>
<tr>
<td>Self-reported health status ((N = 536))</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>68</td>
<td>6 (9)</td>
<td>62 (91)</td>
<td>1 ***</td>
<td>1 **</td>
</tr>
<tr>
<td>Very good</td>
<td>180</td>
<td>23 (13)</td>
<td>157 (87)</td>
<td>1.55 (0.604–3.99) 1.46 (0.56–3.82)</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>180</td>
<td>50 (28)</td>
<td>130 (72)</td>
<td>4.04 (1.64–9.91) 3.89 (1.57–9.69)</td>
<td></td>
</tr>
<tr>
<td>Fair/poor</td>
<td>108</td>
<td>62 (57)</td>
<td>47 (436)</td>
<td>13.77 (5.50–34.49) 16.66 (5.38–34.69)</td>
<td></td>
</tr>
</tbody>
</table>

LRT, likelihood ratio test. *\( P < 0.05 \); **\( P < 0.01 \); ***\( P < 0.001 \).
compared to 76% of those not in work ($P < 0.001$). Only one-fifth of those working thought that once someone has been off work for at least 6 months, there was a 90% chance of never returning to any form of work compared to almost half of those not working ($P < 0.001$). Almost all those in work (99%) disagreed with the statement that being HIV positive means they should not have to work compared to 90% of those not in work ($P < 0.001$).

We found that those currently in work perceived little in the way of barriers to their employment. Almost all (345, 86%) did not consider that they had been stigmatized for their condition by work colleagues, although almost two-thirds (253, 63%) had not disclosed their HIV status to their employers. Those of black African ethnicity were significantly less likely to disclose their status to work colleagues than those of white ethnicity (21 versus 42%, $P < 0.05$). One-third (150, 37%) did agree that being in work hindered them getting to hospital and other appointments needed for the care of their condition. Almost all (378, 94%) agreed that they needed to stay in work for financial reasons but also that work was an important part of their life, they enjoyed their work (374, 93%) and that they intended to carry on working (383, 96%). No barriers to remaining in employment were identified by 83% (333) (Figure 1).

Those currently not working (144) had negative perceptions of their abilities to gain employment and to remain in work (Figure 1). Two-thirds (92, 64%) agreed with the statement that they ‘would not be successful in getting a job because of their condition’. Over half (81, 56%) agreed that they had been away from work too long and no longer had the skills needed to return to work. Only 20% agreed with the statement that state benefits provided all the income they needed. Almost three-quarters (105, 73%) agreed that fluctuations in mood made it difficult to work and 70% felt that they would not be able to cope at work because of symptoms experienced from their condition. Being stigmatized for their condition by colleagues at work was a major concern for 83% and just under half (63, 44%) had concerns that being in work would hinder getting to hospital and other appointments needed for their care. Overall, 78% of those currently not working felt there were significant barriers that prevented returning to work.

### Table 2. Psychological health in those working and not working

<table>
<thead>
<tr>
<th>Agreement with the following statements</th>
<th>All</th>
<th>Not working ($N = 144$), $n$ (%)</th>
<th>Working ($N = 408$), $n$ (%)</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you full of life?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>290</td>
<td>42 (29)</td>
<td>248 (61)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>116</td>
<td>59 (41)</td>
<td>57 (14)</td>
<td></td>
</tr>
<tr>
<td>Are you a very nervous person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>136</td>
<td>59 (41)</td>
<td>77 (19)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>284</td>
<td>49 (33)</td>
<td>235 (58)</td>
<td></td>
</tr>
<tr>
<td>Have you felt so down in the dumps nothing would cheer you up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>95</td>
<td>51 (35)</td>
<td>44 (11)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>317</td>
<td>50 (35)</td>
<td>267 (65)</td>
<td></td>
</tr>
<tr>
<td>Do you feel calm and peaceful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>228</td>
<td>30 (21)</td>
<td>198 (49)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>135</td>
<td>59 (41)</td>
<td>76 (19)</td>
<td></td>
</tr>
<tr>
<td>Do you have a lot of energy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>246</td>
<td>29 (20)</td>
<td>217 (53)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>126</td>
<td>61 (42)</td>
<td>65 (16)</td>
<td></td>
</tr>
<tr>
<td>Do you feel downhearted and low?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>110</td>
<td>61 (42)</td>
<td>49 (12)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>267</td>
<td>39 (27)</td>
<td>228 (56)</td>
<td></td>
</tr>
<tr>
<td>Do you feel worn out?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>160</td>
<td>70 (49)</td>
<td>90 (22)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>196</td>
<td>34 (24)</td>
<td>162 (40)</td>
<td></td>
</tr>
<tr>
<td>Are you a happy person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>341</td>
<td>53 (37)</td>
<td>288 (71)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>70</td>
<td>34 (24)</td>
<td>36 (9)</td>
<td></td>
</tr>
<tr>
<td>Do you feel tired?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most or all of time</td>
<td>215</td>
<td>87 (60)</td>
<td>128 (31)</td>
<td>***</td>
</tr>
<tr>
<td>None or little of time</td>
<td>143</td>
<td>21 (15)</td>
<td>122 (30)</td>
<td></td>
</tr>
</tbody>
</table>

Proportion (%) of those not working and working agreeing that the above statements apply. ***$P < 0.001$. **OCCUPATIONAL MEDICINE**
Fifteen percent (n = 22) of those unemployed did not want any information or advice to assist with obtaining employment. The other 85% wished to have a range of advice provided, with the majority wanting individual employment counselling. One-quarter (23%) wanted information on skill development, 19% wanted information on volunteering, 17% wanted individual occupational health advice and 13% wanted seminars on employment issues. Over 20% wanted general advice from the doctor or nurse as part of their HIV consultation.

Two-thirds (65%) wished to have information and advice on employment from the HIV clinic, as opposed to other settings. In terms of help and advice, patients wanted specific advice on how to explain gaps in their curriculum vitae, how to promote themselves to a prospective employer, negotiating time off for appointments, discrimination laws and benefits advice.

**Discussion**

We found that 73% of female HIV patients and 78% of male HIV patients were working. This compares to national UK employment rates of 76% in women and 89% in men in 2008, indicating that male HIV patients in particular have lower rates of employment than the national average for this age range [9]. Rates of unemployment in HIV patients in this study were comparable to that in chronic illnesses with recognized disability such as rheumatoid arthritis [10] but lower than in other disabling conditions such as multiple sclerosis [11].

Significant factors associated with not working were poor psychological health, a subjective assessment of health status as ‘poor’ and being diagnosed with HIV for >10 years. We found no association between employment status and any objectives measure of physical ill-health such as low CD4 count, suggesting that physical health is not the primary barrier to employment in our patients. This is supported by our finding that only 10% of those not working rated their physical health as poor.

There were high levels of psychological morbidity consistent with reported associations between poor mental health and HIV [12,13]. Low mood was reported in almost half of those not working compared to only a 10th of those in work. Similarly, half of those not working reported feeling ‘worn out’ compared to only a fifth of those in work. The association between chronic disease and depression is well documented and could have an impact on employment [14]. Although we asked validated questions for psychological well-being (based on the SF-36), we did not specifically enquire about treatment of mental health problems.

We found that stigma and fear of discrimination was a concern for almost half of those not working. However, only 11% of those in employment reported stigma and discrimination, indicating a gap between
perceptions and reality of stigma in the workplace. Almost two-thirds of those in employment had not disclosed their HIV status to their employer, although a higher figure might have been expected as employees are entitled to confidentiality and, for most jobs, are not required to disclose their condition. Those of black African ethnicity were less likely to have disclosed status, which may reflect the increased expectation of stigma in African communities to a diagnosis of HIV [15,16].

Negative attitudes to work were significantly more likely in those not working. In terms of the responsibility to work, almost 10% of those not working thought that being HIV positive per se should mean they did not have to work compared to only 0.1% of those in work. Over half of unemployed patients had not worked for >5 years. Patients more recently diagnosed with HIV were more likely to be employed, which is likely to reflect changing attitudes to continued employment following a diagnosis of HIV in the era of anti-retroviral therapy (ART).

Most (85%) of those not working wanted help with obtaining employment, the majority wanting individual employment counselling provided in the HIV centre. Our study is the first one, to our knowledge, in the UK to study employment rates and barriers to employment in HIV-positive patients of working age (20–50 years). Our findings are similar to those reported in other cross-sectional studies that are predominately from the USA. Poor psychological health, objective health concerns such as fatigue and low energy and job skills deficit are reported as the major barriers to returning to employment in the HIV-positive population rather than physical ill-health [2,5]. Our finding of fear of discrimination is also commonly reported as a factor preventing HIV-positive patients from returning to work in the USA [5,17].

Limitations of our study include potential inconsistencies and bias from self-reported anonymized data. We did not collect information on diagnosed co-morbidities (including mental health problems) or confirm the validity of the self-reported information through other routes. However, we did not find objective evidence of more severe physical ill-health or advanced immunosuppression in those not working, and CD4 counts, age, ethnic group or ART status were not significantly associated with not working. Self-rated reports of poor physical health were similar in those working and those not working. However, those not working were more likely to report a low mood. Studies with prospective follow-up report concerns about being able to return to work for HIV-positive patients increasing with time since last employment and that health concerns negatively predicted motivation to return to work [17,18].

As a result of the advent of cART, HIV has been transformed over the past decade from an almost certainly terminal illness to a long-term chronic condition with good health for the majority and near-normal life expectancies. For patients (mainly men) diagnosed in the early years of the epidemic, the cognitive shift from limited life expectancy to likely decades of a full and productive life is likely to have been challenging. Being classed as unfit for work has a major negative effect on individuals [19] and people diagnosed in the early 1990s were told they would always be unfit for work. Decades later both HIV patients and their health care providers may be reluctant to revisit this perception, even if patients remain in good health.

While there are also compounding factors for some patients with HIV, such as substance misuse and mental illness, both of which are significant barriers to successful employment [13,20,21], there is good evidence for the positive benefits of work on health and well-being [6]. Assistance is needed to help patients with HIV address barriers that may prevent them from seeking employment, including psychological interventions to increase motivation to re-enter the workforce, information on support available while working, strategies for disclosing HIV status and the protection afforded by the Disability Discrimination Act [2].

While the most commonly identified employment barriers for HIV-positive patients are well described, there is less on successful interventions for assisting HIV-positive patients return to work [2]. A multidisciplinary approach is likely to be needed, addressing both physical and psychological barriers to working, including overcoming perceived barriers to work, increasing confidence and motivation to work and facilitating skills training and work placement [22]. The potential for the doctor–patient relationship in HIV to help promote a return to employment should be considered, with discussion part of the routine HIV consultation.

This study has important implications not only for our own service but also for HIV services around the UK. There are clear indications for HIV services to be more proactive in helping patients obtain and remain in work and in offering psychological support around attitudes associated with unemployment. HIV services need to consider providing employment advice, scheduling appointments to suit working times and addressing perceptions around stigma and confidence. In our own service, following a successful multidisciplinary team workshop to discuss the implications of the study for service delivery, a working group (including patient representatives) has been set up to explore options for supporting patients to remain in or (re)enter work.
Key points

- Physical health is not the primary barrier to employment for many people living with human immunodeficiency virus. However, those not working were found to have significantly poorer psychological health than those working.
- Negative perceptions about work were more likely in those currently not working who feared stigma at work and problems getting time off to attend health appointments but this was not the reality for the majority of those currently working.
- There is a role for human immunodeficiency virus services in helping support patients obtain or remain in work (and work-type activities), including psychological support around attitudes associated with unemployment, addressing perceptions around stigma and confidence, providing access to employment advice and scheduling appointments to suit working times.

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Conflicts of interest

None declared.

References