In this issue of *Occupational Medicine*

That the workforce and the workplace have changed across a generation is by now too common a commonplace to remark upon in these pages. Regardless of how frequently we may be reminded of this, it remains incumbent on us to understand how and why the workplace has changed to accommodate those it previously excluded, so that these lessons accompany us into the future. Among the more remarkable shifts is the participation of previously excluded or marginalized groups in work; workers who because of age or illness were never considered as able to contribute to society via employment. Whether through altered legal frameworks, improvements in medical therapy, shifts in societal beliefs, or changes in work itself, we all now see employees with disorders previously considered so debilitating, or even fatal, that engagement in productive work was never seriously considered. Both the causes and the consequences of these shifts are worth considering for what they tell us of the future of work and workers, and how we evaluate the capacity of many to engage with it.

In common with many of this journal’s readers, I suspect, my training was quite clear that cystic fibrosis (CF) was an early-onset and uniformly fatal disorder. Most of the afflicted were unlikely to complete an education, let alone graduate into the workforce. This month's article by Targett and colleagues [1] not only notes that 65% of subjects recruited from CF centres in Britain were currently in work or education, but finds them working in essence a full work-week, with a mean of 37.3 hours employed per week. Aside from educational attainment, employment of CF patients was more strongly associated with locality, and with health and role perceptions, and much less with measures of current health status such as pulmonary function indices. Of interest, fewer than half of employed respondents with CF had received any advice on working, and only 6% saw formal occupational health guidance. The difference between past perception and current capacity is striking. Although we have been long aware of the importance of factors such as health perception in the rehabilitation of conditions such as back pain, this suggests that we still have a long road to travel as we grapple with judging work capabilities in those with chronic disease who now find themselves ready to enter working life.

Older workers are a second set of subjects who may be excluded or phased out of current work. Well-described declines in physical strength, flexibility, and cognitive capacity may lead us to conclude that productivity becomes lower and injury risk becomes higher as the workforce ages. Guest et al. [2] address these questions by examining a worker population from an Australian aluminium smelter. Their findings are provocative, since workers do not appear to ‘age-out’ into managerial or supervisory work later in their employment in this traditional heavy-industrial worksite. Overall annual injury rates were 75% higher in the under-30 age group compared with the workers over age 50, without evidence for higher rates of injury in older workers in most domains, particularly in the most commonly reported area of sprains and strains. Vulnerability from age and reduced physical capacities may be outweighed by experience, judgment, and willingness to continue in work, with the benefits which may accrue to the employers who are flexible and attuned to their older workers’ strengths.

Sedlatschek [3] provides additional perspective on these questions in an accompanying editorial that examines both workforce aging and work-related stress. Referencing a poll by the European Agency for Safety and Health at Work, she notes that we may be slow to take on board the findings that we see in the articles discussed above as well as the evidence across the past decade that tells us the older workforce will be growing and that insecure and contingent work represent an ongoing threat to healthy employment. Finally, Sealy [4] provides a concise, informative, and thoughtful approach to vestibular assessment and the complaint of dizziness, a common problem in the older worker. A strategy of rehabilitation and a graded return to the workplace can serve as a template for many other conditions, and guide us back to the importance of workers’ health perception as a determinant of work capability.

**John Meyer**

*Assistant Editor*

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**References**