Sickness absence and musculoskeletal disorders

What can be done?

Maintaining work when possible during ill health and returning to work without delay after sickness absence are important for the social and economic well-being of both the individual and society [1, 2]. Work appears to be associated with better health than worklessness and may bring net health benefit both physically and mentally [3].

Musculoskeletal disorders and their resulting disability are common within the workforce worldwide, representing a major cause of sickness absence and often leading to long-term absence. In the UK during 2009–10, an estimated 572,000 people (2% of the working population) reported a musculoskeletal disorder that they believed was either caused or aggravated by their work [4], taking an average of 13.4 days off work each. Of the 2.5 million people receiving incapacity benefit, a UK entitlement for an individual of working age who is not entitled to statutory sick pay [5], some 9% of the working-age population, ~25% was attributed to musculoskeletal disorders. Due to the personal and societal burdens and costs and the health consequences of job loss, effective strategies are needed to guide the employment, health care and vocational rehabilitation of these people. There is now a concerted effort across Europe to address these problems [2, 6].

A recent review identified that few data link the clinical course and management of illness and injury with disability status and employment [7]. Few clinical assessments include measurements of disability or relate clinical status formally to activities of daily living. Generally, the effectiveness of clinical interventions on disability and working life is not known. An important exception is RA, where early diagnosis and prompt treatment can greatly influence progress of the disease and disability [8]. Studies also suggest that the risks of symptoms and disability—and non-employment—are influenced by individual psychology and by societal beliefs and expectations [9]. This has led to an important new research focus in occupational health, investigating the influence of cultural and psychosocial factors on responses to illness and work [10].

Although vocational rehabilitation reaches beyond health-care needs alone, health-care professionals are key in helping people stay in or return to work. Primary-care doctors are especially important, as their advice can have a major impact on whether an individual takes sickness absence and if so, for how long, what steps they take to return to work, and on the challenges to restoring and maintaining the best possible working life. Clinicians are also in optimal positions to establish links with employers and occupational health services; for example, to enable health-care arrangements that might not impinge on working time. Where wider psychosocial concerns arise due to illness and sickness absence, the clinician can help engage with multidisciplinary agencies to address such matters.

In the UK, to enable their patients on sickness absence to claim social security or statutory sick pay, National Health Service primary care doctors issue a statement of fitness for work [11], which provides advice to both patient and employer on the functional effects of the patient’s condition. This new revised ‘fit note’ offers a fresh emphasis, identifying what a patient can do with adaptations rather than what they cannot. These approaches, often supported by interventions to aid rehabilitation, are increasingly reflected in guidance and developing practice in other developed countries, irrespective of their welfare systems [6, 12, 13].

As the long-term consequences of prolonged sickness absence, including lost contact with the workplace, become better known, the importance of early concerted intervention, covering therapeutic, vocational and psychosocial needs, has also been identified. Delays to treatment might be harmful if reinforcing a mistaken belief that return to work should be deferred or by aggravating the psychological and social impediments that compound the presenting problem.

Naturally, physicians give most attention to their patients’ chief concerns: diagnosis, treatment and clinical care. However, I believe that too few of us appreciate the interplay between health problems, the workplace and conditions of work, or impact of illness and injury at work upon function and well-being. Most patients do not expect this to be part of our expertise. Fortunately, this is set to change: the 2008 Black Review [2] has already stimulated a fresh engagement with UK health professionals in vocational issues integral to clinical management. Major professional bodies have published a consensus statement committing to educating the health-care community, employers and people of working age about the benefits that work can provide and to help people enter, stay in or return to work. Fit for Work Service pilots are testing a case-managed, multidisciplinary approach for individuals in the early stages of sickness absence. These pilots combine health care and employment services with wider support such as debt and housing services. We await with much interest the results from these exciting pilots.

The high prevalence of musculoskeletal problems among the working-age population poses considerable
challenges, but it also provides an opportunity for rheumatologists to move to centre stage. Success in addressing this will be crucial not only to enhance the quality and health of our patients’ lives, but also that of society in general.

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