Worklessness and Health: A Symposium

Where we were; where we are now: an overview

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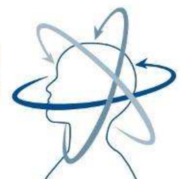


Where we were:

- The Predominance of the mechanistic Medical Model of Disease, Illness and Disability:
- A Fault in the machine that should be fixed.
- Disease Model (Virchow, 1858):

❖Symptoms and signs	–History/examination
❖Infer pathology	–Diagnosis
❖Apply therapy	–Treatment
❖Expect recovery	–Cure

Medical Model:

- **The assumed relationship between health condition, healthcare and (in)capacity:**

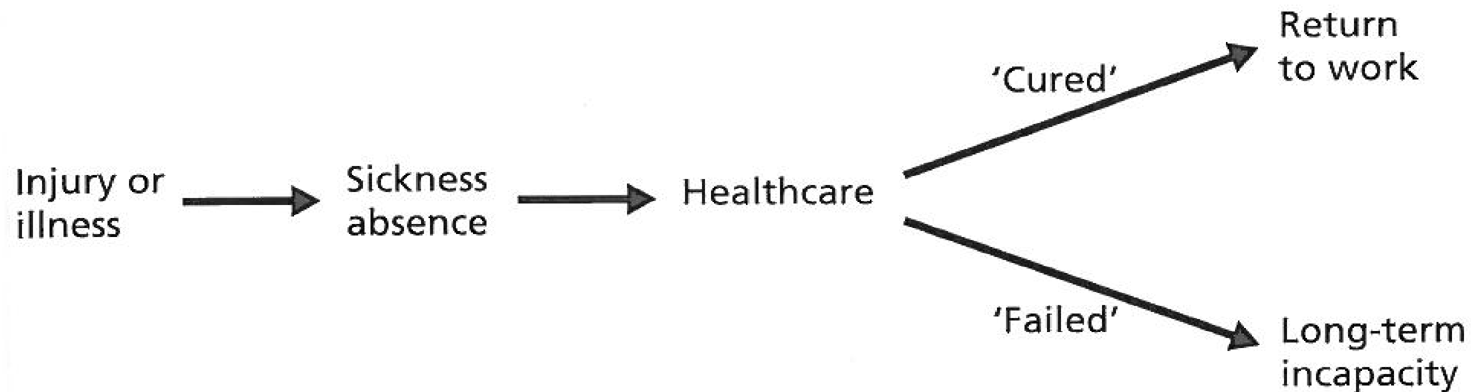


Figure 3 Medical model: the assumed relationship between health condition, healthcare and (in)capacity.

- **All symptoms mean injury or disease: cure is the (only) route to return to work**
- **ICIDH: assumes causal Relationship (WHO,1980)**

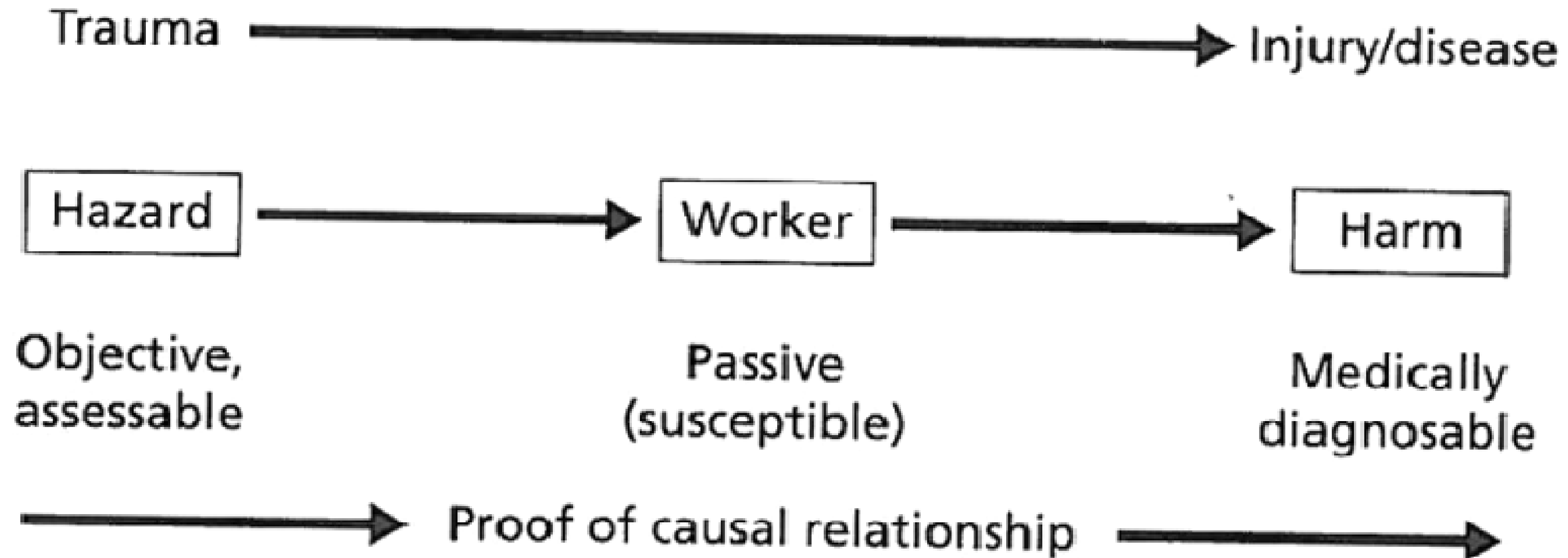
Prussian Paradigm of Workers' Compensation (Medical Model) [1]

Clinical/Administrative Decision:	Criteria:
• Determines cause of health condition	• Injury? Disease? Work-related?
• Has it reached a permanent state?	• Can anything be done to treat or rehabilitate? [2]
• Assess present (partial) disability	• Objective evidence of impairment
• Provide Financial Support/compensation	• Mainly on incapacity for work

1. Adapted from Hadler (1997)
2. UK Workers compensation/social security did not emphasize rehabilitation (Waddell, Aylward and Sawney, 2002)

How we thought about work and health:

- **The Traditional Occupational Health Paradigm:**



- **Work is a potential hazard which risks injury or disease**
- **If a patient fails to recover, the model is less effective and appropriate (Schultz et al, 2000)**

A Change in Thinking:

Medical Model:

- Less comfortable with mental illness
- Crippling weakness: failure to include unique human attributes and subjective experiences (Engel 1980, Peters 1996)
- Cartesian dualist, reductionist and deterministic
- Limited validity for symptoms in absence of identifiable disease
- Fails to explain trends in long-term absence and chronicity

The 'Whole Person' Revisited: Main Determinants of Health

- **Aristotle and Hippocrates: lifestyle, behaviours, social & physical environment**

- **Engel (1977,1980):**
  - **the Bio-psycho-social model for healthcare**
  - **Shift of focus: disease to illness**
  - **Dynamic systems approach**

- **The contemporary, integrated BPS model of human illness (Kiesler 1999, Mead & Bower 2000, Glouberman 2001, Waddell & Burton 2004)**

- **The public health perspective (Marmot 2004)**

Paradoxes[1]

- The typical benefit recipient (perception – vs – reality)
- The health paradox (improved health – vs – IB trends)
- The failure to recover (clinical recovery – vs – poor work outcomes)
- Disability Rights – vs – benefit dependency
- Patient advocacy – vs – beneficial effects of work
- Inequality paradox: economic prosperity – vs – widening socioeconomic gap

1. Waddell G, Aylward M (2005). The scientific and conceptual basis of incapacity benefits. TSO: London

The Psychosocial Dimension

- **Almost anytime you tell anyone anything, we are attempting to change the way their brain works**
- **How people think and feel about their health problems determine how they deal with them and their impact**
- **Extensive clinical evidence that beliefs aggravate and perpetuate illness and disability[1] [2]**
- **The more subjective, the more central the role of beliefs [3]**
- **Beliefs influence: perceptions & expectations; emotions & coping strategies; motivation; uncertainty**

- [1] Main & Spanswick, 2000. [2] Gatchell & Turk, 2002.[3] Waddell & Aylward

Cardiff Health Experiences Survey (CHES): Face-to-Face Interventions [N=1000] GB population:

	Open Question:	Inventory:
Musculoskeletal	13.5%	32.5%
Mental Health	7.5%	38.5%
Cardio-respiratory	3.6%	11.9%
Headache	2.9%	24.8%
G/I	2.4%	7.8%
Without any complaint	72.9%	33.6%
At least one complaint	20.6%	66.4%
2 or more complaints	8.4%	26.3%

Severity of main complaint greater for open question than inventory

Symptoms:

- **Symptoms: subjective bodily or mental sensations that reach awareness and are generally "bothersome" or "of concern" to the person.**
  - **clinical representation/manifestation of disease**
  - **associated with normal or unaccustomed activities of daily living**
  - **unassociated with any identifiable disease [1,2]**
  - **ubiquitous and omnipresent [3,4]**
  - **limited correlation with illness, disability and (in) capacity for work [5,6]**

1. Ursin H: 1997
2. Deyo RA et al : 1998
3. Eriksen H et al: 1998
4. Buck R et al: 2009
5. Waddell,G: 2004
6. Waddel G, Aylward M : 2005

Common Health Problems: Predominantly Subjective Health Complaints

Illness Behaviour: What ill people say and do that express and communicate their feelings of being unwell:

- **Subjective Health Complaints have a high prevalence in the working-age population**
- **Not solely dependent on an underlying health condition (the limited correlation)**
- **People with similar symptoms (illnesses) may or may not be incapacitated**
- **Consumption of health care disproportionate.**

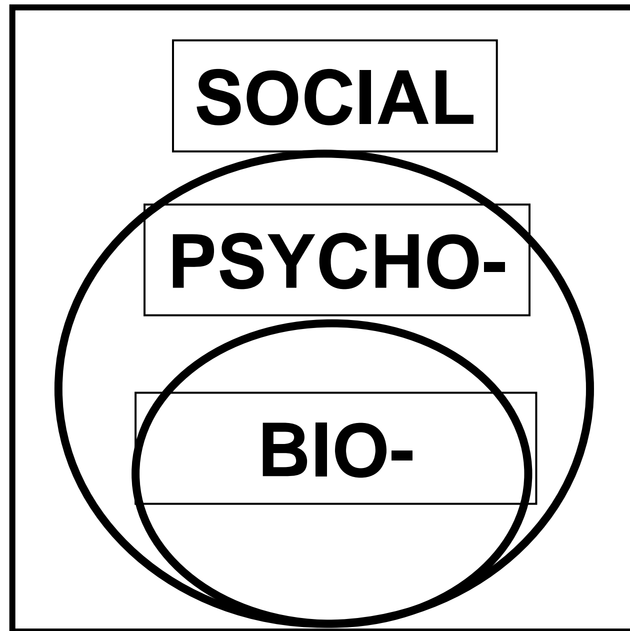
Common Health Problems: disability and incapacity

- **High prevalence in general population**
- **Most acute episodes settle quickly: most people remain at work or return to work.**
- **There is no permanent impairment**
- **Only about 1% go on to long-term incapacity in UK**

Thus:

- **Essentially people with manageable health problems given the right support, opportunities & encouragement**
- ***Chronicity and long-term incapacity are not inevitable***

Why do some people not recover as expected?



- Bio-psycho-social factors may aggravate and perpetuate disability
- They may also act as **barriers to recovery & to return to work**

Cardiff Research: Findings:

Principal negative influences on return to work:

- **Personal / psychological:**
  Catastrophising (even minor degrees)
  Low Self-Efficacy
  Belief that “stress” is causal factor
- **Social:** Lone parents / unstable relationships
  “Victim” of modern society
  Rented or social housing
- **General Affect:** Sad or low most of the time
  Pervasive thoughts about personal illness

Cardiff Research: Negative Influences:

- **Occupational:** Job dissatisfaction
  Limited attendance incentives (esp. work colleagues)
  Attribution of illness to work
- **Cognitive:** Minimal health literacy
  Self-monitoring (symptoms)
  False beliefs
- **Economic:** Availability of alternative sources of income / support

Negative Influence on Return to Work: Principal RTW barrier exhibited in study population (%)

Ranking the Barriers:

	*%	Rank:
• Psychological/Cognitive	38%	1
• Work place	32%	2
• Social	11%	3
• Economic	9%	4
• Symptom Perception (esp: pain, fatigue)	7%	5
• Impaired Function	3%	6
	100 %	

Cardiff Research: Positive Influences

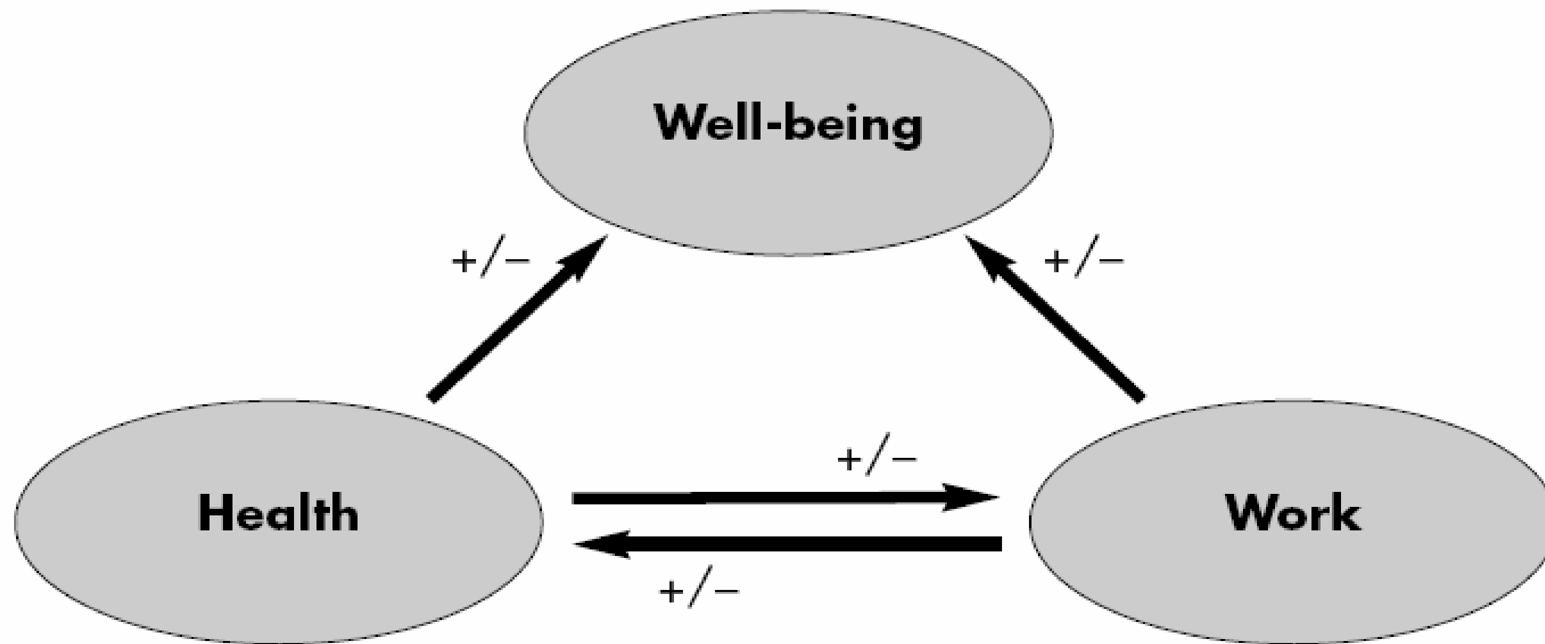
- Respect for employer
- Job satisfaction
- Strong health literacy
- Moral obligation
- Positive attendance incentives (especially: work colleagues)
- Well managed chronic health condition

What Do We Know Now:

- Barriers to recovery and return to work are primarily personal, psychological and social rather than health-related “medical” problems.

- Workplace culture and organisational features dominate.

Work and health



Possible causal pathways between health, work and well-being

WORKLESSNESS

- Worklessness is:

  destructive to self-respect

  risks poor health (physical and mental)

  thwarts the pursuit of happiness

  handicaps achievement of well-being

Is Work Good for your Health and Wellbeing? (Waddell & Burton, 2006)

YES:

- **Strong evidence: Work is generally good for physical and mental health and wellbeing**
- **Reverses the adverse health effects of unemployment**
- **Beneficial effects depend on the nature and quality of work and its social context**
- **Jobs should be safe and accommodating**
- **Moving off benefits without entry in to work associated with deterioration in health and wellbeing**

Without work all life goes rotten, but when work is soulless, life stifles and dies.

Albert Camus

Social Contexts of Economic Inactivity

- Work is central to well-being and correlates with happiness
- Disadvantage is cumulative: prioritise transition to a more advantaged trajectory
- It is never too late, and always good sense to offer a helping hand[1]
- Illness or disability which impairs work persistently reduces life satisfaction[2]

1. Blane D, 1998
2. Schulz & Decker, 1995

UK: The workplace

There is poor understanding of health and well-being initiatives that employers can implement :

- **Many employers are unaware of the business case for investing in health and well-being**
- **Employers often do not have sickness absence policies to enable early and sustained return to work**
- **Many employers have no policy on handling mental ill-health**

  - 60% of line managers underestimate the percentage of the UK population that experiences mental ill-health

The objective: Early Intervention to Prevent Worklessness:

- **Multi – disciplinary integrated approach at the outset**
- **Health professionals <u>and</u> employers confident about health and work links**
- **Health professionals, employers and multi-disciplinary services work together to achieve sustained return to work**
- **Line managers, in particular, need to be better trained to:**
  - **Detect and respond to early signs of ill-health**
  - **Protect the physical and mental health of workers**

Prevention and Management:

- Beliefs, perceptions and personal responses lie at the heart of the problem
- Move away from a “one size fits all”
- Develop organisational and individual interventions
- Key role of line managers-the prism through which climate is perceived by employers
- Early detection: early return to sustained work

Condition Management: Principal Findings

- **Rather than aiming for control of health condition, successful outcomes dependent on learning process towards self management, confidence building and independence**
- **Significant improvements in confidence and coping, independent of changes in health condition, engender successful work outcomes**
- **Work outcome highly dependent on critical elements of the support and management package and the context in which it is delivered**

Where Are We Now?

- **Obstacles to recovery and return to work are primarily personal, psychological and social rather than health-related "medical" problems.**

Culture Change: Where to go?

“ **Much sickness and disability should be preventable. Better management is an immense challenge, but one that is crucially important to everyone of working age, their families and society.**

It can be achieved, but only be fundamental change in our approach and by all stakeholders working together towards common goals.

The biopsychosocial model provides the framework and the tools for that endeavour” *

* Waddell and Aylward, 2010

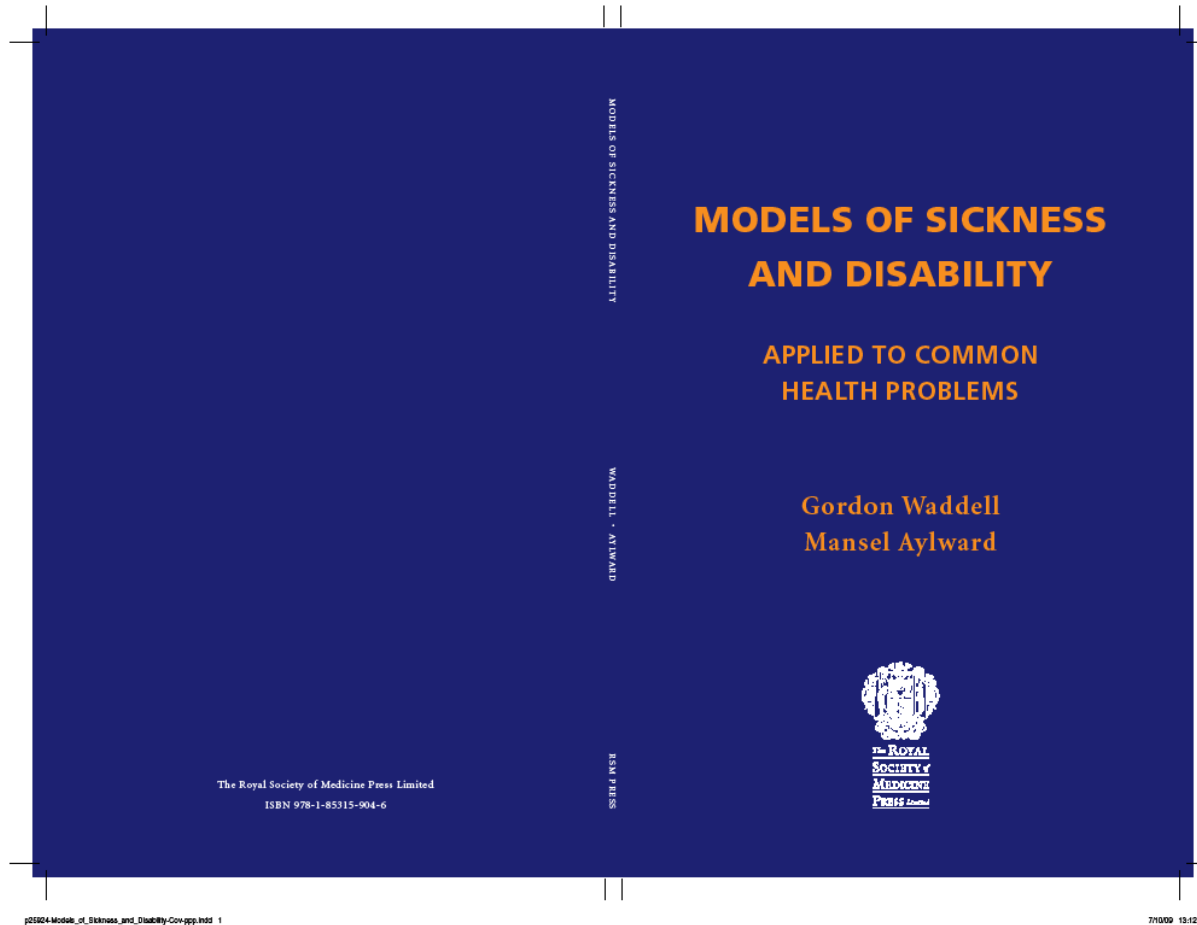
Our Challenge:

There is no greater modern illusion, even fraud, than the use of the single term work to cover what for some is dreary, painful or socially demeaning and what for others is enjoyable, socially reputable and economically rewarding

The Culture of Contentment

JG Galbraith

Models of Sickness and Disability



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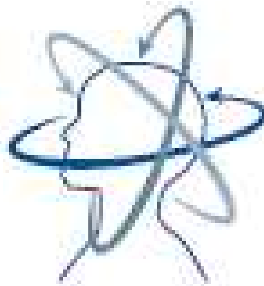

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