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Rehabilitation: Current Thoughts and Activity on Employing the "Unfit"

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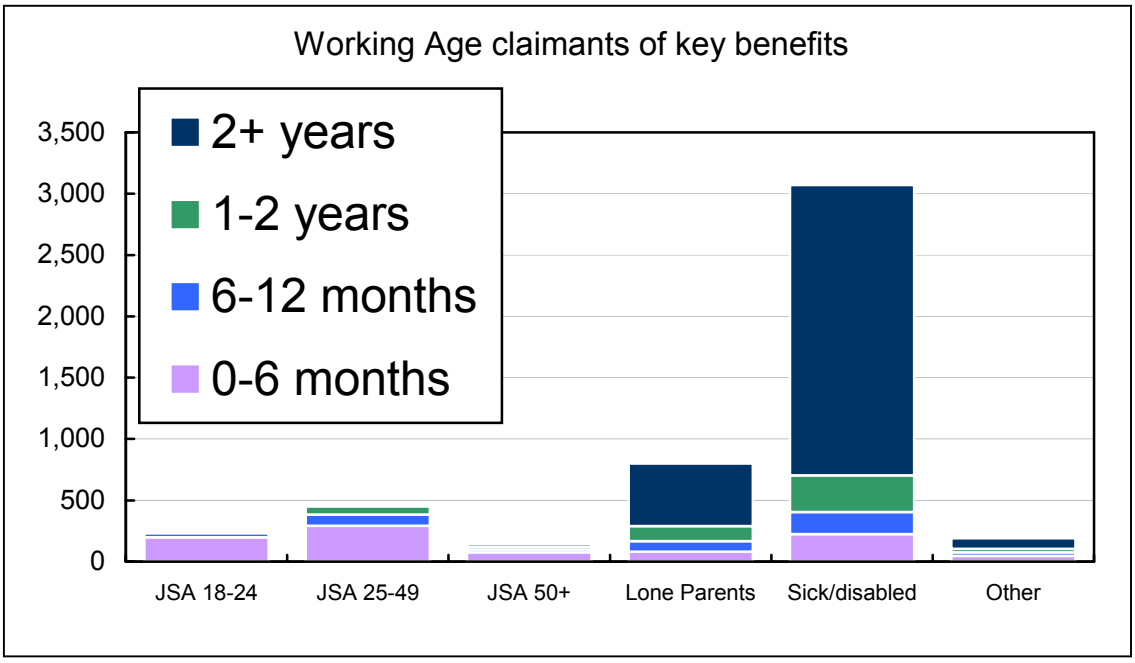
Nery Williams has previously served as Head of EMAS, and had also been BHSEA Vice-President (President-elect) before leaving for another part of the Department of work and Pensions about two years ago. He added that she was now a Principal Occupational Physician in the Department of the Chief Medical Advisor, within the DWP.

Nerys started by describing the "Big Picture" surrounding this increasingly important field and why employers would change their attitude to "fit" or "unfit" employees. She then touched on the reasons why rehabilitation is such a problem, what the government is doing, in contrast to what employers can do, together with what guidance is currently available. Within the UK, the crucial labour statistics were: -

- UK Population 60 million
- Working Age Population 37 million
- Unemployed population 900.000
- Incapacity benefit claimants 2.64 million

The latter figure for incapacity claimants was most worrying for the government because of the demographic change resulting in old age dependency rising from 24% in 2000 to 50% in 2050. The potential impact of this is a massive drop of 20% in GDP. In addition, 75% of people of Working Age are employed, whereas only 47% of disabled people are in work.

Surveys across the world are very difficult to compare because of differences in benefit design, definitions of disability and methodologies. Broadly speaking, however, economic activity due to ill health is a common factor and we need to bring in people normally seen to be outside the labour market.



JSA – Job Seekers Allowance

This slide shows the current situation after the efforts we have made since 1997. On the left are people on unemployment benefit. Then come Lone Parents, and finally those on inactive benefit, before a small group of 'others'. The unemployed are now a minority of those of working age on benefits, and their numbers are about equal to the number of job vacancies. The big group to tackle on our way to 80% employment is that of the sick and disabled, and particularly those on benefit for more than two years.The various changes taking place required a balance to be established between them: -

- Numbers working and those dependent
- Increase in numbers of elderly to support
- Increase in number of people supported for longer
- Increase in healthcare and social care costs
- Expectations of availability of level of health and social care
- Expectations of age of retirement

Factors influencing Entry

- Reduced birth rate (now 1.4)
- Increase in student education (enter workforce later)
- Immigration

Common health conditions

- Early /Ill health retirement
- Attitudes and expectations
- £ commitments
- Poorly performing pension plans
- Pension legislation
- Age Discrimination legislation (October 2006)

The result of all these is that we need to increase working age population employment rate to 80% (Lisbon Agreement) by getting 1 million to work beyond Statutory Pension Age (SPA) and 1 million on Invalidity Benefit (IB) to find work. This would be assisted by giving more support to jobseekers and lone parents, with ***more*** people ***working*** longer!

Nerys went on to say that employers were already doing some of these things and quoted British Airways, which had raised the age for drawing a company pension. On the other hand, poorer pension payouts were already being made, there were difficulties with recruiting and retaining staff. She added that in **2005** there was a **6.8% increase** in the workers in the over 60 and 65 employment market, making it the fastest growing area.

Employers were being forced to change their attitudes by these difficulties, legislation and an appreciation of the skills of older workers.

In future, she added, there would be a different type of workforce, with: -

- More, older workers
- More of them would have health problems
- More workers who would not normally be in the workforce.

This would bring a greater need for more flexibility in work patterns and adjustments by employers, plus a greater use of rehabilitation to maintain the workforce. As an example, Nerys said that an increase in the recruitment of workers with Autism/Asperger's Syndrome produced a lower staff turnover AND less training because of greater retention of facts. On the other hand, it is well documented that Unemployment is one of the most significant contributors to social and health inequalities, leading to increased: -

- consumption of tobacco
- alcohol
- sexual risk taking
- Use of GPs Surgeries.
- Use of Medication
- Admissions to psychiatric hospital

People seem to be reporting more illness at work, Nerys observed, whereas statistics indicate to the contrary. Yet there is plenty of evidence to the fact that being at Work brought with it many health benefits, as well as increased access to health promoting services and schemes. As an example, Nerys quoted the support provided by the Heart of Birmingham NHS Trust: -

Access to:

- Smoking cessation course
- Counselling services
- Physiotherapy
- Health club (weight management)
- Discounted childcare in designated facilities

Financial & Training

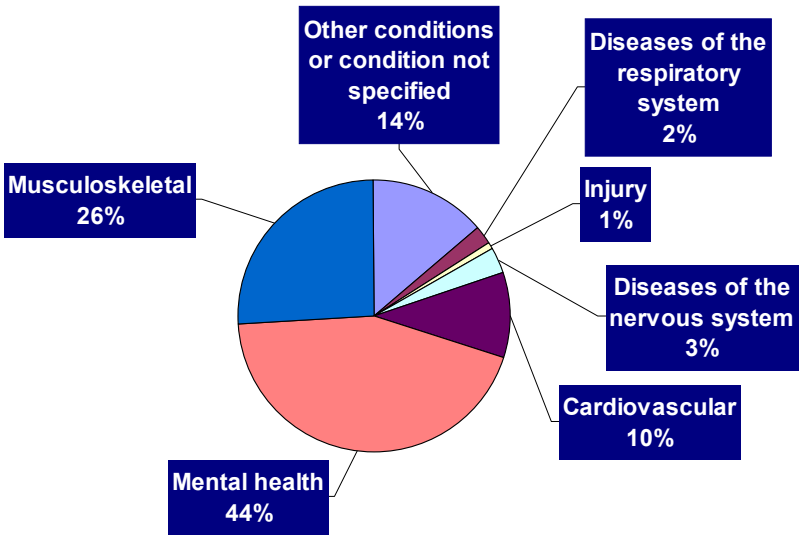
- Tax relief cycle purchase
- Subsidised computer purchase
- Lower rate loans
- Subsidised bus travel
- ECDL/Managing stress
- Presentation skills

Why is it, then that people don't go back to work, Nerys asked? Common 'excuses' are

- A medical 'label – "crumbling spine"
- Beliefs – "Going back will make it worse, as work caused the problem in the first place
- Attitudes – "I don't like painkillers"
- Waiting for a 'cure' – "I can only go back to work when the pain has completely gone"

Many of these beliefs/attitudes are influenced by the healthcare practitioners and follow the medical model of disability.

If we look at the Incapacity-related benefit recipients by diagnosis group, in November 2003, we get this type of spread: -
This represents 1,000 reporting sick each week, of whom, 3,000 remain off work for 6 months! 2,400 (80%) will not work again in the next 5 Years. The commonest causes of



absence for over three weeks are mental health problems and Musculo-skeletal disorders – the so-called "common health problems". Interestingly, recent research showed that when people came into work with an ailment ("presenteeism") the cost of productivity impairment was 10 times the combined cost of "absenteeism plus medical treatment" The biggest work impairment came from depression, back/neck pain and breathing disorders. Other characteristics are: -

• Stress, anxiety, depression, back pain • Limited objective evidence of disease • Largely subjective complaints • Often associated psychosocial complaints	• Symptoms are genuine and significant. • Severe life disruption as well as absence • Urgent need for early intervention and management Bio-psychosocial approach – rehabilitation.

In order to ring the changes we need to bring in a change a shift in perception about work and health: -

Current	Shift to
Work is a 'risk' and potentially harmful to physical and mental health	Work is good for physical and mental health
Therefore	and
Sickness/absence certification 'protects' the worker/patient from work	Recognise the risks of long-term unemployment

This will be achieved by a number of measures in the medical profession: -

- Employment advisors in GP surgeries (help for GPs facing demands for sick notes)
- Web based distance learning for GPs
- Undergraduate syllabus on OH for medical students so all doctors will know something about OH and rehabilitation
- Evidence and consensus based RTW times after common surgical operations

Employers in the main: -

- Don't know what to do
- Don't know what they shouldn't do
- Don't know when to offer adjustments under DDA and what is reasonable.
  i.e. They have a large training need.

What they need to do is: -

- Update policies and procedures
- Keep in touch with sick employees – make this the norm!
- Offer modified adjusted jobs if it means an earlier return to the workplace
- Be alert to common health problems and the need for particular early intervention
- Remember that the line manager is THE most important person in the rehab programme (after the patient) and that EARLY action is the key!
- Modify Working hours (later start/later finish)
- Reduce range of tasks
- Alternate location (say, home)
- Arrange for aids and adaptations

BUT
Do have a plan, as many adjustments are temporary until someone has fully recovered but some may need to be permanent and a legal requirement.

Remember, the aim of rehabilitation is the return of the worker: -

- To do the same job with the same employer
- To do the same job (modified) with the same employer.
- To do different work with the same employer
- To do similar work with a different employer
- To do different work with a different employer.
- To be re-trained and re-educated.

If action is delayed longer than 6-8 weeks, then change in lifestyle makes improvement worse. With a difficult case - multiple issues at work (PI claim, complaints of bullying/harassment), no sign of RTW time, frequently postponed RTW.

It is important to ask yourself: -

- Will this person recover on the job?
- When is it medically safe for them to resume normal activity?
- What adjustments will be required and for how long?
- Will this person ever RTW to normal duty?
- What are permanent redeployment needs and what is practical?

- DDA and IHR issues?

Members' Questions

Francis Quinn of Birmingham City Council asked if the were any exceptions to keeping in touch with the employee? Nerys replied that if there was a specific problem with a particular line manager, then an alternative person should be used. GPs do not normally perform this function for the employer, although they may be consulted.

Liz Prophett of Sandwell MBC asked if an Occupational Health Provider could supply a Sickness Certificate? Nerys said that this was a Department of Health procedure and the GP should always be kept informed. The OH Department would probably be as competent to do it as most GPs.

David Harrison of Birmingham University asked if there was any broad guideline for dealing with sufferers of Autism or Asperger's Syndrome? Nerys replied that some employers provided special training to their line managers so that they could deal with individual cases.

Roger Taylor of National Grid asked about the effect of the employment figures in the face of closures to other countries. Nerys commented that this was a DTI responsibility and the solution was to make the UK more attractive to the workforce.

Peter Evans enquired about the benefits that were stopped after more than 5 years and what proportion was fraudulent? Nerys said that about 5% were fraudulent.

As there were no more questions, the Chairman thanked Nerys for a very informative presentation packed with many interesting new ideas on how to look after the nation's most valuable resource. The members joined him in a heartfelt round of applause!