

ESRC

ESRC Seminar Series

Mapping the public policy landscape

Health and well-being of working age people





Foreword

These two seminars on the health and well-being of working age people are organised by the Economic and Social Research Council (ESRC), the Department of Health (DH), the Department for Work and Pensions (DWP) and the Health and Safety Executive (HSE). The first seminar explores this topic from the employers' perspective while the second addresses the issues involved from the viewpoint of employees.

In a modern world where rising dependency ratios and global market forces place an ever-greater burden on those of working age in supporting others, their health is becoming of increasing importance for Government policymaking. As the balance of the economy continues to shift from manufacturing towards service provision, the type of risks workers face, the hazards they are exposed to, and the injuries people sustain as a result of employment will continue to change. Acute and accidental injury is less common now in many industries as a result of increased hazard identification and prevention, while chronic ill health such as musculoskeletal disorders and stress are more commonly reported.

But it is not just the nature of ill health in the workplace which has changed. Rather the whole terrain of occupational health is transforming. The traditional indicators that measure ill health in the workplace rather than well-being are no longer satisfactory. Concentration on problems such as absenteeism and accidental injury is giving way to a broader vision of what a healthier and happier and more productive workforce can achieve in terms of higher performance and productivity.

Of course, ensuring the safety and security of the UK's workers remains of paramount importance. But, in tandem with these bedrocks of occupational health, we are now eyeing a future in which all working age people have the opportunity to make the optimum contribution to their organisations while enjoying a safer, more satisfying and healthier working life.

The purpose of these seminars is to discuss the policy and practice implications and the evidence base available in making this vision a reality. The seminars will, we hope, assist with the development of policy options following the publication of the Government's Health, Work and Well-being strategy in October 2005.

To date, our public policy seminars have succeeded in bringing the best social science concepts and evidence into the policy arena and in stimulating discussion on how, in the light of these insights, policy can be developed. They have also served to highlight those areas which merit more research evidence before robust policies can be formulated.

The health and well-being of those of working age is an exciting issue and vital to individuals, the economy and society as a whole. We hope these seminars and booklet will make a valuable contribution to a topic that so clearly deserves our attention.

Professor Ian Diamond
Chief Executive
Economic and Social Research Council

Health and well-being of working age people

The researchers

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DR CRAIG JACKSON BSc MSc PhD CPsychol is an honorary senior lecturer in occupational psychology at the Institute of Occupational and Environmental Medicine at The University of Birmingham. Craig has conducted research in several countries and in many industries including hospitals and healthcare, contract cleaning, engineering, aviation, and oil and gas exploration. His interests include pesticide exposure, working hours, stress, research methods, neurobehavioural techniques, and psychological assessments. He has contributed to a number of occupational health textbooks including *The Oxford Handbook of Occupational Health* and the *Pocket Consultant: Occupational Health*. Current research activity involves two projects investigating the neurological effects of manganese exposure in welders, and improving workability. He has written for newspapers, and contributed to television and radio on the topics of stress, the quality of working life, balancing home and work life, rural psychology, and working hours. His additional responsibilities include being an editorial advisor to a variety of health and safety publications, a former associate editor of *Occupational & Environmental Medicine*. He is the current editor in chief of the *International Journal of Rural Psychology*. He is also a research director with Health Research Consultants.



Executive Summary

Introduction

Britain needs a healthy workforce and safe, healthy workplaces. Changing demographics and rising dependency ratios means that having more people in work is vital both for communities and the economy. The health and well-being of people of working age is therefore of fundamental importance to Britain's future.

Work matters to individuals and their families. Growing evidence suggests that work can help improve physical and mental health, reduce health inequalities and offer improved opportunities in life. Moreover, some researchers point to a link between healthier and more satisfied employees and higher performance and productivity.

So, whether it is Government, employers, employees or those currently out of work, the whole of society has a stake in the promotion of health and well-being of working age people.

Policymakers are currently developing strategies to improve the health and well-being of current and potential employees. But to succeed these strategies will need collective support from individuals, families, communities and employers. It is vital, therefore, that this ambitious agenda for change is built on a firm evidence base.

Strengthening this evidence base is now a priority. With that aim in mind, this booklet:

- 1 highlights some current evidence on health, work and well-being
- 2 outlines the Government vision for improving the health and well-being of people of working age
- 3 discusses potential interventions to improve health and well-being from the perspective of employers, employees and those currently out of employment
- 4 identifies topical issues and key areas for future research.

Key insights and implications

- Occupational ill health and injury in the UK have high financial and personal costs for employers and employees. Around 28million working days are lost each year to occupational ill health and seven million days are lost due to workplace injury.
- Figures suggest that the UK's occupational health is improving slightly. But the statistics must be treated with caution. The number of cases is still large and we need to be alert to the possibility of new hazards, especially as these may have a gradual onset. For example, some conditions such as noise induced hearing loss have a gradual onset of many years. The diagnosis of 'new' conditions of problems with many years of exposure, such as vibration white finger, requires extreme case severity. Most agree that reporting systems such as The Health and Occupational Reporting (THOR) tend to produce underreporting of the occupational ill health situation, with little realistic understanding of the severity of such ill health.
- Musculoskeletal disorders and stress and other common mental health problems like anxiety and depression account for approximately 75 per cent of those suffering from work-related ill health.
- Traditionally, it is occupational *ill* health rather than health which has been measured. New, cost effective methods are required that capture the health and well-being of workers not just ill health.

- A growing number of studies point to the multi-factorial nature of workplace ill health. Employee ill health results from a highly individual and complex interaction of physical, psychosocial and personal factors. Faced with the variety of factors involved, the challenge for occupational health is to provide the most appropriate interventions and gain the support of employees in managing their own health.
- A growing body of evidence points to the adverse health consequences of not working. Further research is required into the question of whether work contributes to good health and whether certain types of jobs are more or less likely to have a beneficial effect on health and well-being. Further research is now needed into the possible link between happier, healthier workforces and increased productivity.
- Research indicates the practical value of a growing range of schemes and initiatives which aim at reducing absence, improving workplace health and encouraging those of working age into work.
- Issues which may be expected to have a growing impact on workforces and which merit further research include increases in worker obesity, the continued prevalence of musculoskeletal disorders and stress, those excluded from traditional occupational healthcare (eg temporary, migrant, rural and remote workers), longer working hours, international travel, older workers, mental health and disabled workers.



What do we know about worker health and ill health?

Counting the cost of ill-health

- Around 35million working days are lost each year to occupational ill health and injury. (1)
- Absence due to sickness costs around £12billion each year. (2)
- The cost to employers of stress-related ill health is more than £500million a year.
- Organisations employing over 5,000 staff, annually average 7.4 days' absence per employee: small organisations with fewer than 50 employees average 4.2 days. (3)
- As many as 13 per cent of days taken on sick leave are considered not genuine by employers – at a cost of £1.2billion. (3)
- Sickness absence rates in the public sector currently average 8.5 days per person per year – costing around £4billion a year to the taxpayer. (2)
- Once a person has been claiming Incapacity Benefit for a year, the average duration of their claim will be eight years. (2)
- After two years on Incapacity Benefit, a person is more likely to die or retire than return to work. (2)

Table 1: Regional annual days lost per employee

Yorkshire/Humberside	8.9
Wales	8.4
Southern England	7.7
East Midlands	7.5
South West	7.2
Scotland	7.1
South East	6.5
West Midlands	6.4
Northern England	6.2
North West	6.0
Eastern England	5.8
London	5.1
Northern Ireland	4.7

Source: CBI/AXA Absence Survey, 2006



Measuring it all up

Healthy workers and workplaces may be the ultimate goal but, to date, that's not what has been measured. Historically, occupational health has been measured by the level of occupational ill health that can be observed. Which is something akin to measuring the temperature of hot water by counting the blisters on a burnt hand and then calculating how many degrees away from a safe-handling temperature it is.

The current industry accepted indicators of occupational health are factors such as sickness absence (duration, episodes, and regularity), healthcare consultations, compensation claims and the number of workplace accidents. However, such phenomena are exactly that – indicators. Occupational health can only truly be measured by counting how many workers are healthy not how many are suffering.

Measuring health and well-being

The catch involved in measuring occupational ill health reliably is the size of the head count. At present there are more healthy workers than sick ones – so the job of measuring ill health is easier than measuring good health. Unless more reliable, sensitive and cost effective methods of measuring good health and well-being are developed and implemented, it will remain easier to spot and count the sick workers than the healthy ones – but of course by then it is too late.

What the trends tell us

The current large-scale picture of occupational ill health and work-related problems in Britain is generally heading in the direction that policymakers have hoped to achieve. Occupational ill health is still a sizeable problem, with over 2million UK workers suffering from an illness during 2004/05 that they believe was made worse by work, with almost 576,000 of those being new cases. This was slightly down from the previous 12 months. (4)

The most widespread problems remain those of work-related stress and other common mental health problems like anxiety and depression, and musculoskeletal disorders. These account for approximately 75 per cent of those suffering from work-related ill health. In terms of accidents, the number of fatal and major workplace injuries has been roughly stable in the last few years. In 2004/2005 there were 169 employee fatalities and just over 30,000 major injuries. (4)

Musculoskeletal disorders

Musculoskeletal disorders (MSDs) are the most common occupational illness in Britain, affecting one million people a year. MSDs include problems such as low back pain, joint injuries and repetitive strain injuries of various sorts.

That psychological distress can both manifest as, and exacerbate physical problems (especially chronic pain and cardiovascular problems) is well-documented. One expert view on the role of occupational stress in the development of MSDs suggests that it could be the result of the extra physical demands placed often upon busy and stressed workers. Workers with too much to do often engage in behaviours that enhance the development of any musculoskeletal problems, such as over-work, rushing, or not adjusting equipment properly.

However, research indicates that musculoskeletal problems are unrelated to the amount of physical exertion involved in a job. Physical factors are seemingly unimportant in comparison with the role psychosocial hazards play as predictors of musculoskeletal problems. (5) This may partly explain why the sedentary occupations tend to suffer more from MSDs than the active occupations.

Occupational mental health

More than 500,000 employees were affected by stress, anxiety or depression in 2004/05. (4) The most common mental health problem associated with working people is that of occupational stress. Depression and (acute) anxiety are also common, and can be caused by non-occupational factors (difficult life events, bereavement, relationship breakdown, adjustment to physical ill-health) as well as occupational factors. Critically, prolonged occupational stress can lead to the development of anxiety and depression in many workers.

The term 'Psychosocial Hazard' (to describe any factor that may cause distress or any form of psychological harm) is increasingly well-known. It is now widely held that employees must be free from psychological and mental harm as well as from physical harm. Evidence suggests that the psychosocial well-being of employees is becoming worse. But this may be due partly to increasing awareness of such workplace issues, and partly to workplaces being perceived as more potentially psychologically harmful than ever before.

Accidental injury

In 2004/05 slipping and tripping caused more than one third of the 30,213 major non-fatal injuries. There were over 120,000 other injuries to employees causing them to be off work for more than three days. Two fifths of these were caused by handling, lifting and carrying. (4)

The rate of fatal injuries declined throughout the 1980s and 1990s. The rate rose by 30 per cent in 2000/01 and has dropped since then. In 2004/5 around half of fatal injuries occurred in two industries: construction, and agriculture, forestry and fishing.

What workers tell us about their ill health

Small but interesting variations exist between the problems workers report and the occupational health problems seen by specialist doctors. (4)

In Britain, the list of occupational illness in terms of workers' self-reporting of problems (in descending order) remains:

- Musculoskeletal problems
- Mental ill health (stress, anxiety, depression)
- Breathing or lung problems
- Hearing loss problems
- Skin problems
- Infections.

However, the profile of UK occupational ill health seen by specialist doctors is slightly different, and is as follows:

- Mental ill health
- Musculoskeletal disorders
- Skin problems
- Breathing or lung problems
- Infections
- Audiological problems.

Table 2: How Britain's industries rate on employee ill health

- | |
|---|
| ■ Health and social work (4,800 employees per 100,000) |
| ■ Public administration (4,300 per 100,000) |
| ■ Construction (3,900 per 100,000) |
| ■ Education (3,900 per 100,000) |
| ■ Manufacturing (3,400 per 100,000) |
| ■ Transport & communications (3,400 per 100,000) |
| ■ Financial services/business (3,100 per 100,000) |
| ■ Agriculture (3,000 per 100,000) |
| ■ Retail/wholesale/hotels/restaurants (2,300 per 100,000) |
| ■ Average for all workers (3,400 per 100,000) |

Source: HSC Health & Safety Statistics 2004/05. Estimated prevalence rates of self-reported work-related illness per 100,000 people working in the last 12 months, 2004/05



The most common workplace hazards

The most common hazards workers face are organisational, physical, and psychological. These include shift work, long hours, high demands, violence, noise, dust, chemicals and vapours, and vibration. The majority of these hazards appear to be becoming more, not less prevalent in the workplace.

1 Shift working

About one in five UK workers are employed on shift work involving night work. In future, a growth in retail and service organisations operating 24 hours is likely to increase the need for shift working.

The potential adverse health consequences of shift working include: reduction in quality and quantity of sleep, fatigue, anxiety, depression and increased neuroticism, negative pregnancy outcomes among women (eg premature delivery) and increased risk of accidents both at work and travelling to and from work. Studies also suggest links to gastrointestinal disorders and cardiovascular problems (although the exact mechanisms of this are not yet known). (6)

2 Long hours

'Long-hours' workers can be defined as those who work more than 48 hours per week. The numbers working in excess of 48 hours per week has fallen regularly since 1998 but despite the European Working Time Directive, UK workers still work longer hours than most other European workers. Approximately one third of shift systems in the UK involve 12-hour shifts.

Studies, although limited, have shown a variety of health effects linked to long working hours including reduced quality and quantity of sleep, generalised fatigue – both physical and psychological, anxiety, depression, neurotic complaints, adverse cardiovascular effects, gastrointestinal disorders and increased rate of accidents (especially at night).

3 Psychosocial hazards

In 2004/2005, some five million employees believed they were experiencing work related stress at a level that was making them ill. More than 13million working days were lost to stress.

But it is not occupations involving extraordinary events or routine danger that induce stress in employees. Rather, mundane offices or ordinary workplaces with on-going/long-term psychosocial hazards and risk factors pose the greatest risk of stress. Chronic stress appears to be more problematic than acute stress.

Stress can occur when the demands placed upon people outweigh their ability to meet those demands. But it can also arise when workers are under-utilised and bored. Indeed, the types of demands that can cause stress can be either psychological, physical, or both. Workers who may be suffering from stress may not necessarily be aware that they are stressed.

At work, the risk factors associated with chronic stress include: job content, how work is organised, the prevailing culture in the workplace, work roles, workplace structure, relationships at work, environmental factors (such as noise), the home-work interface and commuting.

There is no universal profile of what constitutes stressful situations for everyone. And the effects of stress are exacerbated or mitigated by individuals' coping styles, personality types, prior experience of similar situations and learned behaviours of how to cope with difficult situations.

4 Violence

The British Crime Survey (2004/05) estimated incidents of violence experienced by workers in England and Wales at 655,000. But there has been a steady fall in workplace violence since a peak of 1.3million incidents in 1995. Violent incidents at work are rare.

The 2002/03 British Crime Survey reports that the majority (61 per cent) of violent incidents involved offenders who the victim did not know before the incident – the majority of these were likely to be customers or clients. A further 22 per cent were customers or clients known to the victim.

5 Physical hazards

- Noise – the common effects of prolonged exposure to loud noise can include noise induced hearing loss (both temporary and permanent). Entertainment venues rather than factories are now the greatest problem in terms of noise, as awareness of the risk of hearing damage is usually highest in industrial settings.
- Dust, chemicals and vapours, and work place carcinogens – the effects of dusts, vapours and chemical exposures can be extremely varied in both nature and effects. Common effects of exposures to dusts and chemicals can include acute and chronic respiratory problems such as asthma or alveolitis.
- Vibration – the effects of prolonged exposure to vibrating tools or other vibrating equipment, such as vibration white finger and peripheral nerve damage, can take some time to manifest. Due to strict control, technological advances and exposure reductions, cases of vibration effects are becoming less common.

The complex determinants of employee health

A growing number of studies point to the multi-factorial nature of workplace ill health. For example, musculoskeletal disorders (MSDs) affecting the upper limbs, back and lower limbs are one of the two most common workplace health problems. But some musculoskeletal symptoms may result from non-occupational sources (eg hobbies, sports activities) as well as occupational factors. Studies further show that it is necessary to take not only physical factors (such as heavy work or repetitive movements) into account as risk factors for MSDs but also psychosocial (work organisation, interpersonal relationships, poor management) and personal factors (gender, exercise habits, life style, psychological characteristics). (7)



Not working can make you ill

A range of studies point to the adverse health effects of not working. Unemployment seems to influence physical and mental health in many ways, from its consequence of low income to the psychological stress of social exclusion. Evidence further suggests that not only unemployment but also retirement can result in poor health.

- A high proportion of unemployed people suffer psychological distress (8) and have higher rates of ill health than those in employment. (9)
- Unemployment causes symptoms of depression, distress, insomnia and reduction in confidence. (8,10)
- High levels of unemployment appear to influence premature death. (11)
- Findings from Denmark and Finland show that unemployed people have a higher mortality rate than those who are employed. (12)
- Some studies indicate that complete retirement can lead to a 23-29 per cent increase in mobility difficulties and further difficulties with daily activities. In groups of recently retired workers, health problems increased by eight per cent, with mental well-being declining by 11 per cent.
- Retiring at a later age may reduce or postpone poor health outcomes for older adults, improve well-being, and possibly reduce the over-use of health care services.

Employment: the healthy option?

The fact that unemployment appears to be linked with poor health does not definitively prove that employment must therefore be good for health.

There is currently very little evidence on the positive association between employment and health. Using longitudinal data, and taking into account social and demographic characteristics, research has found that the health of a person influences their employment status and also that employment status influences their health. (13) However, the complex association is not completely understood because features of the individual, the employment status and the employment context all influence worker well-being.

Indeed, some workplace factors appear to lead to worse health if, for example, employment is insecure, workers have little autonomy with poor control and task discretion, workers feel 'taken for granted' and if they cannot be confident they will be treated fairly by their employer. (14)

Clearly, the relationship between employment (and unemployment) and well-being is very much dependent on the individual and the situation. When employment fulfils an individual's needs physically, socially and psychologically, people report high levels of well-being. This will be different for different people and different for each person at different times. So the answer to the question 'Is employment good for well-being?' for the moment is, 'It depends'. The challenge is to provide useful information to individuals and organisations about the likely effect of a specific job upon well-being. (15)

- Employment can fulfil a large number of psychological needs (16) and enhance the sense of well-being (17) but at worst it can make individuals ill (18) and some aspects of it can even kill.

Workplace well-being and productivity

Little research has been conducted into the relationship between a healthy workforce and productivity. However one study by the Harvard Medical School and the Institute for Health and Productivity Management suggests that the healthiest 25 per cent of the work force is some 18 per cent more productive than the least healthy quarter. (19)

Certainly, there can be little doubt that improving the quality of care for any chronic disease that workers may be suffering would have positive consequences for productivity and absenteeism.

- A study offering workers with depression an advanced personal treatment compared with a standard treatment continued to show benefits for up to two years after treatment, especially in terms of productivity and absenteeism which improved by eight per cent and 28 per cent respectively. (20)

But the evidence concerning the link between worker happiness or satisfaction and improved working, profits or turnover has been contradictory. The possibility of such a link is intuitive, but there are few reliable studies which have assessed the economic benefits of workplace happiness.

Interestingly, workers who have to fake happiness or who are required to remain 'outwardly happy' when dealing with difficult situations or with customers have been shown to be associated with increased levels of depression and cardiovascular problems. (21)

A new view of workplace ill health

A growing number of professionals believe that the psychosocial processes that workers possess (their personality, coping styles, learned behaviours, and previous experiences) are perhaps a bigger influence on the overall picture of occupational ill health than had been originally envisaged. For that reason, not all workplace ill health (especially the conditions with acknowledged psychological components) can ever be prevented. The thoughts, beliefs and attitudes that workers bring to the workplace are equally important in preventing or exacerbating ill health and promoting recovery as the nature and details of any hazards or exposures they may face.





What's the Government's approach to improving health and well-being?

In its strategy document report *Health, work and well-being – Caring for our future*, (2) the Government sets out its vision for improving the health and well-being of working age people:

“ Together we will create an environment that promotes the health and well-being of all those in work and all those who wish to work ”

This vision is a central element of a wider welfare reform agenda that is set out in the Government White Paper *Choosing Health: Making Healthier Choices Easier* (22) and Green Paper *A New Deal for Welfare: Empowering People to Work*. (23)

This vision aims to achieve:

- improvement in the health and well-being of people of working age
- increased employment – with more people able to work than ever before
- optimal performance and attendance – with people at work for more of the time
- people and their employees empowered to promote and protect their own health
- increased productivity – so that people are more effective when they are at work
- a reduction in health inequalities and social exclusion – resulting in benefits for individuals, families, communities and society
- people being able to work to a later age if they wish
- people with health problems or disabilities being able to optimise work opportunities.

How will the vision be realised?

The Government, at both national and local levels, will work together with employers, trade unions, individuals, professional organisations, voluntary bodies and a range of other stakeholders to deliver its new, innovative and far-reaching strategy for better health and well-being of working age people.

Government strategy has three key themes:

- 1 Engaging stakeholders
- 2 Improving working lives
- 3 Healthcare for working age people.

Engaging stakeholders

The strategies for engaging stakeholders include appointing a national Director for Occupational Health to work across the DWP, the DH and the HSE; creating a National Stakeholder Council; holding a stakeholder summit; creating a National Stakeholder Network; developing a Charter for Health, Work and Well-being; initiating a national debate; and supporting the creation of stakeholder councils.

Improving working lives

The key to improving working lives lies in creating workplaces that both protect the health and well-being of employees and help people improve their own health and well-being. In this, the NHS, Government and local authorities will lead by example and become exemplars of healthy workplaces and good occupational health practice. It is vital that workplaces in general have access to competent occupational health advice and support for all employees.

Healthcare for working age people

Healthcare services must be designed and delivered in ways that assist people of working age to either remain fit for work, or to return to fitness for work. This will require supporting healthcare professionals to fulfil their key role in helping their patients to remain in and return to work; improving the provision of, and access to, interventions for the management of common mental health problems; and improving return to work services and vocational rehabilitation.

How will workers and those currently out of work benefit from this strategy?

1 Helping people manage minor health problems in work: Sprains and strains often reduce a person's capacity to do their job effectively in the short term. Left untreated a minor injury can, over time, become a major problem leading to absence from work. Access to appropriate treatment may not currently be readily and quickly available in the early stages. A key aim of this strategy is to find ways of supporting employees in getting swift treatment so that they can remain in work.

2 Helping people return to health following an absence from work because of illness: After a long-term absence from work it can be difficult to return to work, even when the original health problem has been dealt with or is under control. This strategy will support healthcare professionals to help people who are out of work due to ill health to plan and, if necessary, access specialist support in managing their condition and returning to work. This might be through employment advice and help to find a suitable job – not necessarily what they were doing before their illness. Adaptations to workplaces and work practices can be another key to the return to work.

3 Helping people avoid work-related health problems: Many people work in organisations with little or no access to good quality occupational health advice – advice that can be essential in helping employers to manage risk and to protect and promote the health and well-being of employees. This strategy will increase the number of people whose workplaces have access to occupational health support.

“ It is very welcome that the Government is taking work seriously as a public health issue. A range of initiatives over the past three years shows that the intentions are good. Even so, policymakers have yet to tell a compelling story about the actions that employers, unions and others need to take to make British workplaces healthier. Most importantly perhaps, Government must unite the objectives of healthier work and more productive workplaces. The business case is compelling and it should be made with energy and commitment. The DTI has a critical role to play alongside the DH and the DWP. Without their engagement the strategy will fall short of expectations.”

David Coats, Associate Director – Policy, The Work Foundation

What's working in the workplace?

A range of current schemes and initiatives have the aim of reducing absence, improving workplace health and encouraging those of working age into work:

Occupational health support

A 2003 survey reports that only three per cent of all UK companies provide comprehensive occupational health support although this varies significantly according to size of company (44 per cent of large companies provide support but only two per cent of companies employing less than ten people). (24) Studies show that the provision of occupational health support is valuable for both employees and business:

- Provision of occupational health advice to individuals in primary care settings brings tangible benefits to workers' well-being. In a two-year study patients attending their GP surgery were provided with information on health hazards and solutions to problems at work. Some 93 per cent rated the advice useful or very useful. And 45 per cent felt their work-related symptoms had reduced as a result of the advice received. Nearly a quarter said they were very much improved (25).
- Workplace Health Connect (WHC) (0845 609 6006). This new service underpins the Health, Work and Well-being Strategy (2) offering SMEs free and impartial advice on occupational health, safety and return to work issues. The service consists of an advice line and workplace visits aiming to transfer knowledge and skills directly to managers and workers. It complements 'Safe and Healthy Working', an existing service for small companies in Scotland. WHC is being fully evaluated and currently operates in five regional pathfinders located in Greater London, the North East, the North West, South Wales and the West Midlands. The service will be expanded in 2007 to cover two thirds of SMEs in England and Wales.

Healthier workplaces: lower absenteeism

“ Employers live in the real world and recognise that the majority of absence is due to genuine, minor illnesses. Nobody wants staff to drag themselves into work when they are genuinely ill. But there is clearly concern that a culture of absenteeism still exists in some workplaces and this must change... Absence is best managed with both carrot and stick – schemes that reward the good attendees work best together with those that deter the worst offenders.”

John Cridland, CBI Deputy Director-General

Evidence points to the benefits of workplaces that not only protect the health and well-being of employees but also help people improve their own health and well-being:

- A 2004 review of over 20 evidence-based survey articles on work-based health promotion programmes and studies concluded that health-promoting programmes can have a positive impact on the workforce. The articles show that heart conditions and other risk factors were lessened by participation in an occupational activity programme. Fourteen evaluation studies examined absenteeism and reported that health promotion measures led to a reduction in sickness absence of between 12 per cent and 36 per cent. This led to a saving of 34 per cent in absenteeism costs, concluding that every pound spent on promoting health in the workplace could lead to a £2.50 saving for businesses. (26)

- Standard Life Healthcare cut staff turnover by 25 per cent, reduced staff absence by almost five per cent and convinced more workers to adopt health options within a year of the introduction of an on-line health management programme for staff. (2)
- AstraZeneca, a pharmaceutical company, made a £5million saving in one year through a programme of initiatives, including standalone projects and improved management aimed at reducing sickness absence levels. (27)
- The Port of London Authority (PLA) introduced a sickness management policy in 2003 which resulted in a 70 per cent drop in absence rates from 11-12 per cent to 3.4 per cent. (27)

Getting back to work

Even relatively common health problems can have a disproportionate effect if investigation and treatment are delayed or appropriate forms of rehabilitation are not available. One survey shows that employers who provide early access to treatment experience significantly lower absence levels – 19 per cent and 13 per cent reductions for manual and non-manual workers respectively. (3)

In a recent study, GPs generally expressed the view that a return to work can be of benefit to patients for a range of physical, social and psychological reasons. However, the GPs described themselves as having limited occupational health expertise. (28)

Several initiatives point to the value of supporting return to work:

- Pathways to Work is a joint initiative between the Department for Work and Pensions and the Department of Health. It provides additional support to help those who are on Incapacity Benefit to return to work including targeted support for individuals through mandatory work-focused interviews together with a range of choices packages. The health-focused choice is the Condition Management Programme (CMP). This provides a short, focused intervention that assists individuals to effectively manage their condition, in order to help them gain the confidence to return to work. Early evaluation of Pathways to Work shows an eight to ten per cent increase in the rate of people coming off incapacity benefits after four months of their claim compared to non-pilot areas.
- A series of on-line learning modules for doctors about fitness for work, work and health and dealing with difficult consultations is being developed by Department for Work and Pensions. The first module has received very positive comments. (29)
- The Royal Mail has reviewed its trigger points for referrals to occupational health advisers. Anyone absent for 14 days gets an automatic referral, but for stress and musculoskeletal disorders, Royal Mail operates a one-day referral. The Royal Mail estimates that its action to improve management of sickness absence and help staff return to work has led to the equivalent of 2,000 extra staff being at work each day. (27)
- The introduction of a rehabilitation scheme at British Polythene Industries plc has led to an 80 per cent reduction in the average number of working days lost due to musculoskeletal disorders, increased productivity, and a significant reduction in the length of time employees stay off work after they have been injured from an average of 26 days to four days. (27)

Improving workplace standards

New initiatives aimed at improving overall standards in the workplace include:

- Expansion of the Investors in People (IIPUK) award. The White Paper *Choosing Health* (22) gave IIPUK the remit to develop a new 'healthy business assessment' in conjunction with the Department of Health.
- Encouraging companies to report their occupational health and safety performance as a key part of their business performance reporting, using the HSE's Corporate Health and Safety Performance Indicator (CHaSPI) system and the equivalent Health and Safety Performance Indicator for small businesses, and to benchmark themselves against others.
- The HSE Stress Management Standards, published in November 2004, insist that systems are in place to allow for an appropriate response to concerns raised by employees on issues ranging from workload to appropriate behaviours in the workplace and employee engagement in organisational change.

Action on workplace hazards and effects

Several recent studies point to the value of participatory approaches and improved access to health information/education at work as playing a key role in improving occupational health. For example:

- **Shift working** – there is some evidence to suggest that allowing workers to design their own shift schedules improves their performance and that changing of shifts systems is best done in consultation with staff. (6)
- **Musculoskeletal disorders** – modern approaches to ergonomic interventions have shown the importance and value of a participatory approach involving facilitation, access to information and appropriate worker participation. (30)
- **Stress** – a study of a risk management approach to controlling stress at work in hospital staff finds that a high degree of employee consultation and involvement in the process is crucial. (31)



What are the key current and emerging issues?

Workplace hazards and effects – stress, musculoskeletal disorders, hearing problems, skin complaints and respiratory illnesses continue to be key areas of research interest.

But subtle shifts are occurring in the types of hazards workers face. For example, vocal strain and load is an emerging area of concern for workers including teachers, lecturers, coaches and call centre staff.

The British Occupational Health Research Fund (BOHRF) is currently focusing its efforts on:

- musculoskeletal disorders
- speedy rehabilitation techniques
- ways to restore workers' health in the shortest possible time
- intervention techniques for acute cases to prevent chronic illness
- methods of reducing stress by reorganising work
- the use of Cognitive Behavioural Therapy to beat mental health problems.

Globalisation – greater globalisation is accompanied by increasing flows of migrant workers to the UK. A proportion of these migrant workers will work in low paid employment and some will be working illegally. Most are unlikely to benefit from occupational healthcare. What are the possible implications of this?

Remote and isolated workers – an increasing number of employees work either away from the office and their colleagues or spend a substantial amount of time on the road. This way of working raises issues ranging from safety to increased stress. For example, those working on the road are driving longer distances which may result in problems of fatigue, back complaints, poorer diet and increasing stomach complaints from eating 'on the move'. Many workers who are on the road for the majority of their working week do not have office space or suitable work conditions, and this raises ergonomic issues.

International travel – more workers than ever before are routinely travelling in the course of their work. This may increase the risk of DVTs, gastrointestinal problems and jet lag. It will require better health management both before and after travelling.

Temporary and voluntary workers – the use of temporary and contract workers is on the increase. These types of workers are at a greater risk of injury than permanent workers due to:

- lack of job experience
- inadequate induction
- inadequate safety training
- deployment to the most hazardous jobs.

Longer hours and shift working – despite the European Working Time directive, more workers may find themselves working longer hours. The growth of the 24-hour 'service' sector may result in more shift-working, and more on-call and on site living.

Computer use – new technologies continue to keep computer use and its ergonomic implications high on the occupational health agenda.

Working into older age – the proportion of older workers in the workforce is set to increase.

Recent evidence dispels some of the myths concerning the employability of older workers (ie that they take more time off and find it hard to learn new skills). (32) What implications, if any, will result from a greater proportion of older workers in the workforce who will face a natural decline of some physical abilities?

Workability – developed in Finland but not in use much beyond Scandinavian countries, this is a quantifiable way of measuring how well workers can perform their jobs – based both on subjective and objective aspects of workers' well-being. The Workability Index (WAI) (33) has proved to be reliable in predicting the natural decline in function of older workers or workers with health problems. Workability, and similar concepts, could prove to be a future measure of occupational *health*.

Unusual body shapes – what are the implications of more unusual body shapes (eg extremely short or tall people, obese people and disabled people) entering a uniform workplace? Obesity is a growing problem and a greater proportion of obese employees will have consequences for workplace health. This could result in ergonomic issues for many workers, and may have implications for personal protective equipment and hazard reduction.

Psychosocial surveillance – health surveillance in the workplace is attracting some attention. One of the aims of psychosocial surveillance would be to identify those workers most prone to stress. However, this tool is in its early stages and the benefits of such an intervention are not yet understood.

Occupational health provision – occupational health provision can be patchy in places, for example, in rural areas, or among migrant workers, and for those working in small/medium sized enterprises.

When ill health is not ill health – some element of sickness absence is due not to ill health but to social reasons such as taking time off to care for a child or an older relative. As the demographic balance in the population alters towards a greater proportion of older aged people in the population, may more workers prefer to attribute time off to sickness rather than their caring responsibilities?

Conclusion

Occupational ill health and injury continue to cost employees and employers dear. Far too many people who are currently unfit for work will never work again. To improve this situation we see a clear shift in policy emphasis from occupational ill health to the promotion of health and well-being among all those of working age. The aim is healthier, safer, happier and more productive workplaces. The question that remains is whether both employers and employees are willing to take greater responsibility for securing greater health and well-being at work and how this can be measured reliably.



Some final thoughts

DR BILL GUNNYEON, Director, Health Work and Well-being and Chief Medical Adviser, Department for Work and Pensions: We know that being out of work has negative health effects and can lead to social exclusion, health inequalities and relative poverty for individuals and their families. Being in work brings positive benefits in building self confidence, maintaining self esteem, ensuring social contact and allowing individuals to optimise opportunities for themselves and their families. And this in turn has benefits for communities and for society as a whole. Against this background it is clear that we need to support people with health conditions and disabilities to help them remain in or wherever possible to return to work. These seminars will help to consider how as a Society we can rise to the challenges we face.

JONATHAN REES, Deputy Chief Executive, Health and Safety Executive: HSE has long been committed to improving health and safety of Britain's workforce. And significant results have already been achieved with workplace accidents falling by two-thirds over the last 30 years, workplace fatalities at the lowest level ever, and work-related ill-health probably down ten per cent over the last five years.

But, as the nature and composition of the economy changes, as the workforce changes (and ages), and as the attitude of society changes, so we need new ways of intervening. HSE, together with our local authority partners, is doing much more on mental health issues like stress, and common health problems like backache than a few years ago, and is trialling exciting new approaches like Workplace Health Connect.

That is why we are committed to the joined-up approach in the Government's Health, Work and Well-being strategy. We have a unique contribution to make from our knowledge of the workplace, and our links with Trade Unions and employers of all sizes. Equally to realise the ambitious aims we have set, we need all the relevant players in the public sector at the national, regional and local levels to work closely with the private sector; worker representatives and voluntary organisations. New ways of working are required to facilitate the level of co-operation required. We are all learning how to do this.

We also need to improve our knowledge and evidence base in respect of the interaction of health and work. We need a better understanding, for example, of the characteristics of 'good' jobs which protect and promote health and well-being from 'bad' jobs which do not. We need to know what evidence exists that certain policy interventions work.

The ESRC seminars will play an important role clarifying what we know, and the gaps that we need to try to fill, as we develop policies that improve the health of all people of working age, and promote a healthier workplace.





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Further information

The full papers presented at the Health and well-being seminar held at the Department of Health on 11 July and Health and Safety Executive on 13 July, both in London, including full details of academic references, are available on the ESRC Society Today website at: www.esrcsocietytoday.ac.uk

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