Occupational Health Support: new policy options

Policy Brief

This policy brief:

- Explains how ‘occupational health’ prevents workloss;
- Provides evidence-based options for a modern service to support worker health

Good Work, Good Health

Working Knowledge in Work & Health

Overview

Over recent decades there has been little change in the number of people falling out of employment due to health problems. Paradoxically, this has happened during a time when clinical guidelines have led to improved healthcare, and workplace regulations have led to safer work. Something is clearly not working.

This policy brief explains existing occupational health and vocational rehabilitation services, and indicates how the principles underpinning these services do not fully align with today's health and employment challenges, and so are not 'fit for purpose'. Based on this analysis, we define a new 'smart' occupational health support approach, and provide policy options that could facilitate change.

The Problem

‘Occupational health’ is often used as an umbrella term for other related and complementary services or allied health professions, including vocational rehabilitation and occupational therapy. Here, we will outline why they are not currently ‘fit for purpose’:

- Occupational health provision originated in the factories and mines of the industrial revolution, and was initially a trauma service based on the assumption that work causes ill-health (via injury or occupational disease): this led to a focus around health risk management, surveillance, and advice.
- Vocational rehabilitation was traditionally a service focused on gaining and maintaining employment for people who remained outside of work due to serious injury or disease: it was a late intervention delivered after treatment was complete.
- • Occupational therapy originates as far back as the 1700s: it was a response to changing public beliefs about how mental illness should be treated, based on supporting people with a disability to maintain independence.

It is apparent that the traditional medicalized solution to the perceived ‘disease/injury’ model of workloss due to ill health underpin current occupational health services. Some of these principles remain necessary, but they are clearly insufficient.

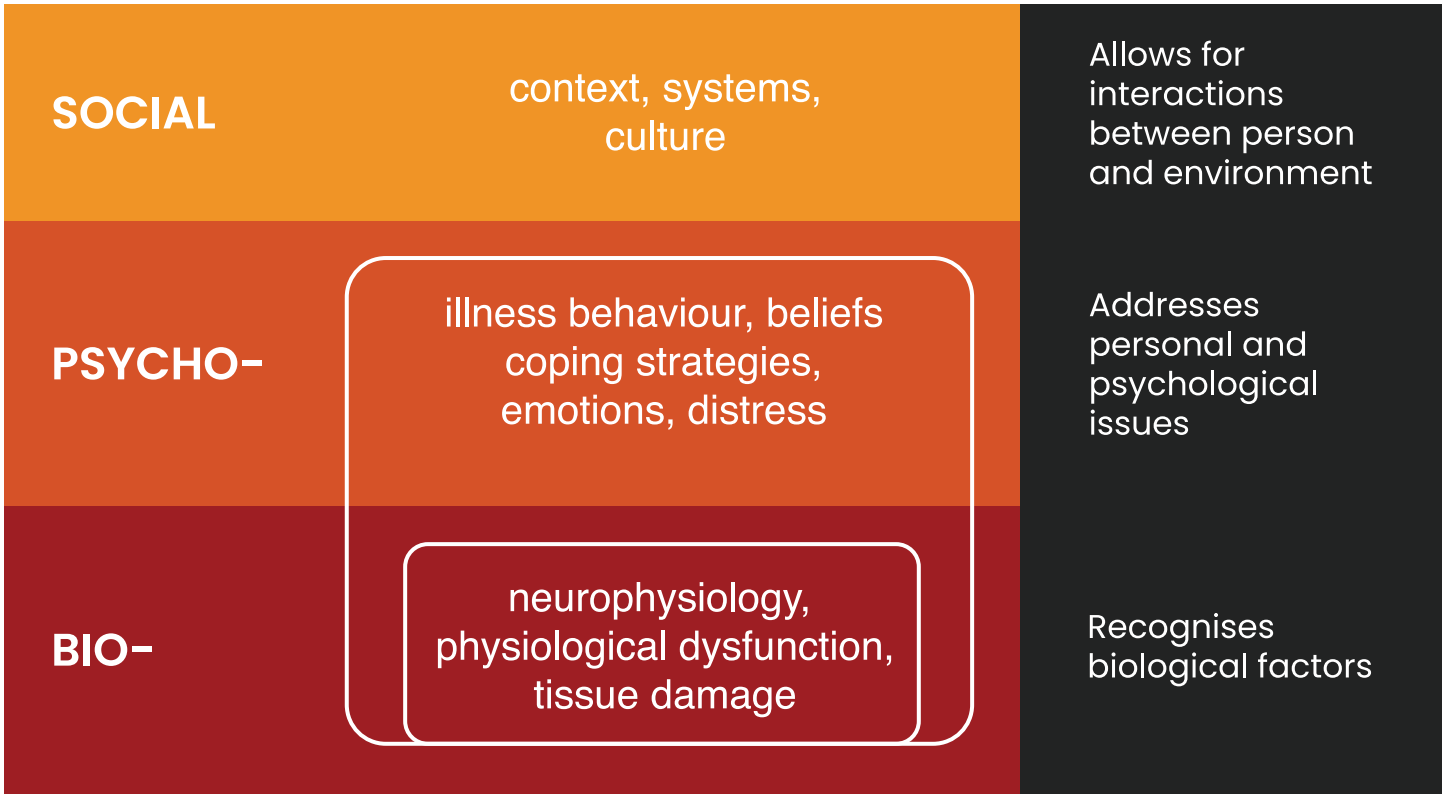
Why is this?

- The majority of workloss due to ill health is no longer a result of serious disease or severe (work-related) injury: rather, two-thirds of people fall out of work because of common health problems (mild-moderate mental health and musculoskeletal problems) – the health problems that affect us all.
- Typically these problems are episodic, vary in severity, and fluctuate across the life course, but do not result in job loss for most people.
- Workloss due to ill health is largely avoidable with the right support at the right time

What is the evidence to support the need for a new approach?

People with common health problems often face obstacles to work participation. These obstacles are a combination of biological, psychological, and social factors – it is best understood as a biopsychosocial problem (see figure below).

Effective occupational health must simultaneously address all three biopsychosocial domains illustrated in the above figure. In practice this means work-focused healthcare + workplace accommodation: both are necessary to prevent unnecessary work loss. Achieving this requires early coordination across the health and work systems.

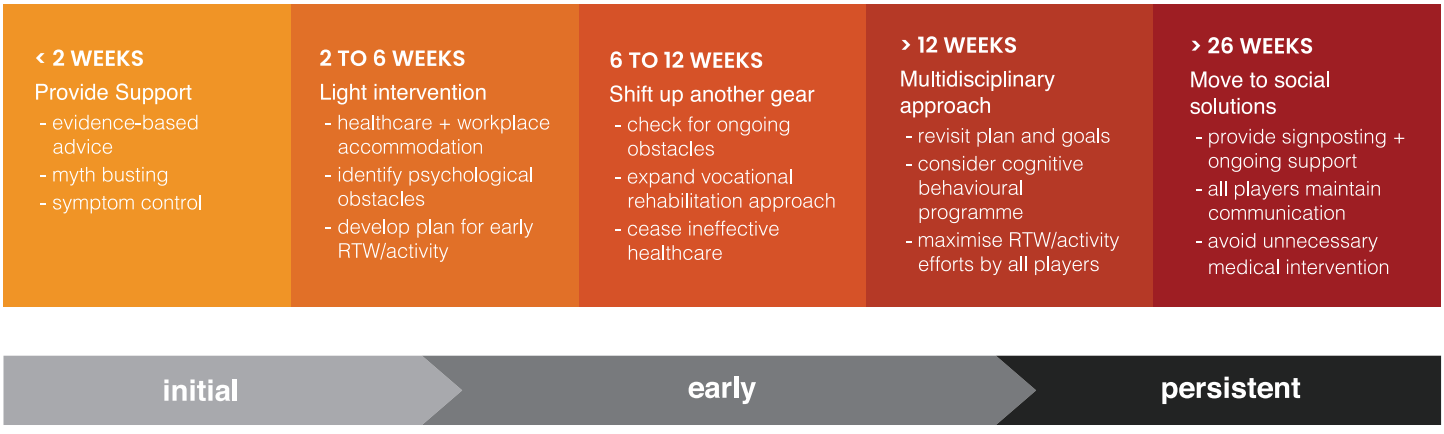


New policy options for evidence-based occupational health support

- **An underpinning principle of early support whilst working is central.** The longer anyone is off work, the less likely they are to return. It is simpler, more effective, and cost-effective to prevent people with common health problems going on to long-term sickness absence and risk falling out of work.
- **Workplace accommodation is essential.** To help people stay at work, the workplace will need suitable information, tools, and training. Traditional health risk management, while important, is not sufficient. It is a separate service that would sit alongside the new occupational health support.
- **A stepped/tiered approach (see figure below) recognises the fluctuating nature of common health problems, and the fact that many people need little, if any, healthcare: with the right support, they can stay at or quickly return to work.** Simple, low-intensity, low-cost biopsychosocial support will be adequate for many workers, moving to progressively more intensive and structured support for those who need additional help. This approach allocates finite resources most appropriately and efficiently to meet individual needs. Sharing responsibility between healthcare, the workplace and society can be coordinated through a new occupational support service that that educates as well as facilitates.

There are several effective examples in the literature: locally commissioned/delivered models involving some (re)training elements show clear promise – these models need exploration and testing at scale in the UK setting.

Stepped approach "just what's needed when it's needed"



Timeframes - progressively fewer people remain as time passes- step times are appropriate

Research Team

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Professor Kim Burton is an occupational health and ergonomics consultant at the University of Huddersfield. He is an Honorary Fellow of the Faculty of Occupational Medicine, and is an expert adviser to the Government's Joint Work & Health Unit. Kim's current research focuses on implementing novel vocational rehabilitation and educational interventions to support people and their workplaces. He was appointed an OBE in 2011 for services to occupational healthcare.

Including contributions from Dame Carol Black (Principal, Newnham College Cambridge, Dr Steve Boorman (Chair, Council for Work & Health) & Dr Christian van Stolk, (Vice-President, RAND Europe)

Underpinning references

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