Sickness absence and rehabilitation: what hope of change?

Sickness absence is a continuing blight on working life. It causes enormous financial loss to employers, it decreases production and it increases stresses and strains on those employees who have to take on the extra work that results from the absence of their colleagues. Employers are concerned about sickness absence because of its financial consequences and will generally require their occupational health department—if indeed they have one—to reduce it. In most cases, employers suppose that there is a medical solution, but in the case of short-term absence the cause is much more likely to be organizational troubles at the workplace which are breeding low morale and low motivation. In my experience employers are not very receptive to this explanation, since it requires them to change working practices, a costly undertaking. Long-term sickness absence may be the result of poor work practices including badly designed work stations, inadequate lifting and handling techniques, long hours and shift work; the two most important causes now are musculoskeletal disorders and stress.

The provision of a safe workplace is expensive and many employers still prefer to treat the symptoms rather than the cause since this is less costly, certainly in the short term. Occupational health services are patchy at best and the proportion of the workforce that has access to an occupational health service varies from about two-thirds in the public sector to about one-third in the private sector. Of businesses with under 25 employees, only 5% provide any kind of medical or other support to their employees. Moreover the quality of provision, even in the National Health Service, is very variable; there are no national standards.

The Government has lately professed an interest in occupational health but its recommendations on how to improve delivery and reduce sickness absence are more form than substance. *Working Together*¹ suggested several objectives for the NHS with respect to the health of its employees—to achieve ‘year on year improvement in sickness absence rates’ and to have in place ‘occupational Health Services and counselling available for all staff’. More

recently the Occupational Health Advisory Committee of the Health and Safety Commission has made recommendations to ‘raise the profile of occupational health’; it sees no role for putting a levy on employers for occupational health provision and clearly expects occupational health services to be provided increasingly by doctors and nurses in primary care who will have no specialist training in the field². The committee does not consider that the Health and Safety Executive has much more to offer than the provision of ‘generic guidance’, but it does make one useful suggestion—that more research should be directed towards identifying the economic benefits of occupational health interventions. The cost–benefit of occupational health provision has never been adequately explored in the UK and such a study is long overdue; I suspect that practitioners have been opposed to it because they are not entirely confident of the outcome. Some information on the efficacy of counselling services, which employees now see as a panacea, is long overdue.

One effective measure for reducing time off work, with musculoskeletal disorders at least, is the provision of adequate rehabilitation services and this is the subject of another document, from the British Society of Rehabilitation Medicine (BSRM)³. The report highlights the deficiencies in treating musculoskeletal and especially spinal pain—long waiting times, inflexible services, a lack of understanding of the impact of disease and disability on work and poor cooperation between occupational health departments and the NHS. A typical history of a patient with low back pain in my experience would be that he is treated for some weeks by his general practitioner, then, when the pain is no better, is referred to an orthopaedic surgeon; a wait of several weeks ensues before the first appointment. A magnetic resonance scan is ordered; another wait for several weeks, and then the second appointment after a few more weeks. In all, it may take six to nine months before any specialist treatment is offered, by which time the chances of the patient returning to work have dropped to about 50%. If the patient is off work for a year, the chances of a return to work are 25%, and after this few individuals will return to any sort of work, irrespective of further treatment. Active rehabilitation and an early return to work with supervision by the occupational health staff is the best way to secure a satisfactory outcome. The BSRM report recommends allocation of more resources to rehabilitation, cutting excessive waiting times for radiology and therapy services,

improving the understanding by health professionals of employment issues and the setting up of a new Institute of Rehabilitation Research. I can find little in the document to suggest where the money would come from, although since the cost of work-related ill-health is reckoned (in 1995/6 prices) at £2.5 billion, there seems plenty of scope to pay for them from savings that might be expected to follow.

The BSRM is not alone in its reluctance to spell out what is really needed—namely, cash, and plenty of it. In its role as an employer, the Government exhorts the NHS to reduce sickness absence rates without being willing to put up the money needed to provide working conditions on par with those in other parts of Europe, and the Health and Safety Commission is remarkably coy about saying what its own role should be. In truth, the Health and Safety Executive has been a great disappointment, not because it does not have excellent people working for it, but because it does not have enough to provide an adequate policing role. There is no likelihood that we will ever get a national occupational health service; this opportunity was lost in the political manoeuvring that took place when the NHS was being set up after the Second World War⁴, but we could at least have an effective agency to ensure safe working conditions. It is a sad fact of life that employers will only be certain to pay proper attention to the health of their staff if stringent occupational health laws are in place and they know that they may be subject to random unannounced inspections of their workplaces and that any infringements of the law will be severely punished. The pitiful fines that were imposed upon employers whose negligence resulted in

the death of employees was a scandal that has only recently been rectified; the prospect of a jail sentence is more effective than 'lunch with the factory inspector' in making an employer think seriously about his employees' conditions of work. The latest proposal from the Health and Safety Commission is that company directors and board members of public-sector organizations should be made more accountable for health and safety⁵. This may help; but what we really need is a shift to a culture in which health and safety are vigorously pursued by government agencies, where occupational health services in the public sector are refashioned to become a model for private enterprises and where the NHS is funded to ensure that the workforce, on which the wellbeing of the country depends, is safeguarded when well and treated promptly when ill.

H A Waldron

St Mary's Hospital, London W2 1NY, UK

REFERENCES

- 1 Department of Health. *Working Together. Securing a Quality Workforce for the NHS*. London: DoH, 1998
- 2 Occupational Health Advisory Committee. *Report and Recommendations on Improving Access to Occupational Health Support*. London: HSC 2000
- 3 British Society of Rehabilitation Medicine. *Vocational Rehabilitation. The Way Forward*. London: BSRM 2000
- 4 Waldron HA. Occupational health during the Second World War: hope deferred or hope abandoned. *Med History* 1997;**41**:197–212
- 5 Health and Safety Commission. *Draft Code on Health and Safety Responsibilities*. London: HSE, 2001