Icelandic Vocational Rehabilitation Fund

Assessment of work capability for a social security benefit

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Fundamental Precepts:

- Main determinants of health and illness depend more upon lifestyle, socio-cultural environment and psychological (personal) factors than they do on biological status and conventional healthcare.[1]
- Work: most effective means to improve well-being of individuals, their families and their communities.[2]
- Objective: rigorously tackling an individual's obstacles to a life in work.

1. Marmot M. *Status Syndrome,* Bloomsbury, London: 2004

2. Waddell G, Burton K. *Is work good for your health and well-being?* TSO, London: 2006

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

Health: A New Definition?

WHO (1948): …"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1]

Proposed definition[2]:… "as the ability to adapt and self manage in the face of social, physical and emotional challenges."

1. WHO 2006 Constitution of the WHO
2. Huber et al 2011 BMJ 343: d4163

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**

The Hypotheses:

The Assessment of Work Capacity is frustrated by the meaningless pursuit for objectivity.

Barriers to entry into/return to work are primarily psychological, social, personal and cultural: not medical issues.

The Consequences

- **Illness, Sickness and Incapacity**
  are Psychosocial rather than Medical problems.

- **More and better healthcare is not the answer**

Confounding Issues:

- Lack of consensus of opinion among health care professionals
- Erosion of public confidence in expertise of medical profession
- Failure of the Bio-medical model of illness and disability
- Disagreement about what constitutes capacity / incapacity for work
- Escalation of subjective health conditions among recipients of incapacity for work benefits.

PARADOXES

- The typical disabled person (perception-vs-reality)
- The health paradox (improved health-vs-claims' trends)
- The failure to recover (clinical recovery-vs-poor work outcomes)
- Disability Rights-vs-Sick Worker Advocacy

Unbundling illness, sickness, disability and (in)capacity for work

- Disease: objective, medically diagnosed, pathology
- Illness: subjective feeling of being unwell
- Sickness: social status accorded to the ill person by society
- Disability: limitation of activities/ restriction of participation
- Impairment: demonstrable deviation / loss of structure of function
- Incapacity: inability to work associated with sickness or disability

**The terms are not synonymous: there is no linear causal chain.

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

Cardiff Health Experiences Survey (CHES): Face-to-Face Interviews [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

Common health problems as causes of long-term sickness (Sissons et al, 2011)

	Percentage
Musculoskeletal condition / injury	37
Mental health condition	32
Long-term systemic condition	16
Don’t know / prefer not to say	02

Base: 2945 respondents reporting health condition at baseline

Mental Health Problems: Challenges in Recognition and Assessment:

- Their subjective nature
- What constitutes “caseness”?
- Distinguishing recognisable mental impairments from subjective self-reported symptoms
- Validity of clinical guidelines for the rating of psychiatric impairments
- The ubiquity of mental health problems and “stress”

The Crux of the Problem:

For the assessment of disability and(in)capacity for work,

how much should be based on:

- **"Objective" measures of impairment and observed function**

  versus
- **"Subjective" self-reports of illness and functional limitations?**

Complicated by:

- **Failure to address the major psychosocial and cultural barriers to entry into/return to work**

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.

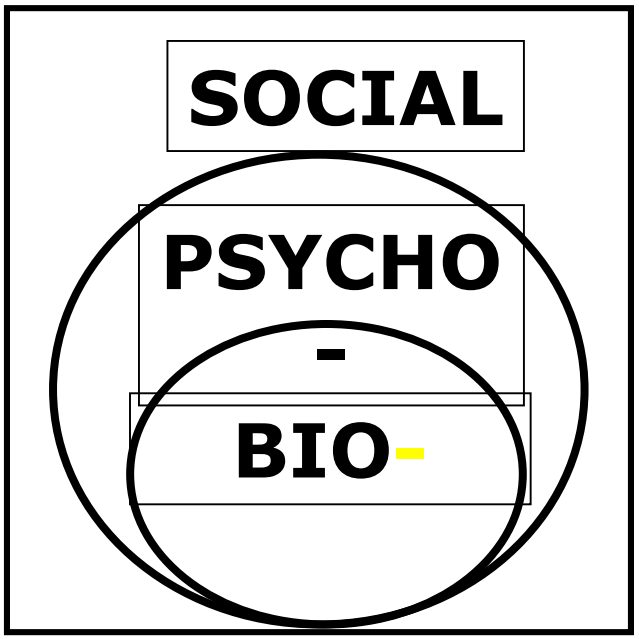
Common Health Problems: disability and incapacity

- 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

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 **obstacles to recovery & barriers to return to work**

Cardiff Research: 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 illness

Findings: 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 %	

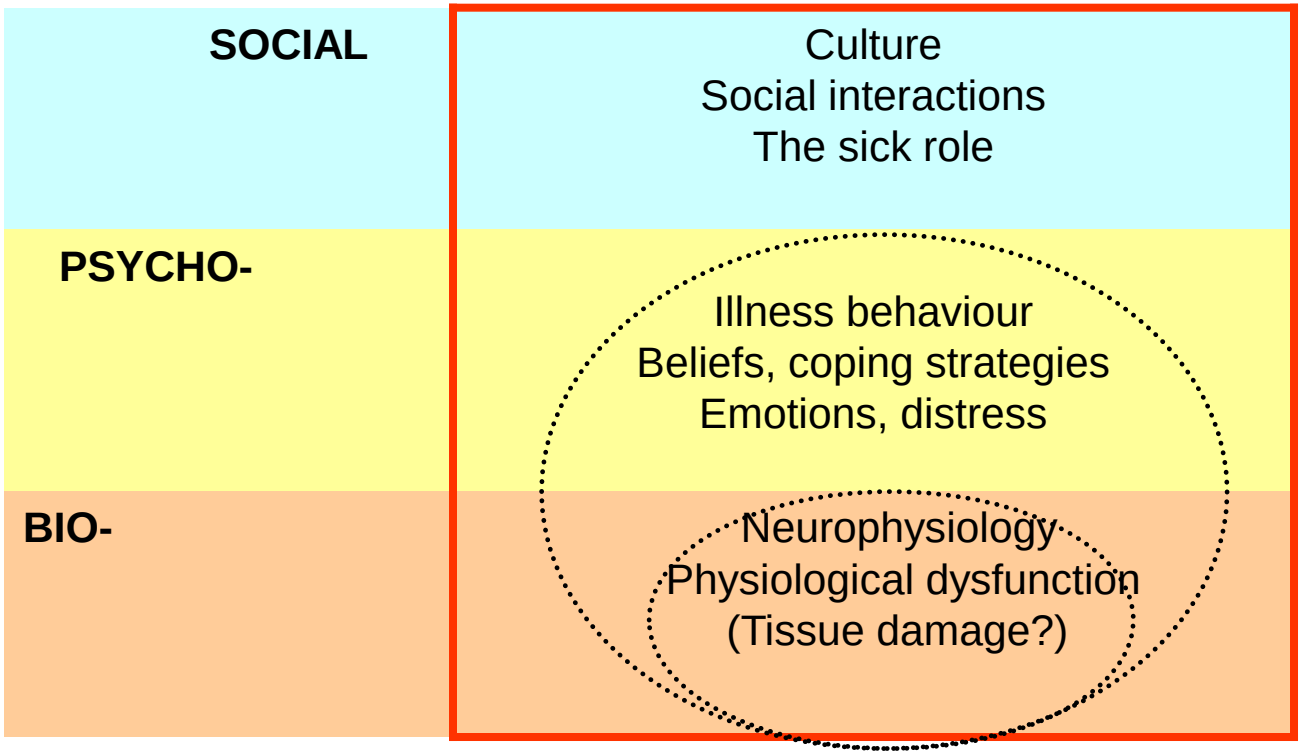
Cardiff Research: Positive Influences

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

Deductions:

- **Obstacles to recovery and return to work are primarily personal, psychological and social rather than health-related "medical" problems.**
- **Workplace problems dominate**
- **A bio-medical model cannot adequately address these issues**

Biopsychosocial Model



Strengths of BPS Model

- Provides a framework for disability and rehabilitation
- Places health condition/disability in personal/social context
- Allows for interactions between person and environment
- Addresses personal/psychological issues.
- Applicable to wide range of health problems

Social Contexts that influence Health and the pursuit of a life in Work:

- **A person's past social experiences become written into the body's physiology and pathology[1]**
- **Lack of autonomy in life is an enduring negative influence leading to poor health, worklessness and frustrated well-being**
- **Work is central to well-being and correlates with happiness and health**
- **Class difference in mortality, morbidity and economic inactivity are a consistent feature of the entire human lifespan.[2]**

1. Blane D. In Social Determinants of Health, WHO: 1998
2. Black D. Inequalities in Health, HMSO: 1998

Social Gradient, Health and Work: Social Disadvantage

- **Most powerful determinants of (ill) health are social gradients and linked problem of regional deprivation [1,2]**
  - **10 fold variation in incapacity rates between local authority areas.[3]**
- **Multiple disadvantage and barriers to (return to) work among IB recipients [4]**
  - **Concurrent health problems; secondary mental health problems**
  - **Low skills: 40 % no qualifications; low skill trap**
  - **Local labour market**
  - **Uncertainty, a key issue**

1. Marmot,2004
2. Aylward and Phillips, 2008
3. Waddelll and Aylward, 2010
4. Waddell and Aylward, 2005

A Cautionary Tale:

If the principal barrier to return to work is the adverse social context then only dealing with barriers posed by the health condition and psychological elements to achieve a successful outcome is a forlorn hope

Assessment of Work Capacity and Enabling Return to Work in the UK:

- Attempts a fusion of the bio-medical and bio-psycho-social approaches to work capacity assessment and work-focused interventions
- A structured functional assessment of capacity and (potential) capability
- A division of labour between Medical Experts and Non-Medical Decision-Makers
- A work programme, support and condition management for Return-to-Work

Evidence & Assessment: UK:

Evidence:	**Sources:**	**Independent check:**
•Medical Evidence on Health Condition	•General Practitioner's Statement Claim Form	•Health Professionals Medical Records Independent Medical Assessment
•Functional Capacity Assessment	•Self-reporting questionnaire	•Medical Expert Scrutiny Independent Medical Assessment

Eligibility for Incapacity Benefits:

- Exemption from Work Capability Assessment (WCA):
  - Severe (and enduring) health conditions
  - Severe and permanent impairments
  - Severe (defined) mental illnesses
  - Receipt of certain other disability benefits
- Structured functional assessment:
  - Limitations and/or restrictions
  - Validated scoring system (single and co-existing disabilities)
  - Benefit "threshold"
- Independent Appeals Service

Support into Work

Evidence:	**Sources:**	**Independent check:**
•Obstacles to recovery and (return to) work	Self-report questionnaire	•Independent Capability Assessment Personal Advisor (DWP) interview
•Support needs		•Employment Focused interview (condition-management)

Principles of Condition Management:

- Voluntary option routed through the Personal Advisor
- Cognitive/educational interventions common to all conditions
- Evidence based
- Tailored to individual needs – biopsychosocial approach
- Case-managed
- Goals “owned”; not imposed.

Successful Strategies:

Practical Elements of Condition Management

- Address the main health conditions
- Clear work focus, vocational goals, outcome measures
- Address biological, psychosocial and social components
- Address individual's obstacles to RTW
- Increase activity and restore function
- Shift beliefs and behaviour using CBT (talking therapies)
- Working partnership with Personal Advisors

Condition Management: The Pathway to Success

- Shift perceptions, attitudes and beliefs
- Modulate expectations, exploit values and build confidence
- Recognise and address the social contexts of health, disadvantage and economic inactivity
- Promote emotional/physical well-being
- Engender clear work focus and vocational goals
- Encourage behaviour change
- Living with fatigue/pain

The objective: Early Intervention to Assist Recovery:

- **Multi – disciplinary integrated approach at the outset**
- **Health professionals and 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 employees**
- **Early detection: early return to sustained work**

An Independent Review of Sickness Absence (Black and Frost, 2011)

- UK Government's Response (2013):
- Independent Assessment Service (IAS) around 4 weeks sickness absence.
  - State funded: occupational health multidisciplinary team and case management.
  - Advice to employers and employees on tackling barriers that prevent return to work.
  - Signpost to appropriate interventions.

UK Government's Response (2013)

- 'Fit Note' revised guidance: GP advice on work in general – not specific to current job.
- GP support/education/workshops (eg. mental health, e-learning, phone apps, workplace).
- Tax relief: Employee Assistance Programmes.
- Free job-matching service.
- Universal Credit replaces 30 benefits by one benefit: conditionality/RTW support at outset.

UK Costs of Sickness Absence (2011)

- Economy £15bn
- Employers £9bn
- Individuals £4bn

Government £2bn

Black C and Frost D (2011) *Health and Work – an independent review of sickness absence.*

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**

Culture Change:

" **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**

Obstacles (barriers) to optimal recovery and return to work are predominantly personal, psychological and social rather than health-related "medical" problems

- Early and accurate identification of all obstacles
- Robust assessment of negative influences on recovery and RTW
- Scoring and predictive modelling and interaction effects
- Selection and design of bespoke interventions
- Optimises resources and timely return to work

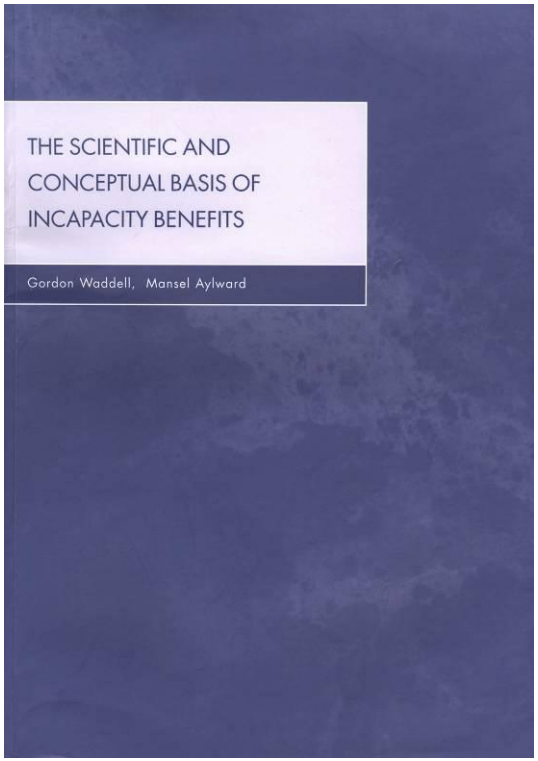
A Strategy for Success

- Abandon the forlorn pursuit for objectivity
- Moderate sole reliance on the bio-medical model
- Embrace the bio-psycho-social paradigm shift and recognise the social context
- Identify and address obstacles to recovery and to (return to) work
- Widen the pathways to work, health, happiness and well-being.

Hot off the Press:

- “Fitness for Work” 2013. fifth edition (Eds: K T Palmer, I Brown, J Hobson) Oxford University Press.
- Chapter 4: *Support, rehabilitation and interventions in restoring fitness for work.* Mansel Aylward, Deborah A Cohen and Philip Sawney.

The Scientific and Conceptual Basis of Incapacity Benefits



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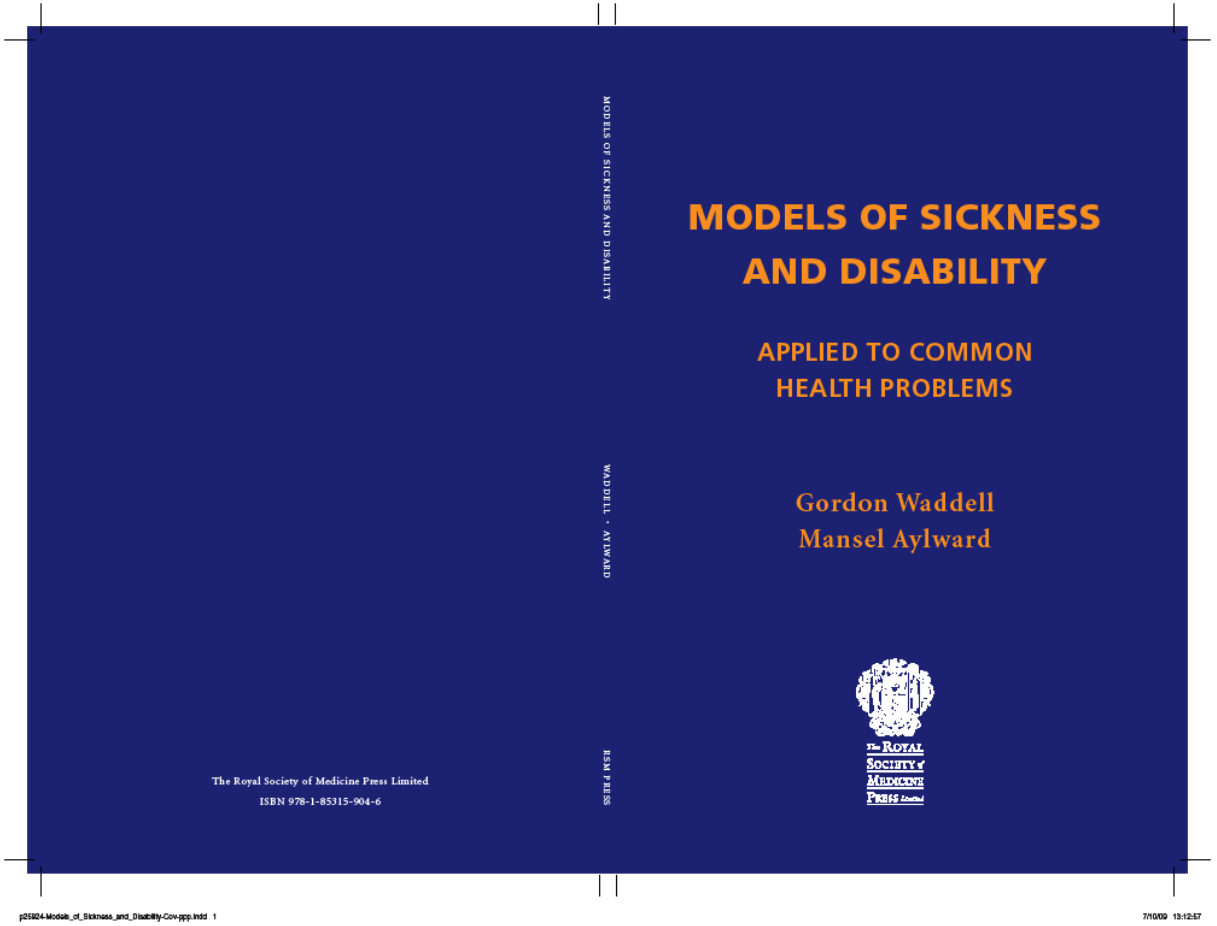
Models of Sickness and Disability



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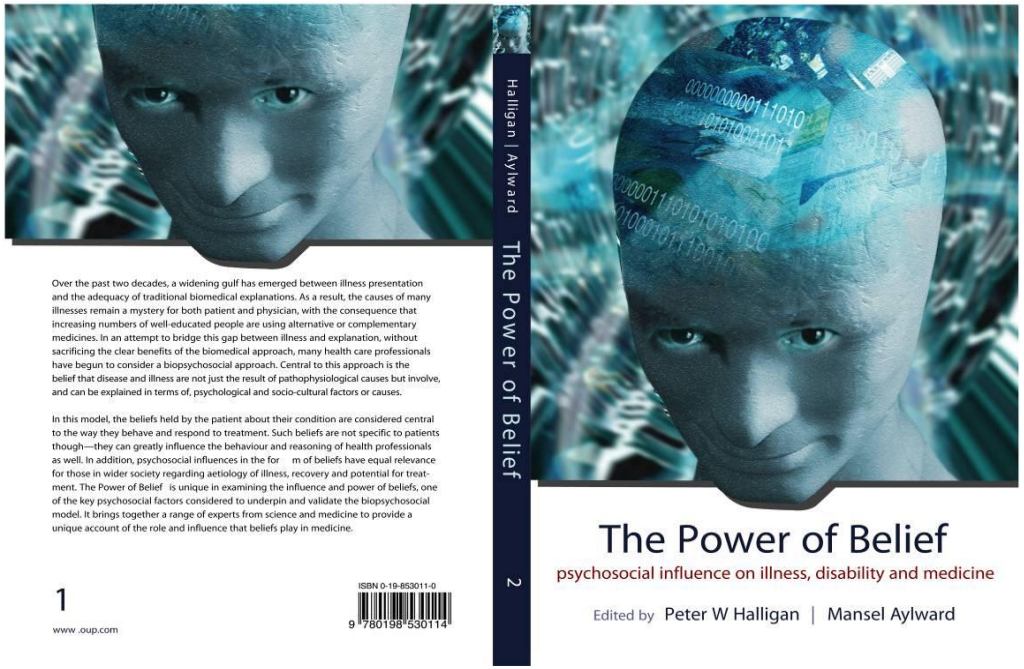
The Power of Belief



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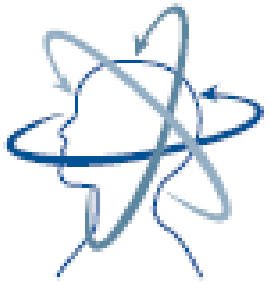

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