Is work good for you? Professor Kim Burton explains the UK's changing answer

By: Anna Kelsey-Sugg

In this interview with UK expert we learn that modern vocational rehabilitation is not about delivering an expensive service.

Professor Kim Burton is internationally recognised for his research into musculoskeletal disorders. He is Director of the Spinal Research Unit at the University of Huddersfield (UK) and Associate Professor of Clinical Biomechanics at the British School of Osteopathy in London. Here he speaks with RTW Matters about changing attitudes in the UK towards the benefits of work, doctors' roles and the good business of vocational rehabilitation.

Your work on the health consequences of long term worklessness has highlighted the health effects of being out of work. Has this started to filter through in the UK? Are doctors starting to take notice of this and inform their patients about the pros and cons of return to work?

The report that Gordon Waddell and I prepared for the Department for Work and Pensions (*Is work good for your health and well-being*, 2006) has certainly had an impact at the policy level, and has been well received among numerous groups of health professionals. There is also wide stakeholder support for the concept of work being good for us.

Yes, the basic message has definitely been filtering through, but probably somewhat patchily, concentrated among forward looking, well informed professionals and organisations. Changing the culture takes time, even with the implementation of a number of coordinated initiatives – it can be done, just not in a hurry.

What do you see as the main barriers to vocational rehabilitation in the UK (or elsewhere)?

The most problematic barriers are contextual, notably those presented by 'systems': benefit systems, sick certification rules, access to rehabilitation, and the like. Arguably, we know a lot of what to do around vocational rehab, as we found in our latest review (*Vocational rehabilitation: what works, for whom, and when?* Waddell, Burton & Kendall, 2008).

However, we're not doing it optimally, partly because the systems get in the way, but also because of the host of personal and workplace psychosocial obstacles that impede the individual; these need to be tackled, but unless the systems are compliant successful vocational

rehab is unlikely.

Another, related issue is that of timing: different obstacles appear/develop as time progresses following symptom onset or start of absence – different interventions are therefore needed at the various stages – all the players need to recognise and work to this. Ensuring the right early intervention is a prerequisite if we are to reduce the number of people needing further interventions – that brings us back to the need for systems that permit it to happen.

Do you consider doctors to play a major role and if so what is the most effective way to influence them?

For sure, doctors play a major role but we have to remember doctors work within systems, which of course differ from country to country. We have to work out what it is we are expecting health professionals to do, and then give them the tools to do it – that means tools that help overcome psychosocial obstacles to rehab as well as changes to the systems.

Health professionals are known to be a tough bunch to influence, which is to some extent a good thing – we'd not get very far if doctors and therapists simply locked onto every new fad.

What we're learning is that health professionals, like the general population, respond best to evidence-based messages that are also intuitively attractive. It's probably best to keep the messages uncluttered, so that they are easily assimilated and the behaviour changes they dictate are readily achievable. Good examples are activity not rest for back pain, or work is good for health, or early return to (accommodating) work is therapeutic. It's often said that the easiest way to change health professionals' behaviour is through financial routes, and doubtless that can be the case.

However, that's not really dealing with the issues and the strategy has generally been found lacking and unsustainable. Simply throwing guidelines at them doesn't seem to be the answer either. I think we've got to be smart and come up with a sequence of initiatives that are interlinked, and deal with multiple obstacles across domains (healthcare, workplace and systems).

Education is obviously a potential means to influence health professionals, but it may be that educating their patients is an equally powerful approach – the well informed patient may well request the right things and criticise offers of the wrong. But, the health professional needs the tools and freedom to respond in the right way. The same applies to the workplace.

The bottom line is that all the players need 'influencing' - concentration on one group probably won't achieve much.

The community's approach seems to be important. For example, the major focus and drive of

the Danish system to help people back to work has paid off in reducing work disability. Would you comment on the UK system at this stage and whether community attitudes are shifting?

Accepting that the community is a major player, then yes, their beliefs and behaviours are important. Of course, we're all part of the community, so tackling attitudes and beliefs at the population level will potentially influence all the players.

I think it's really too soon to know whether community attitudes in the UK are changing. Far more needs to be done to shift the underlying culture before we are likely to realise major behavioural change. Achieving that change will require a combination of trickle-down education and changes to the systems. One without the other doesn't work – everyone may accept that early return to work is beneficial, but if workplaces don't adopt the accommodation message little can change.

In Australia rehabilitation is broadly divided into two groups, depending on whether the health condition is considered work or non work related. Work related conditions have a stronger return to work emphasis and employers typically drive the return to work process. However if the health condition is not work related the employer is less likely to support return to work. Do you have a similar divide in the UK?

Not to anything like the same extent, probably because we don't have a workers' comp system. We have a difficulty in UK in identifying any particular group as being the primary driver of the return to work process. Of course, it should be quite irrelevant whether the problem was (perceived to be) caused by work – the principles of vocational rehabilitation should be applied regardless, especially if the symptoms/disability are work-relevant.

The key factor is communication between healthcare, the workplace and the worker: agreeing goals and putting plans into action, irrespective of the reason for absence.

What are the major policy changes occurring or planned in terms of work injury rehabilitation?

The UK government has recently responded to a report by Dame Carol Black (*Working for a healthier tomorrow*) that made a number of innovative recommendations ranging from reform of the medical certification for fitness to work (move from the traditional sick note to a 'fit note' telling people and their employers what they can do not what they can't) to provision of access to a 'Fit for work service' (an integrated, early case-management approach based on biopsychosocial principles).

The Government has responded very favourably to Dame Carol's suggestions and has committed to considerable action over the next few years (*Improving health and work: changing lives*). [These reports can be obtained from the Working for Healthier Tomorrow website].

Do you think the economic issues we are all hearing about at the moment will impact vocational rehabilitation over the next few years? Can effective rehabilitation assist employers to reduce costs, or is it a cost burden they will try to avoid in harder times?

I sincerely hope employers (and policy makers) will grasp the idea that modern vocational rehabilitation is not about delivering an expensive service.

Good vocational rehabilitation starts early, very early, and follows a stepped care approach whereby straightforward work focused healthcare and accommodating workplace management (which is all most people need) should be a cost-neutral provision. For the fewer people who need heavier duty support, there is obviously an additional cost, but the benefits should far outweigh the expenditure: there is a good business case for modern vocational rehabilitation, and that should operate in bad times as well as good.