Select 74 Underwriting Forum

“ Back pain is enough to drive you nuts!”
An evidence – based approach.

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Cheltenam:
13th December 2007

Changing the path to economic inactivity:

- Shifting Attitudes to Health and Work (Cultural Change)
- Unbundling: Sickness, Incapacity, Work and Health
- Illness Behaviour
- Obstacles to recovery and return to work
- Myths to truths about back pain
- New concepts for intervention and rehabilitation

Worklessness:

- **Risks and Harm:**

Loss of fitness
Physical and mental deterioration
Psychological distress and depression
Loss of work-related habits
Increased suicide and mortality
Social exclusion
Poverty

What do we know about being out of work?

- Unemployment is bad for you:
  - Loss of Income[1]
  - Destructive on self-respect[1]
  - Risks of ill-health[2]
  - The “psychosocial scar” persists[3]
  - Transgenerational effects[4]

1. Winkelmann and Winkelmann 1996
2. Clark, Georgellis, Samfey 2001
3. Clark and Oswald 1996
4. Aylward 2006

Long-term worklessness is one of the greatest known risks to public health

- Health Risk = smoking 10 packs of cigarettes per day (Ross 1995)
- Suicide in young men > 6 months out of work is increased 40 x (Wessely, 2004)
- Suicide rate in general increased 6x in longer-term worklessness (Bartley et al, 2005)
- Health risk and life expectancy greater than many “killer diseases” (Waddell & Aylward, 2005)
- Greater risk than most dangerous jobs (construction/North Sea)

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 Impact:

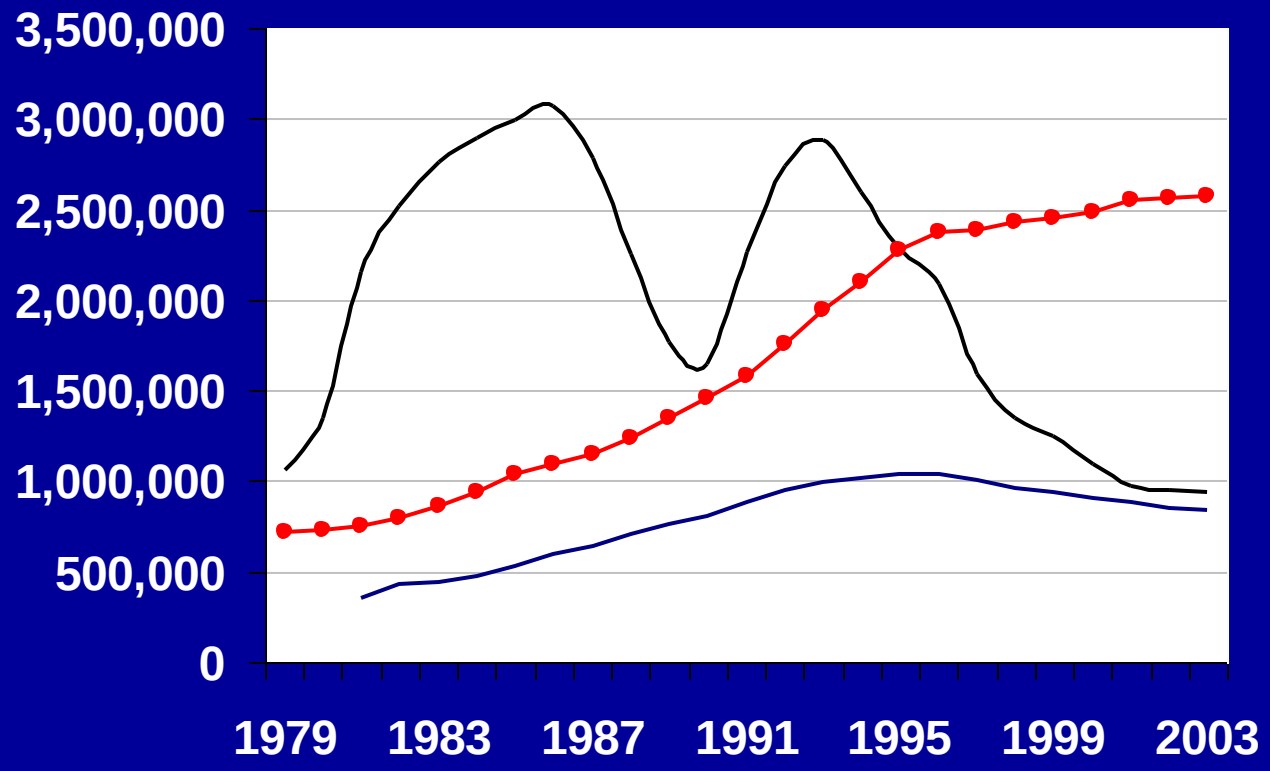
Sickness and disability among main threats to full and happy life;

Work incapacity most significant impact on individual, the family, economy and society.

Current context

- 1 million report sick each week; 3000 remain off work at 6 months and 80% of these will not work again in next 5 years
- 2.7 million people of working age on a state incapacity benefit [less than 1 million unemployed]
- demographics not good; ageing population; IB load projected to rise further; regional dimension
- Sickness Absence
  - industry costs £11 bn pa (underestimate)
  - 16% of salary costs
  - best management practice and occupational health meagre

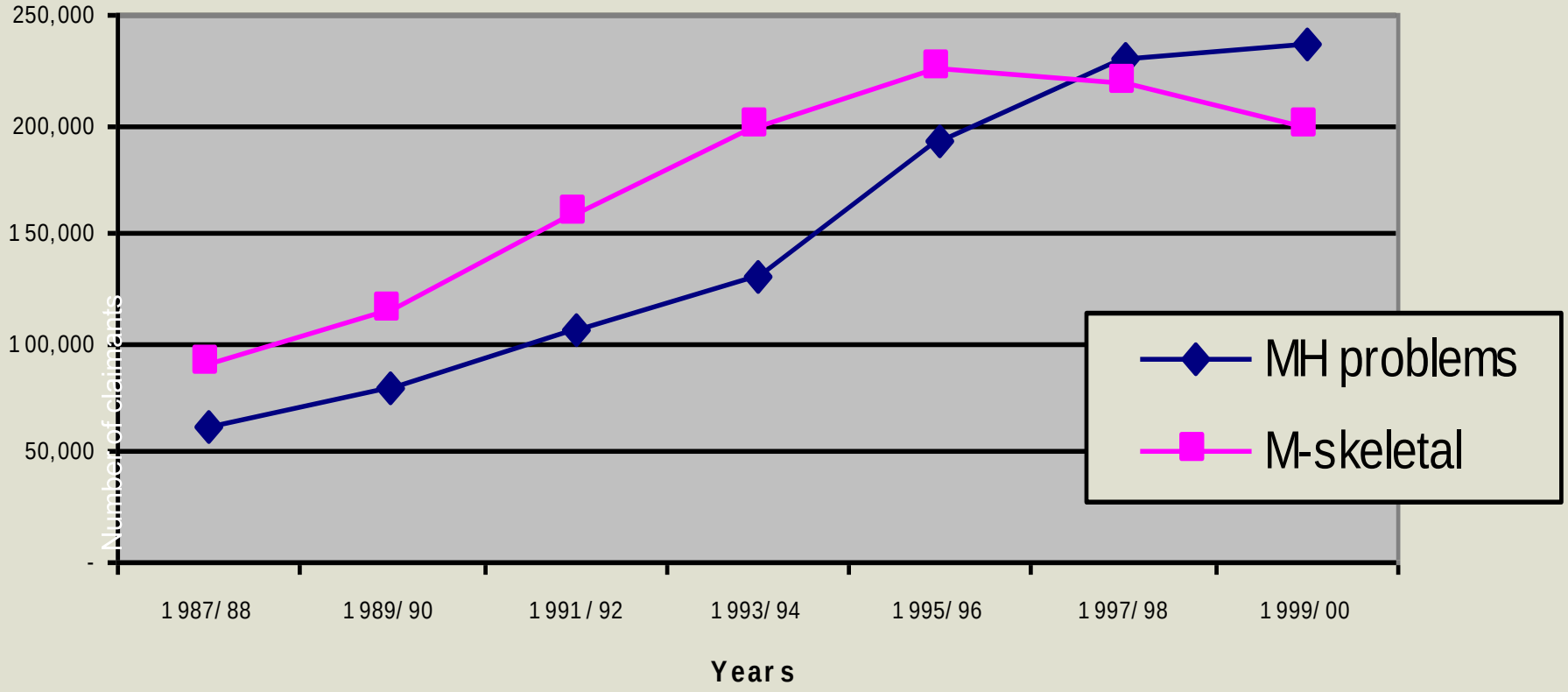
Recipients of key working age benefits



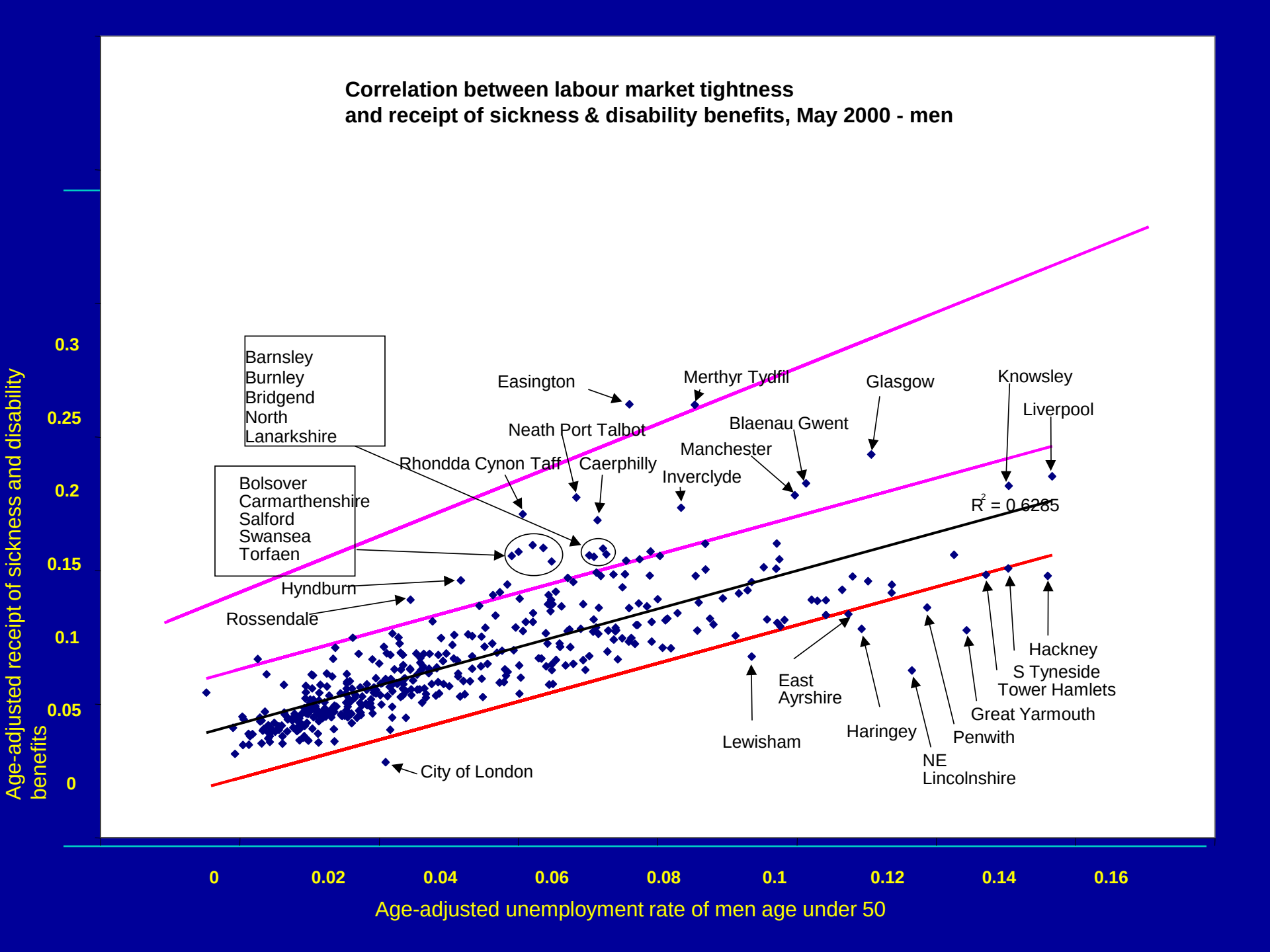
Source: DWP and ONS

Incapacity Benefit Claims

Source: 1% sample of all IB claimants

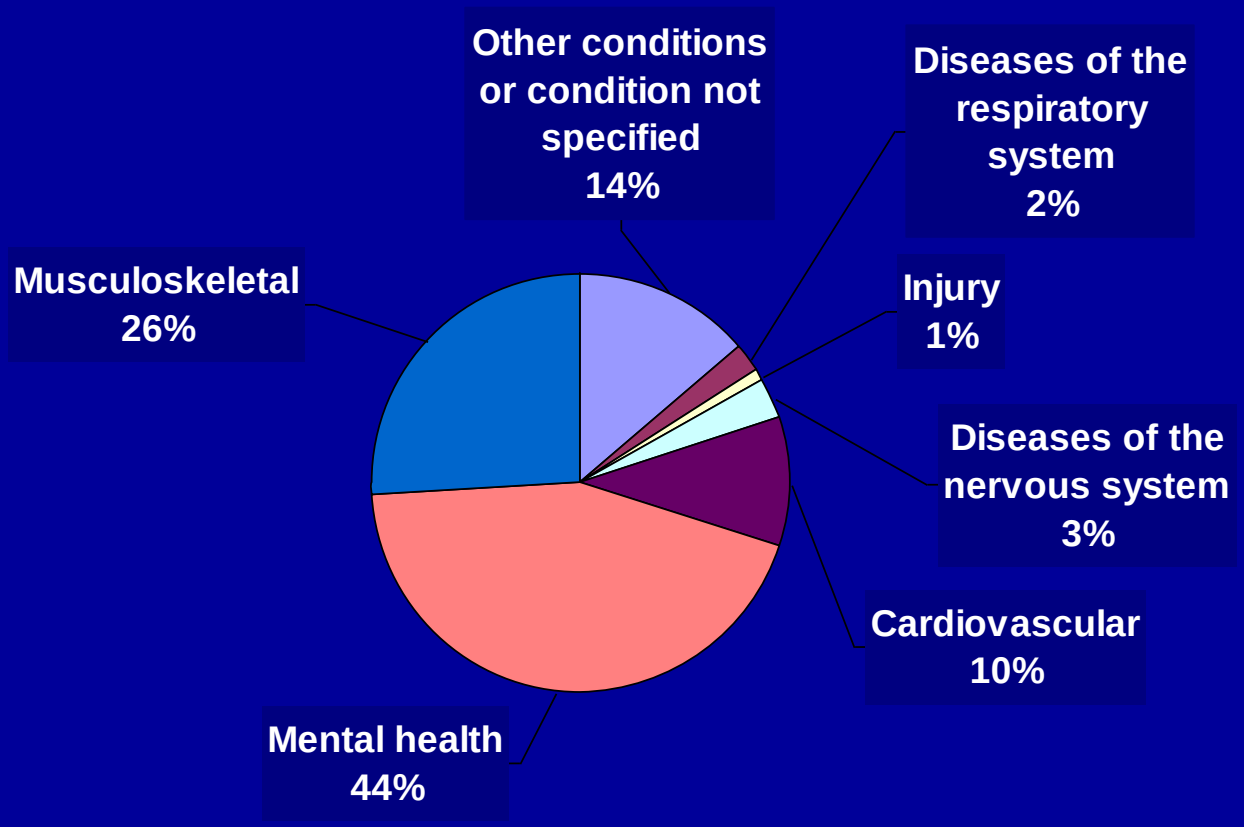


Waddell, Aylward & Sawney, 2002


Correlation between labour market tightness
and receipt of sickness & disability benefits, May 2000 - men
Age-adjusted receipt of sickness and disability benefits
0.3
0.25
0.2
0.15
0.1
0.05
0
Barnsley
Burnley
Bridgend
North
Lanarkshire
Bolsover
Carmarthenshire
Salford
Swansea
Torfaen
Hyndburn
Rossendale
City of London
Easington
Neath Port Talbot
Rhondda Cynon Taff
Caerphilly
Merthyr Tydfil
Inverclyde
Manchester
Blaenau Gwent
Glasgow
Knowsley
Liverpool
R2 = 0.6285
Lewisham
East
Ayrshire
Haringey
NE
Lincolnshire
Penwith
Great Yarmouth
Tower Hamlets
S Tyneside
Hackney
0
0.02
0.04
0.06
0.08
0.1
0.12
0.14
0.16
Age-adjusted unemployment rate of men age under 50

IB Recipients - Diagnoses

Incapacity-related benefit recipients by diagnosis group, November 2003



UK Incapacity Benefit

- ‘Severe Medical Conditions’ <25%

- ‘Common Health Problems’
  - Mental health problems 44%
  - Musculoskeletal conditions 25%
  - Cardio-respiratory conditions 10%

Common health problems

Less severe mental health, musculoskeletal and cardio-respiratory conditions

Limited objective evidence of disease

Largely subjective complaints

Often associated psychosocial issues

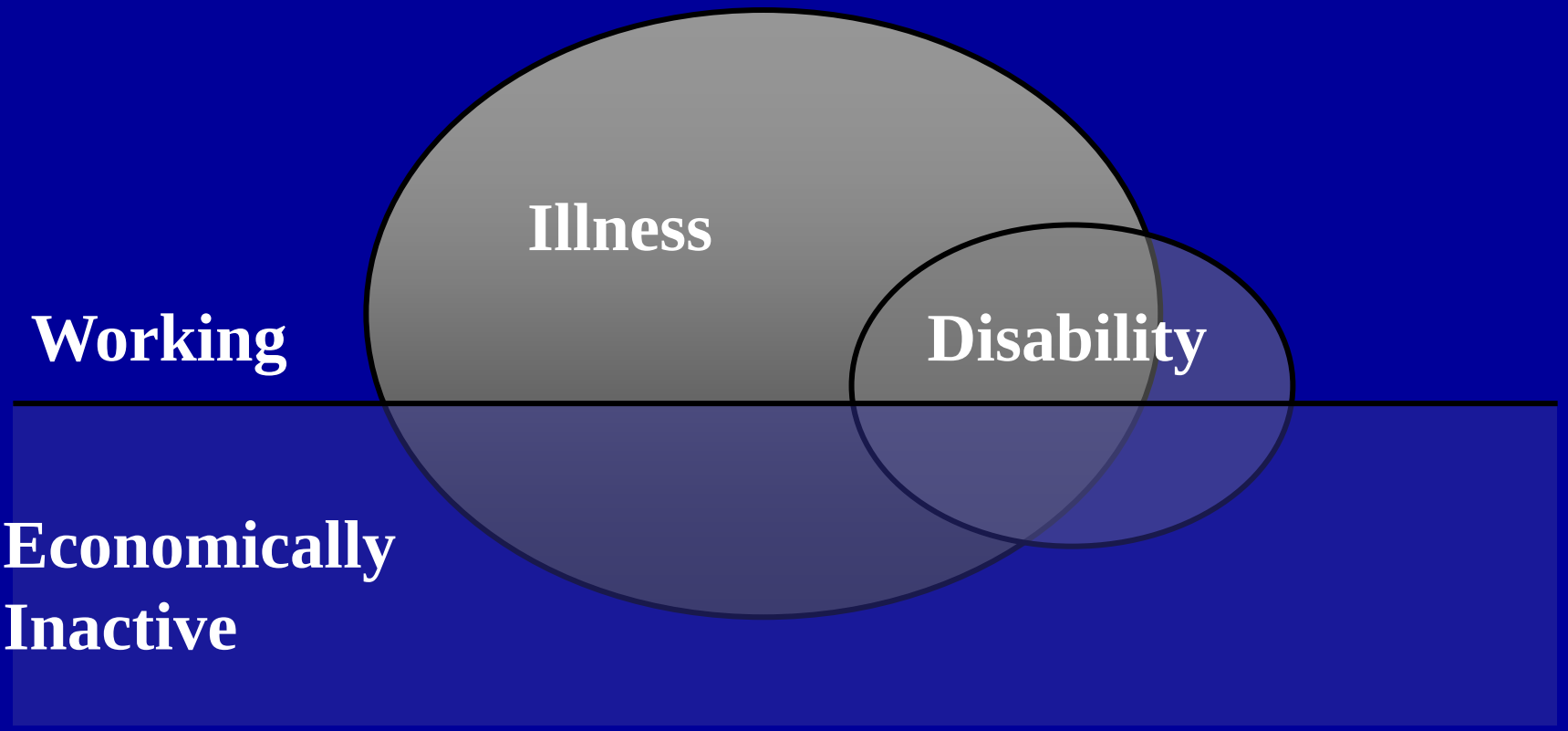
Unbundling illness, sickness, disability and (in)capacity for work

- 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.

Limited Correlations:

The need to ‘unbundle’ Sickness, Disability & Incapacity



Prevalence of subjective health complaints in the last 30 days in Nordic adults (after, Eriksen et al, 1998)

	Any complaints		Substantial complaints	
	Men	Women	Men	Women
Tiredness	46%	56%	17%	26%
Worry	38%	39%	13%	15%
Depressed	22%	28%	5%	10%
Headache	37%	51%	4%	9%
Neck pain	27%	41%	9%	17%
Arm/shoulder pain	28%	38%	12%	17%
Low back pain	32%	37%	13%	16%

>50% reported two or more symptoms

Cardiff Health Experiences Survey (CHES): Face-to-Face Interventions [N=1000] GB population:

	Inventory:	Open Question:
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

Subjective Health Complaints

- High prevalence in the general population (Eriksen et al, 1998; Ursin, 2003, Barnes et al, 2006)
  - *Symptoms: self reported*
- Unexplained symptoms in people accessing healthcare:
  - *On average < 10% symptoms attributed to organic causes (Kroenke & Mangelsdorff, 1989)*
  - *Limited objective evidence of disease, damage or impairment (Page and Wessely, 2003)*
- Regional (Pain) Disorders [Hadler, 2001]
  - *Low back, upper limb, neck, etc*
- Medically unexplained Symptoms in Outpatient Clinics:
  - *30-70 percent without identifiable disease (Bass, 1990, Maiden et al, 2003*

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: Early Findings:

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 personal illness

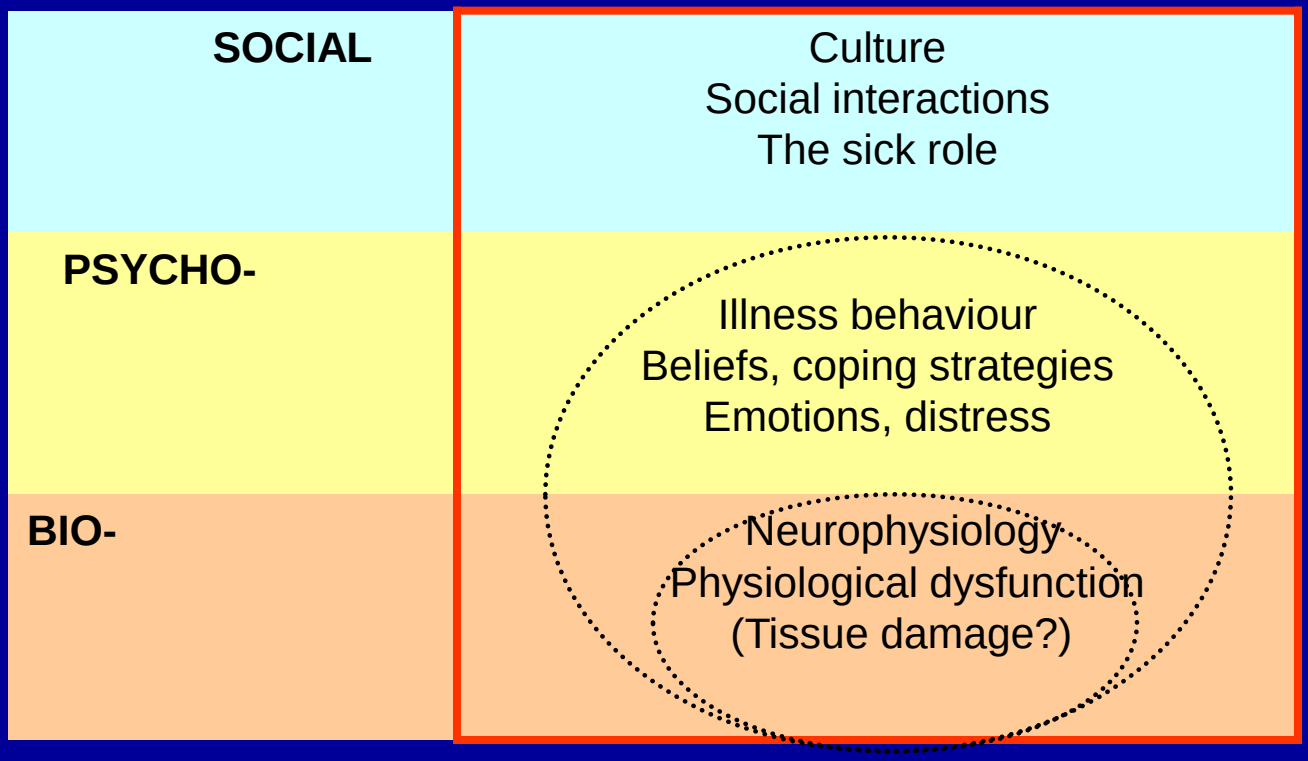
Early Findings: Negative Influences:

- **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

- **Obstacles to recovery and return to work are primarily personal, psychological and social rather than health-related “medical” problems.**

- **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

- **Barriers to recovery and return to work are primarily personal, psychological and social rather than health-related “medical” problems.**

- **Workplace culture and organisational features dominate.**

Focusing on Recovery: 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] Maid & Spanswick, 2000. [2] Gatchell & Turk, 2002.[3] Waddell & Aylward

Some Pertinent Facts:

- More and better healthcare is not the answer

- False beliefs play a pivotal role in propagating and perpetuating common health problems, and especially chronic disabling back pain

Chronic Disabling Back Pain: The Facts

- Back pain is common: 70% life-time incidence
- Most people remain at work or return to work quickly (even with some pain)
- Little or no evidence of permanent damage or impairment
- Important role of psychological factors; beliefs, attitudes, emotions, expectation, social and cultural contexts

Back Pain: The Myths

Outdated – ill informed – seriously impede recovery:

MYTH	REALITY
• "Slipped disc" requires surgery	• Majority heal without surgery (last option
•X-Rays, MRI & CT Scans always needed	•Degenerative changes are mostly normal, age – related changes
•Take it easy until pain goes away	•Staying active or quickly returning to activity (including work), even if still painful, enhances recovery

Back Pain: Some More Myths

MYTH	REALITY
• Most back pain caused by heavy lifting	• Cause mostly unknown; not usually following lifting; sedentary = manual workers
•Is usually disabling	•Few people are disabled beyond a few days
•Bed rest is mainstay of treatment	•Bed rest is anathema: leads to longer time to recovery and return to work

Shifting attitudes to health & work

Current:	Shift to:
Work is a ‘risk’ and (potentially) harmful to physical and mental health.	Work is generally good for physical and mental health
therefore	and
Sickness absence/certification ‘protects’ the worker/patient from work	Recognise the risks and harm of long term worklessness

UK Government
"Pathways to Work" Initiative

- Return to Work Payment

  £40-120 Mandatory Work-Focused per week

- Interviews (Case Managers)

- New Condition-Management Programmes:

  (focus: m/s, Mental Health; Cardiorespiratory)

  - helping people to understand and manage their condition

  - using CBT and related interventions

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

PATHWAYS TO WORK

- 6-800 new job entries each month in existing *Pathways* areas
- Doubling of claimants entering work
- Take-up around 5 times that expected from previous RTW interventions
- Exceeds threshold for cost-effectiveness
- Welfare Reform :extending provision across country by 2010

  :Reducing by 1 million the number on Incapacity Benefits

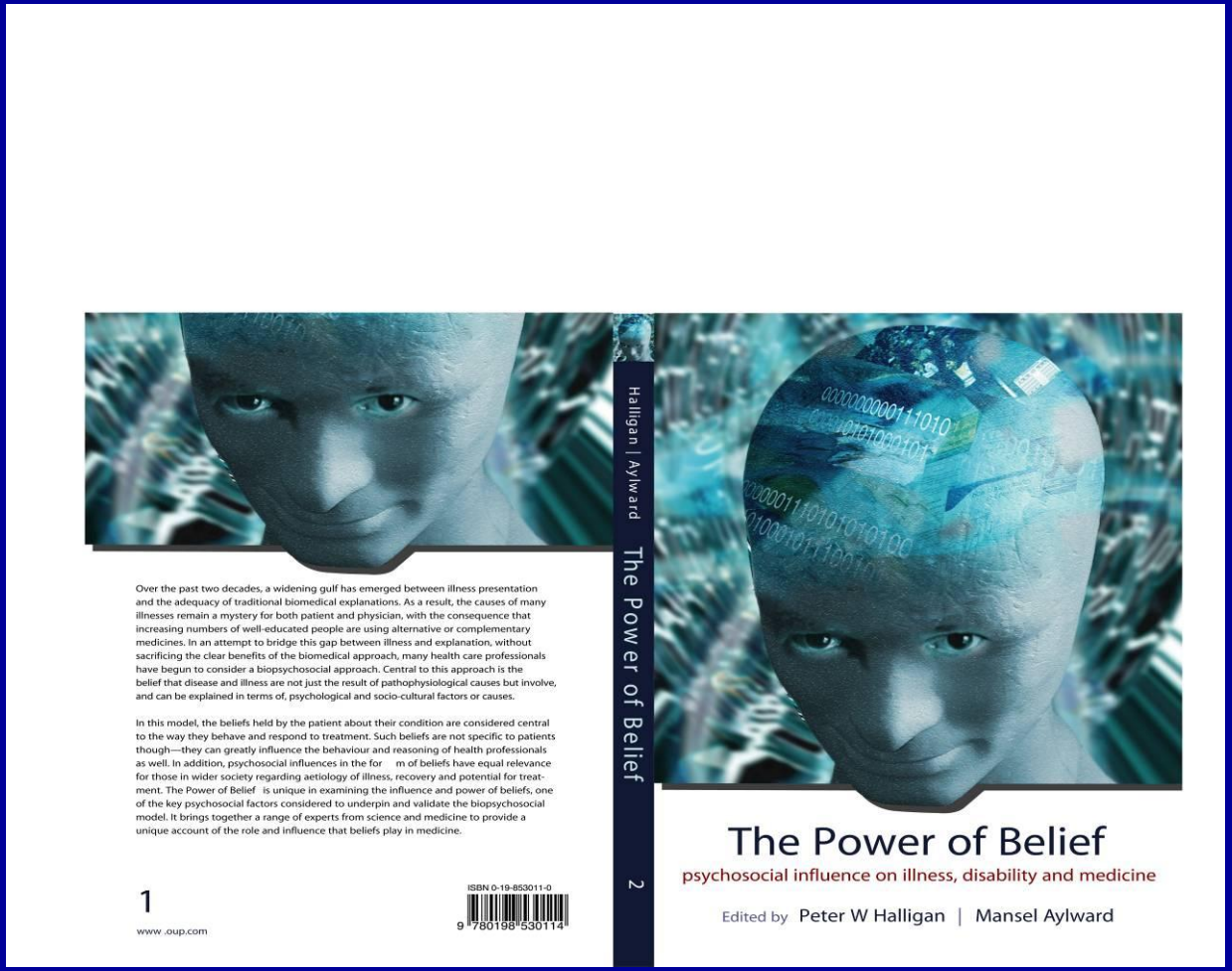
  :employment rate = 80% working population

At the heart of culture lies belief

- *Beliefs drive behaviour*
- *Modified by experience*
- *Dispelling the myths*
- *Public policy initiatives*

Transforming the culture depends on shifting core beliefs about health, illness, sickness and work

The Power of Belief



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