
OA has long been seen as a not very interesting disorder: a natural result of the wear and tear on the cartilage, a disorder of elderly people, hardly any treatment options. But this view has changed [1], and along with the development of a wider, biopsychosocial perspective on OA [2], the diverse personal and social consequences of OA have attracted more attention in research and clinical practice. The insight that in people of working age OA may cause productivity loss and eventually work loss has raised awareness of the socio-economic component of the disease (both for individuals and society), since a large increase in prevalence of OA is anticipated. Wilkie et al. [3] designed a population-based prospective cohort study in a primary care setting in the UK to determine the frequency and determinants of premature work loss (PWL) due to OA. The authors concluded that PWL in adults consulting with OA is common (almost one in four over 6 years). Those adults at risk could be identified by brief questions about pain interference with function and workplace support. The authors suggest that early identification, treatment strategies focusing on maintaining function and maximizing workplace support should be investigated for their potential to prevent PWL.

Knowledge about the diverse course of OA, its effects and its determinants offers opportunities for treatment and prevention. Interestingly, Wilkie et al. [3] explore the potential for preventing work loss in OA, aimed both at individuals with the disorder and their work situations. Many clinicians will probably consider this latter aim to be an issue for the disciplines of occupational health or ergonomics, but a stronger involvement of primary care clinicians in this field may be needed for prevention to be successful. However, it presumes an interest in the work setting of patients and access to this field, which is not a natural attitude for every clinician, although adequate training may improve this [4].

An important strength of the study by Wilkie et al. [3] is the longitudinal design that enabled prospective identification of factors associated with PWL. Furthermore, because of the setting, the study sample is representative of primary care consultors with physician diagnosed OA. In this setting the work-related aspect of OA is expected to become more apparent. As Wilkie et al. propose [3], early identification of individuals at risk is an important step that allows monitoring and prevention. This is a task for clinicians, in addition to starting a treatment that is aimed at maintaining physical function in the presence of pain interference. At the same time, very specific work conditions may exist for each individual regarding physical work load, ergonomics of the workplace, work and rest times and co-worker support. Work disability is always a misfit between individual capability and work demands, with physical, psychological and social components. These should be addressed by the clinician, but also the individual should be advised to disclose the problem at work to allow interventions in that setting. Workplace ergonomic interventions may decrease arthritis-related work difficulties [5].

Estimates of the impact of OA on work have long been scarce and probably biased by differences in the definition and diagnosis of OA (self-report or clinical, physician or radiological diagnosis) and international differences in health care and social security systems. Besides the study by Wilkie et al. [3] in the UK, recent studies in different countries have shown a variety of effects of OA on work ability. The work participation rate in an early OA cohort in the Netherlands was low when compared with an American OA cohort [6]. Radiographic joint damage was clearly more progressed in the American cohort, but the Dutch subjects presented more pain, stiffness and problems in function, which illustrates that the mutual relationships between these factors and work are not immediately obvious. A Swedish study based on health care and social security registers [7] found a substantial impact of OA on sick leave and disability pensions. To date, fragmented data exist from separated stages between the earliest phase of OA and the work-related end point of disability pensions. Research should focus on completing the timeline for the course of OA in relation to work-related outcomes to gain insight into the progression of the problem and opportunities for intervention.

A relevant question, briefly addressed by Wilkie et al., [3], is whether prevention of work disability in OA requires a very different approach from that in low back pain (LBP). A lot of evidence regarding LBP in relation to work disability has been made available for clinicians (e.g. Shaw et al. [8]). Efforts to prevent work loss in OA might benefit from the lessons learned in this field. It is noteworthy that physical workload as a risk factor for OA has been established for many years and is still being confirmed [9], yet the conversion to implementation of preventive actions is lagging. The opposite relationship, i.e. the impact of OA on work ability, is a relatively new research topic. Awareness of this issue may challenge
clinicians to adopt a role in the prevention of work disability in OA, as in LBP.

The existing gap between clinical practice, occupational health care and business and human resources management is a difficult issue, but research in this field offers opportunities for collaboration between disciplines and for practical implementation [10]. Occupational health and primary health care are part of a chain of stakeholders, and together they can address every aspect of an individual’s health, including the issue of work. Health care professionals in this field may have specific legal, practical and financial barriers to overcome in their countries, but it is a challenge to contribute effectively to solutions for individuals with OA. Understanding the context of work setting and OA will help clinicians engage additional resources in order to prevent PWL in OA, as Wilkie et al. [3] conclude. The results and recommendations of their study are a useful example of applying a bio-psycho-social approach to therapy and prevention.

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Hendrik J. Bieleman

1Expertise Center Health, Social Care and Technology, Saxion Universities of Applied Sciences, Enschede, The Netherlands. Accepted 25 October 2013

Correspondence to: Hendrik J. Bieleman, Expertise Center Health, Social Care and Technology, Saxion Universities of Applied Sciences, Enschede, The Netherlands. E-mail: h.j.bieleman@saxion.nl

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