Musculoskeletal conditions are a major cause of work loss [1], with consequences for the individual and clinicians who manage the condition, as well as employers. An editorial published in 2009 [2] highlighted the increasing recognition by all stakeholders that the effect of musculoskeletal conditions on work is preventable, and in the UK, the potential for sickness certification impedes this. As part of routine practice, clinicians were urged to consider work in their assessment and its management because of its benefits to individuals, employers and society. The piece concluded that a multi-disciplinary approach is well placed to achieve a satisfactory outcome.

Our follow-up editorial considers the models for managing musculoskeletal health and work that are evolving in developed countries, strategies or approaches that need to be in place (beyond improved and more rapidly responsive early diagnostic and treatment services) to improve workers with musculoskeletal health problems and the implications for clinicians. We also draw on the UK’s response to the report, ‘Working for a healthier tomorrow’ [3] and the subsequent introduction of the UK’s Fitness to Work approach to certification. This new direction for the UK state-based system, which has previously dealt with work absence only as an issue for the state doctor with provision for compensation, provides a model similar to those in North America where there is greater employer involvement and a push to reduce absenteeism and improve worker performance. The objectives of these models are to aid sustained participation in work or return to work, and to direct a work-focused approach to patient care. Clinicians should consider working-age patients as workers as much as people with an illness, explore their occupational practices (tasks involved and expectations for completion) and consider their environment (e.g. employer’s attitudes and capacity for supporting sick or disabled workers), to provide advice and for appropriate completion of the new fit note. This model highlights a need for training and support, particularly for primary care physicians who manage most working-age adults with musculoskeletal conditions. Such training will need to increase awareness of the solutions and support mechanisms that will assist employees to sustain participation in work or return to work and manage potential conflicts that this new approach may cause during consultation [4]. Identifying work-related problems may be as simple as directly asking about work absence and performance, but may require more systematic approaches, using already existing tools [5–7] that allow patients or workers to report work performance, ability and barriers. These could potentially become part of routine information gathering before, during or after the consultation.

Linking with the purpose of the new approach, empirical work from North America and the Fit-for-Work pilot studies provide examples of how consultations can become routinely work focused and can reduce absenteeism. However, these models will inevitably result in more presenteeism, i.e. more people will continue to work despite symptomatic musculoskeletal conditions, unable to complete important tasks in their job. What will then be the impact on performance and productivity, or cost to employers? These are the key issues that must be addressed, because the impact of this new approach may fail if people with musculoskeletal conditions remain in the workplace with reduced productivity and place potential economic burdens on employers. The danger is that, as a consequence, employment rates of people with musculoskeletal conditions may decrease.

This changing work agenda means a greater role for employers. The success of the new approach partly rests on the ability of clinicians to match ‘accommodations’, which could be in the form of a phased return, flexible hours, amended duties or workplace adaptation to the patient’s or worker’s needs. Appropriate workplace accommodations are effective for enabling return to work, preventing work loss and disability, reducing related costs and the likelihood of subsequent fall in work absence [8]. But this is very much dependent on the willingness and the ability of employers to offer such accommodations. So the success of the new approach is perhaps more dependent on employers. Occupational barriers and policies may restrict the ability of workers with musculoskeletal conditions to stay in work. The role of line managers, return-to-work coordinators and human resource departments, and their interaction with the health care professionals, will become increasingly important and crucial to the success of this initiative.

Line managers need to consider the symptoms and functional limitations of such workers to optimize their performance. However, reducing absenteeism, and managing return to work and presenteeism, may depend...
more on competencies in ergonomic job accommodation, communication and conflict resolution than on direct management of the medical condition [9]. At an organizational level, large employers may be better placed to act in line with positive policies to prevent absence and encourage return to work. Good examples of the positive influence of vocational rehabilitation and linkage between health professionals and managers are available [10]. Smaller and medium-sized employers (which in 2007 employed 13.7 million people in the UK) may not have the capacity to offer these accommodations in the same way. Greater collaboration between policy makers with different agendas (e.g. the Department of Health and the Department of Work and Pensions in the UK) is crucial to support a change in culture and policy.

The musculoskeletal community needs to maintain the current level of interest in work as a vital component of the conditions and patients they manage. Policies should continue to target improving work participation for people with musculoskeletal conditions to reduce the sizeable cost lost due to productivity and sickness benefits. National Clinical Directors for Musculoskeletal Services could gather momentum and help services develop with the work agenda in mind. The introduction of the fit note in the UK should be viewed as a starting point.

Further progress is challenging and evidence is needed to underpin this in the management of work participation. In addition to a biopsychosocial approach to managing musculoskeletal conditions, multidisciplinary and multicentre studies are needed to explore barriers to work participation and to evaluate future interventions, which involve interaction between health care and employers. Working with researchers in occupational psychology and sociology, as well as agencies and workers, will help health care professionals to plan future research and enhance work participation for people with musculoskeletal conditions. Local and systematic interventions in other countries have successfully improved outcomes for such patients and many of these principles can be translated here in the UK. The challenge has only just begun and we must continue to grasp the opportunities that arise.

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