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NICE testimony: Workplace practices to improve health

Worker health is a business opportunity that needs managing like any other issue.

1. What is good work?

a. Management style – not that simple?

The Scope refers to "promoting the wellbeing of employees through proactive and supportive leadership style" but it's not that simple. There are, for example, many situations where an authoritarian leadership style might be appropriate.

b. Job security – not a big issue?

The Scope refers to Marmot's commentary on 'precarious jobs' and the "ample evidence on the adverse effects on health and wellbeing produced by" them. However, this illustrates the problem of relying on prominent reviews rather than the evidence. Marmot refers to and relies on Benach and Muntaner (2007) who actually wrote "Current conceptual and empirical scholarship on precarious employment and health is still limited." and "the study of precarious employment and health is still in its infancy". The evidence is not ample, rather there is evidence that precarious jobs are not so important. The Good Work Commission (2011) noted that "almost everyone understands that guarantees of job security are unrealistic – and therefore not credible" and reported data from the British Social Attitudes Survey 2008 showing that only half of workers consider job security is a "very important" attribute of a job.

The reliance on reviews is commonplace in workplace health and a potential source of significant error. For example, in a commentary on a report from Kim Burton's team I showed that their reliance on one of their own previous reviews of yet another review had resulted in the very cautious conclusions of the original research becoming a far less equivocal endorsement of cognitive-behavioural approaches for musculoskeletal issues (Preece 2009a).

c. Presenteeism – not that bad?

A lack of clarity about the definition of presenteeism has resulted in the assumption that this is a bad thing. This assumption should be challenged – at its simplest level doing any work means a worker is more productive than one doing none. The Scope suggests presenteeism is the phenomenon of "people attending work while they are sick" and suggests this may have long term adverse effects. Recent editorials in both the British Medical Journal (Dew 2010) and Occupational Medicine (Roeleen and Groothof 2011) have both addressed the adverse impact of presenteeism – in both cases I was able to show that the conclusions were based on unsubstantiable conclusions and small studies (Preece 2010a, Preece 2011a). Presenteeism is an important concept but as I wrote in the BMJ "Only limited evidence suggests that presenteeism leads to significant morbidity (especially when health issues at work are effectively managed). Workers have health issues. Employers need to take action and provide suitable occupational health support."

2. Measuring the opportunity

a. Productivity

There have been numerous studies in the USA suggesting both productivity is reduced by the presence of general health risks (eg Burton et al 1999) and intervention can improve productivity (Burton et al 2006) and health (Loeppke et al 2011 and 2013). There is almost no similar research in the UK where the health support from employers and state are very different. There is considerable cause to believe these studies (a) may not be widely generalisable to different employers (Preece 2009b) and (b) may overstate the benefit (Preece 2012 and 2013).

A rare example of a UK study was reported from Merthyr Tydfil (Wynne-Jones et al 2009). This was an ambitious project. Whilst the research team showed that "health variables accounted for the largest proportion of explained variance in both absence and performance" in reality almost all of the variance in absence (96%), for example, was not explained by health (Preece 2010b).

b. Outcomes

i. **Some outcomes are assumed to be good** – It is important that an outcome should not be assumed to be universally good. It has been suggested that flexible working is beneficial (see Foresight Project) but the negative consequences are not always made clear: Flexibility for one person may not be so desirable for their colleagues (eg Kelliher and Anderson 2008). Choosing to leave employment by choice may have long term adverse impact: Early retirement is an important risk factor for cognitive loss/dementia (Dufouil C et al 2014, Lupton et al 2010, Roberts et al 2011)

ii. **Some work outcomes are forgotten** – The commonest cause of death related to work is due to road traffic accidents (Clarke et al 2005).

iii. **Some outcomes are poorly defined** – 'Stress' is widely accepted as a major issue, yet it is poorly defined. 'Stress' as it is reported in the NHS staff survey explains just about all the 'stress' in the UK as it is reported by the Labour Force Survey (Preece 2011b).

iv. **Changing the work outcome may change the conclusion** – In the clinical guideline for back pain early physical therapy is not supported by the evidence. In the workplace guidance on reducing sickness absence early physical therapy is supported by the evidence.

v. **Some work impacts are not addressed in clinical guidance –** There are good quantitative and qualitative data on employment of cancer patients (eg Taksila-Brandt et al 2004, Wells et al 2013). However, there is little guidance on how clinicians and managers can collaborate to protect employment.

3. Steps in managing health risk

a. identifying potential risks and hazards
b. identifying vulnerability
c. creating enabling environments

4. Investing in the opportunity – some issues

a. Occupational health services

Models were reviewed by Kirk (2009). Evidence is scarce. A review of the international literature identified only one report comparing outcomes from different models: That was

from a tri-ennial survey of OH services in Finland. The report showed more employees were supported per physician and per nurse in large multidisciplinary centres .

In a recent study for NHS North West Ford, Kirk and Denman (2010) surveyed all Trusts and NHS OH providers in the region and interviewed all the Heads of OH units. The data were analysed together with information on CQC ratings, sickness absence rates, and the NHS staff survey.

Larger OH provider units, supporting multiple Trusts, were significantly more likely to:

- Comply with service accreditation standards
- Employ specialist occupational health clinical staff
- Provide access to physical therapy and counselling
- Make more use of information technology

Ford, Kirk and Denman provider organisation should be large enough to offer access to OH specialist medical and nursing staff and support for clinical training and continuing professional development.

b. Immunisation

Who should provide this for (examples):

- TB in abbatoir workers
- Hepatitis B in morticians
- Influenza in home care workers

c. Incident response

Preventing morbidity also involves properly preparing for serious incidents at work. This is not limited to events such as fire and accidental injuries. About 5% of strokes occur in the workplace (Frederic et al 2014).

d. Prioritising

Manual handling training is mandated by regulations but is ‘largely ineffective’ (Clemes et al 2010). Resources are scarce: It is difficult for employers to invest prudently in the health of the workforce when ineffective measures are mandated by legislation.

5. General lessons from specific studies

There are potentially generalisable conclusions from single issue studies with a specific focus. For example, Fisher et al (1998) described the success of systematic measures to reduce allergy to laboratory animal allergen in biomedical research. These steps were associated with no new cases of allergy in three consecutive years. The measures included education and training; modification of work practices; engineering controls; the provision and use of personal protective equipment; and, health surveillance. All of these measures might be considered elements of good management practice that are more widely applicable and might result in a broader range of health outcomes in other contexts.

6. OH study pitfalls

a. Lack of critique / peer review

See commentary on Loeppke et al, Roelen and Groothof, and Dew above

b. Credible expertise

See commentary on Burton et al and Marmot Review above

c. **Hard to study most illnesses**
   See commentary on most common cause of work-related fatalities (RTA) above.
d. **Lack of intervention studies**
   See NICE guidance on Mental Wellbeing
e. **Dealing with the difficult stuff**
   See Preece et al (2012) on implementation of NICE workplace guidance – few attempts to address obesity.
f. **Over-generalisation**
   See commentary on Dew above
g. **Size of effect v statistical significance**
   See commentary on Wynne-Jones et al above

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