Fit for Work Czech Republic

- Findings & Recommendations -

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Fit for Work?

- A brief history
- The global burden of Musculoskeletal Disorders (MSDs) – and why it matters
- The impact of MSDs on work ability
- MSDs & Work in Czech Republic
- Conclusions and recommendations

A Brief History of ‘Fit for Work’

Brief History (1)

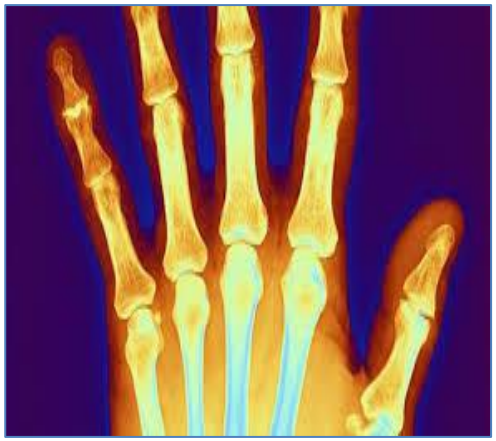
- First report in UK in 2007
- Highlighted the high prevalence of Musculoskeletal Disorders (MSDs) in the working age population
- Big effect on sick days & productivity – generally poorly managed in clinical & workplace settings
- Report had strong profile & impact in UK

Brief History (2)

- Extended the work to most EU Member States
- Produced influential Pan-European report
- Built a Fit for Work Europe Coalition to:
    1. Influence Policy in Brussels
    2. Support the development of National Coalitions
- Reports in non-EU countries (Turkey, Israel, Norway, Switzerland) in North & South America
- Four reports in Asia-Pacific

Global Burden of MSDs

Global Burden of MSDs



2nd greatest cause of disability in all regions of the world

Disability due to MSDs increased by 45% from 1990 to 2010

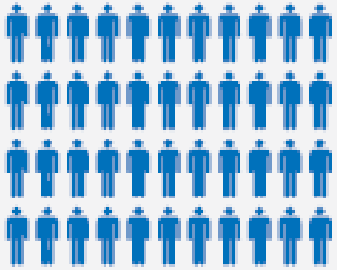
1.7bn Affected:
Back pain 632m
Neck pain 332m
OA knee 251m
Other MSD 561m

MSDs and Disability

- Ranking of major causes of death and disability (% DALYs)
  - Cardiovascular and circulatory diseases 11.8%
  - All neoplasms 7.6%
  - Mental and behavioural disorders 7.4%
  - **Musculoskeletal disorders 6.8%**
- Yet MSDs not considered a priority non-communicable disease – Low mortality but High morbidity

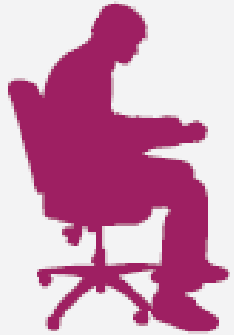
Impact of MSDs on Work Ability

Musculoskeletal Disorders in the EU Workforce



ACROSS THE EU **44M WORKERS HAVE MSDs** WHICH ARE CAUSED BY THEIR WORK

COST TO THE EU EACH YEAR IN LOST PRODUCTIVITY AND SICKNESS ABSENCE **(2% OF GDP)**



THESE CONDITIONS ACCOUNT FOR **HALF OF ALL ABSENCES** FROM WORK ...

... AND FOR **60%** OF PERMANENT WORK INCAPACITY [3]

RA & Work

- At least 1 in 5 give up work within 5 years
- Most patients are in careers when RA diagnosed
- Popular 'mythology' about RA persists
- RA can reduce productivity by 40 days pa
- Workers with RA 3-5 times more likely to stay in work with changes to job demands
- Almost 1 in 5 report poor support at work as a barrier to job retention
- Relationship between RA and depression poorly understood

Fit for Work – Czech Republic

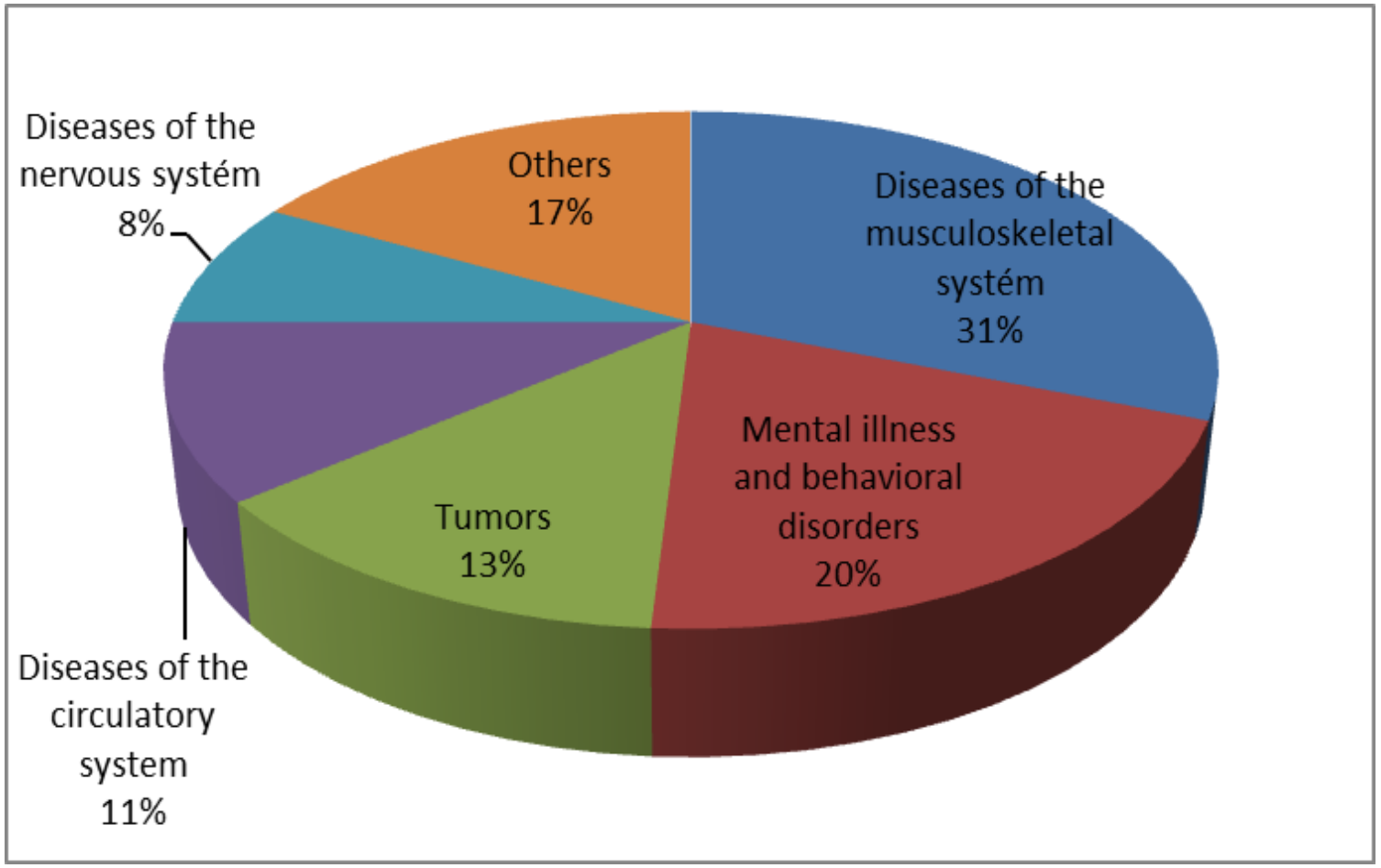
Czech Republic Report

- Purpose is to highlight the impact of MSDs on work ability, productivity and labour market participation among people of working age with MSDs
- Conducted desk-based research & analysis together with expert interviews
- Focus on Back Pain, Upper Limb Disorders, Rheumatoid Arthritis (RA) & Ankylosing Spondylitis (AS)
- Recommendations for key stakeholders who can improve work outcomes for patients

Prevalence & Impact of MSDs

- First finding is that data on prevalence of MSDs in the working age population is hard to find – as is the impact of MSDs on absence from work
- Up to 39 per cent of Czech workers experience work-related back pain
- At least 38 per cent of Czech workers experience muscular pain in their neck, shoulders and upper limbs
- Rheumatoid arthritis is prevalent in 610 per 100,000 adults
- Ankylosing spondylitis is prevalent in 118.9 per 100,000 adults
- In 2007, MSDs accounted for almost 40 per cent of all inflows onto disability benefits in the Czech Republic

Primary Causes of Disability



Source: Czech Social Security 2010-2011.

Impact of MSDs on Work Productivity (1)

- In 1995 the average number of absence days as a result of MSDs was 38.9 per employee each year
- By 2011 this figure had risen to 69.1 days
- In the decade up to 2005 MSDs accounted for 33 per cent of all reported occupational diseases
- The prevalence of MSDs in males is most pronounced in construction
- Among women, MSD prevalence is highest in the education and health care sectors

Impact of MSDs on Work Productivity (2)

- Absence rates for patients with RA and AS are 8.4% and 10.8% respectively Presenteeism (working while ill) is 40.2% for patients with RA and 33% among those with AS
- Patients with AS, RA reported overall work productivity loss of 40.8% and 42.9%
- Average annual lost productivity costs per patient with RA & AS were CZK48,380 (1,913 euros) and CZK45,750 (1,809 euros) respectively
- Productivity losses among RA patients receiving biologic therapies 22% lower than those on traditional treatments

Conclusions & Recommendations

1. Early Intervention for MSDs

- ***Better treatment***. The quicker an individual receives a diagnosis, the more rapidly they can get access to appropriate treatment which can stabilise or control their symptoms;
- ***Reducing the risk of developing co-morbid conditions***. For many people with chronic conditions issues like pain, fatigue, depression or anxiety can become a significant issue which can increase healthcare costs and reduces functional capacity;
- ***Aiding a return to activities of daily living***. Early intervention can ensure people with chronic conditions can become more self-reliant and rely less on health and social care services;
- ***Staying in or returning to work***. People whose health conditions are being well-managed are more likely to remain economically active, continue to pay taxes and be less reliant on welfare payments
- ***Early Intervention is cost effective***. An investment not a Cost

Example: Early Intervention for MSDs

- Early Intervention Clinic in Madrid – after 5 days

- Reduce the duration of temporary disability by 39%
- Reduce the incidence of permanent disability by 50%
- Reduce the utilization of health care resources by 40%
- The analysis showed that 1 dollar invested in the early intervention program yielded 11 dollars of benefit

If replicated across the EU this intervention would allow <u>1m additional workers</u> to attend work each day

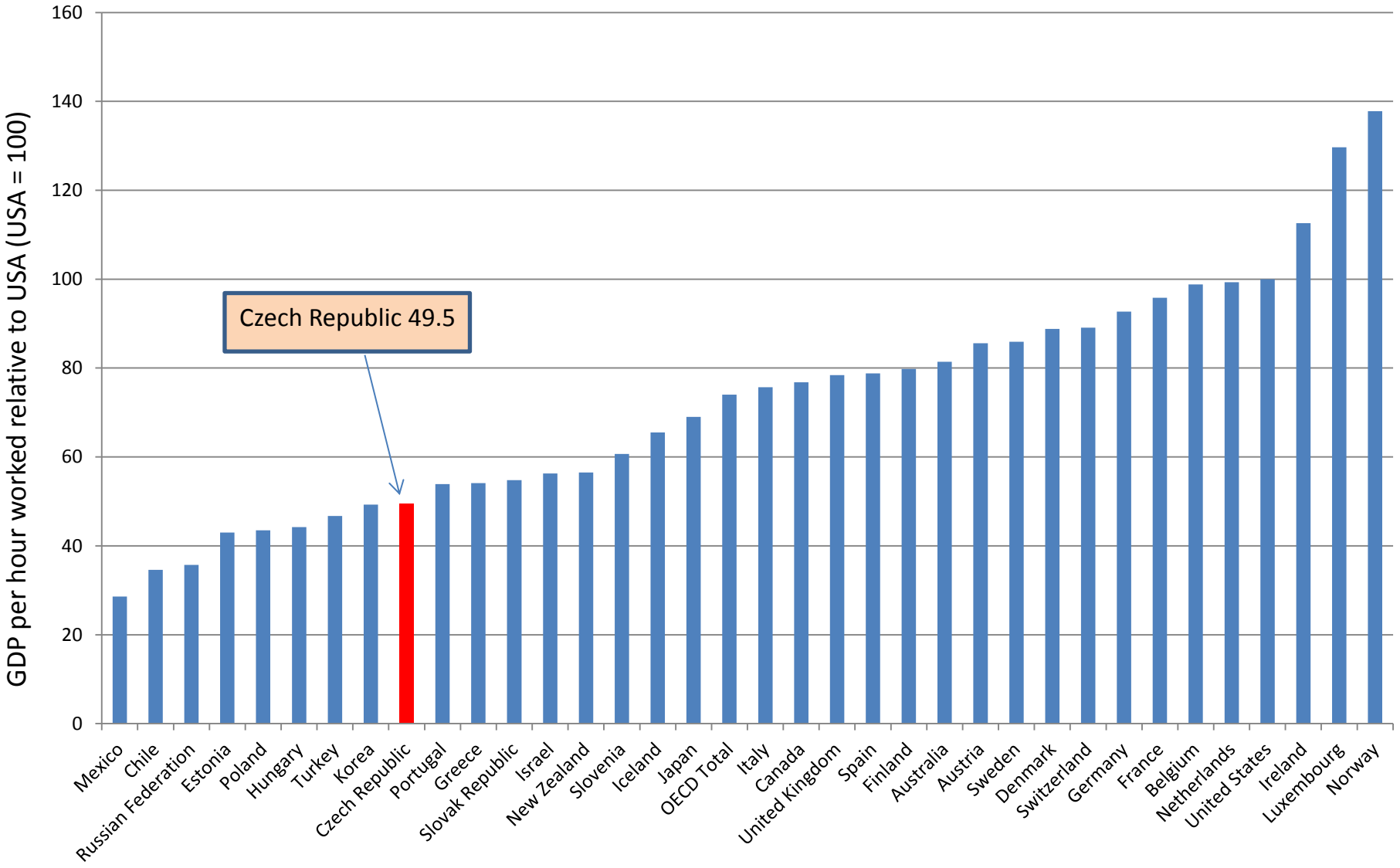
2. Work Should be a Clinical Outcome

- Good Work is Good for Health – can have therapeutic benefits (biopsychosocial model)
- Clinicians, employers and individuals too often focus on ‘Incapacity’ rather than ‘Capacity’
- Some assume work is always harmful (it can be, but is often better than unemployment)
- Work should be regarded as a clinical outcome of care – incentives & care protocols rarely reflect this principle

3. Poorly Managed MSDs & Productivity

- Labour productivity is an economic priority in most OECD countries – workforce health is a key component but is often ignored by policy makers
- Between 60-70% of the costs of MSDs are attributable to sickness absence & lost productivity
- ‘Presenteeism’ – going to work when unwell – can cost 1.5 times the cost of absence
- Premature withdrawal from the labour market can diminish productive capacity – a particular challenge with ageing workforces & later retirement

Productivity in the OECD



4. Workplace Interventions

- Job retention initiatives
- Early referral
- Phased return to work
- Job Redesign
- Flexible working
- Focus on ‘Capacity’ not ‘Incapacity’
- Self-management at work
- Awareness of comorbid mental health risks and the impact of fatigue

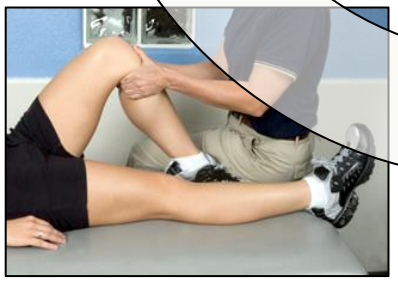
Examples

"The best workplace accommodation is a great manager"

Workplace Accommodations

Vocational Rehabilitation

Job Design



Early Referral

Line Management

Remaining Challenges

- Workforce health as a ‘Human Capital Asset’
- The need to prevent premature work loss
- Interventions to support independent living
- Cost effectiveness of early interventions – making the case for investment
- Joining up the work of Healthcare, Social Insurance & Employers – and placing patients at the centre of their care
- Every Minister should be a ‘Health’ Minister

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