

## Executive Summary

There is now broad agreement on the importance of rehabilitation and the need to improve occupational health and vocational rehabilitation in UK. However, there is considerable uncertainty about what 'rehabilitation' is, and about its (cost)-effectiveness, particularly for the common health problems that cause most long-term disability and incapacity. The aim of this paper is to develop a theoretical and conceptual basis for the rehabilitation of common health problems.

The stereotype of disability is a severe medical condition with objective evidence of disease and permanent physical or mental impairment (e.g. blindness, severe or progressive neurological disease, or amputation). In fact, most sickness absence, long-term incapacity for work and premature retirement on medical grounds are now caused by less severe mental health, musculoskeletal and cardio-respiratory conditions. These 'common health problems' often consist primarily of symptoms with limited evidence of objective disease or impairment. Importantly, many of them are potentially remediable and long-term incapacity is not inevitable.

Rehabilitation has traditionally been a separate, second-stage process, carried out after medical treatment has no more to offer yet recovery remains incomplete: the goal was then to overcome, adapt or compensate for irremediable, permanent impairment. That approach is inappropriate for common health problems, where the obstacles to recovery are often predominantly psychosocial in nature rather than the severity of pathology or impairment. In this situation, rehabilitation must focus instead on identifying and overcoming the health, personal/psychological, and social/occupational obstacles to recovery and (return to) work.

This implies that rehabilitation can no longer be a separate, second stage intervention after 'treatment' is complete. The evidence shows that the best time for effective rehabilitation is between about 1 and 6+ months off work (the exact limits are unclear). Earlier, most people recover and return to work uneventfully: they do not need any specific rehabilitation intervention and the priority is not to obstruct natural recovery. Later, the obstacles to return to work become more complex and harder to overcome: rehabilitation is more difficult and costly, and has a lower success rate. To take maximum advantage of this window of opportunity and minimize the number going on to long-term incapacity, rehabilitation principles should be an integral part of good clinical and occupational management:

- Clinical management should provide timely delivery of effective health care, but that alone is not enough. The primary goal of health care is to treat disease and provide symptomatic relief, but too often that fails to address occupational issues. Rehabilitation demands that health care should *both* relieve symptoms and restore function, and these go hand in hand. Work is not only the goal: work is generally therapeutic and an essential *part* of rehabilitation. Every health professional who treats patients with common health problems should be interested in and take responsibility for rehabilitation and

occupational outcomes. That requires radical change in NHS and health professionals' thinking.

- Common health problems are not only matters for health care, but much broader public health issues of 'health at work'. Sickness absence and return to work are social processes that depend on work-related factors and employer attitudes, process and practice. This requires employers, unions and insurers to re-think occupational management for common health problems: addressing all of the health, personal and occupational dimensions of incapacity, identifying obstacles to return to work, and providing support to overcome them. The same principles are equally applicable to job retention, early return to sustained work and reintegration.
- This should not obscure the importance of the individual's own role in the management of common health problems. Rehabilitation is an active process that depends on the participation, motivation and effort of the individual, *supported by* health care and employers.

Better clinical and occupational management and rehabilitation of common health problems is the best way to reduce the number of people going on to long-term incapacity. Even with the best possible management, however, some will always need further help; consideration must also be given to long-term benefit recipients. Social security is then not just about paying benefits: the 'welfare to work' strategy is also about providing support to (re)-enter work. Rehabilitation in a DWP context must address the additional obstacles facing people who are more distanced from the labour market, including the particular problems of the 'hard to help', the disadvantaged and excluded, and those aged > 50-55 years. It must also fit the practicalities of the DWP context, including issues of: early identification of those at risk; recruitment, engagement and retention; incentives, disincentives and control mechanisms.

Action depends on accepting ownership of the problem. Everyone – workers; employers, unions and insurers; health professionals; government and the taxpayer – has an interest in better outcomes for common health problems. Effective management depends on getting 'all players onside' and working together to that common goal. This is partly a matter of perceptions (by all the players). It requires a fundamental shift in the culture of how we perceive and manage common health problems, in health care, in the workplace, and in society.

Better management and rehabilitation of common health problems is possible, can be effective, and is likely to be cost-effective. We have sufficient knowledge and evidence to reduce sickness absence and the number of people who go on to long-term incapacity, and to improve job retention, return to work, and reintegration. All of these outcomes could potentially be improved for the common health problems by at least 30-50%, and in principle by much more (fully recognising the practical problems of achieving this).