

Response



Health, Work and Older People

Evidence from TAEN - The Age and Employment Network

A submission in response to Dame Carol Black's
Call for Evidence for her *Review of the Health of
the Working Age Population*

30 November 2007

Health, Work and Older People - TAEN response to the call for evidence for the Review of the Health of the Working Age Population

Contents

	Summary of evidence	5
1	Introductory comments	7
1.1	About TAEN	7
1.2	Commitment	7
1.3	This evidence	7
2	The context	8
2.1	Employment	8
2.2	Long-term illness, phased returns and rehabilitation	8
2.3	Extent of work-related ill health	9
2.4	Early retirement on grounds of ill health	9
3	Comments on health, work and older people	10
3.1	Why do older people work?	10
3.2	Relationship of work and health	11
3.3	The importance of work for older people	12
4	Pathways to Work	13
4.1	Experience of older people in Pathways to Work	13
4.2	Experience of the Condition Management Programme	14
4.3	Barriers to employment	14
4.4	The value of preventative approaches	15

5	Occupational health provision	15
5.1	The role of occupational health services	15
5.2	NHS Plus and Workplace Health Connect	16
5.3	Examples of new approaches to OH provision	16
6	The Finnish work ability model	17
6.1	What is meant by work ability?	17
7	Towards gendered approaches to health, age and work	18
7.1	Note on accompanying documents	18
7.2	Older Women, Work and Health	18
7.3	Older Men, Work and Health	19
8	Additional comments	21
Appendix 1	The Finnish Concept of Maintaining Work Ability	22

Health, Work and Older People – TAEN response to the call for evidence for the Review of the Health of the Working Age Population

Summary of evidence

Ill health is clearly an important factor in early retirement. There is insufficient data on the precise causes of health-related early retirement, though it would seem likely that such causes reflect the causes of absenteeism and ill health generally in the population and the specific older workers' cohort.

More people who continue in work beyond state pension age do so because they wish to remain mentally and physically active, like work or wish to have something interesting to do, than because they want the extra money. Work has value beyond its financial rewards.

It is important neither to exaggerate the health benefits nor minimise the dangers work may pose to health. It is clear that when things go wrong, work can be damaging physically and psychologically. But it also seems clear that the absence of work, particularly to those who feel able and willing to work, is a debilitating and negative experience.

We should emphasise the difference between the health benefits of different kinds of work by noting that there is *good work* and *bad work*. Bad work has numerous ill-health consequences for all workers involved, but insofar as it may lead to departure from the workforce and prolonged inactivity thereafter, bad work may be more damaging to the older worker.

Evidence suggests that Pathways to Work is less successful with the over-50s than with the under-50s. TAEN believes more effort must be put into developing a programme that works for older people. However, TAEN's view that work-based approaches to prevent workers from quitting their jobs and going onto incapacity benefits (IB) are preferable to working to get them off benefits.

The emphasis should be on keeping older workers in the job market – not necessarily in the same job – sufficiently healthy and fit to hold down a job and with the requisite skills and competencies to perform it, rather than to suffer the flypaper trap of IB and the acute, sometimes desperate difficulties of escaping from it.

We believe that it is essential that occupational health (OH) services should be provided to all members of society if we are to adequately safeguard their health and well-being. This of course includes those who work for very small employers. We believe that having good OH provision and maintaining health through life-course interventions is the key to good health in mid and later working life.

We believe that a range of innovative approaches should be encouraged by government, in order to grow OH services. We favour tailoring the precise form of provision to local circumstances and conditions. We propose the establishment of an Occupational Health Partnership Fund to encourage collaboration between employers, unions, NHS trusts and other parties.

We propose an appropriate, fit-for-purpose, free form of occupational health service to support small employers (many of whom have very limited financial resources), rendering advice on the telephone and web-based access points and supported by local opportunities for face to face advice and consultation and in some cases workplace visits.

We see the foregoing as part of an attempt to build a more comprehensive OH infrastructure in the UK. We offer a number of additional innovative proposals for building such an infrastructure, not necessarily linked to large employers with the resources to provide their own OH service.

We see one such option to be the development of work-world medical services in or adjacent to large employer organisations. This would involve GP practices building working relationships with OH professionals to deliver services to employees of the organisations concerned. Other members of the public could attend the centre as a GP practice.

We see another option to be the development of GP services offered on a 'drop in' basis in busy work transit locations or close to places where large numbers of people work. Such services would, we feel, logically develop an OH approach and work with employers as well as patients.

A further formula would be the specialist centre (along the lines of the NHS Plus Centre of Excellence being developed in Cambridge to focus on hazards presented by the new technologies and medical research) which might be established to deal with particular health issues of an industry or some group of industries or some group of hazards – for example noise problems, wood dust etc. OH specialists who develop a particular knowledge of specialist subject areas in this way could help to build up working relationships with stakeholders, including employers and unions, to promote interactivity between health and safety and medical knowledge.

We see all the above points as being examples of innovative approaches to build occupational health provision in the UK. We believe that without a major effort focusing on health and well being at work and including such initiatives, many organisations will be unable to find sufficient fit and healthy older workers to address the demographic challenges and people needs of their organisations.

We suggest that employers should be encouraged to provide health and well-being facilities to employees, encouraging their fitness in various ways.

We suggest employers and union representatives should work with individuals to take responsibility to adopt healthy life styles. We realise that this would require investment in training managers and union representatives in health and well-being issues. We acknowledge that it is a role that will not appeal to all but we believe that championing fitness and healthier living at work could make a significant impact on employees' responses.

We explain the Finnish Work Ability model as an approach offering practical benefits. If individuals can be helped to remain in work, by attending to their own health and well-being as well as their skills and career expectations, this clearly offers them better life chances. If companies can be encouraged to keep their skills, know-how and talents by providing health and other interventions, considering flexible ways of working, undertaking ergonomic assessments, re-designing work in appropriate cases and using other approaches that have been tried and tested, this seems to offer the universally desired *win-win* solution.

We observe that the Finnish government sponsored a massive education and training approach to ensure that the work ability approach was adopted in Finnish workplaces. There seems no reason why the UK government should not look closely at this example and seek to apply any lessons it can usefully learn.

We highlight the value of a gendered approach to health and work. We draw on the work commissioned by TAEN and Help the Aged to make a series of points in relation to the particular problems of older men and older women at work.

1. Introductory comments

1.1 About TAEN

TAEN – The Age and Employment Network is an independent charity whose aim is to help create an effective labour market which works for people in mid and later life, for employers and for the economy. TAEN is supported by Help the Aged who share the conviction that getting things right in mid-life helps prevent disadvantage in old age.

1.2 Commitment

TAEN believes that people should be able to work for as long as they want or need to and that a life-course approach to promoting health and preventing work-related ill health is key to extending working life. We recognise that in many cases there has been no such life-course approach and that ill health is a major barrier to employment for many older people. **We believe that the age of the person may affect the support that is needed to help someone remain in or return to work, particularly if the person is older, and that age needs to be taken into account.**

1.3 This evidence

This paper sets out some observations for Dame Carol's review. It summarises a number of ideas and issues which we believe to be of particular importance. We have not attempted to cover the whole spectrum of issues or the whole working population, but have focused in particular on issues affecting the older worker. Having said this, we are of course aware, that the health of the older worker is a product of his or her health history throughout a life-course.

In addition to this paper we are providing copies of the following two reports commissioned by TAEN and Help the Aged.

- *Older Women, Work and Health: Reviewing the Evidence*¹
- *Older Men, Work and Health: Reviewing the Evidence*²

The first was published in 2006. The second report (*Older Men, Work and Health*) is to be published in January 2008, but a pre-publication copy is provided in the knowledge that its contents will be relevant to Dame Carol's review.

We are also submitting for the attention of Dame Carol, the following paper, which we feel is particularly apposite both to the concerns of TAEN and the need to consider the position of the older worker in reviewing health and work.

- *Healthy work for older workers: work design and management factors.*³

Since its formation in 1998, TAEN has been keenly interested in health issues affecting older workers, though it was not until 2005 when with the generous support of Help the Aged, we began to undertake serious analysis in this area. In 2007 TAEN and Help the Aged jointly organised a seminar for Dame Carol on health and older workers. We aim to continue with this work, developing our contacts among a wide range of interested parties, in particular, occupational health professionals and representatives of employers. (More details of TAEN's programme of events and activities can be obtained from our web site, www.taen.org.uk)

¹ Doyal and Payne, 2006

² Granville G and Evandrou M 2008 (forthcoming)

³ Griffiths, A (2007) *Healthy Work for Older Workers: Work Design and Management Factors*, in Loretto et al, *The Future for Older Workers* (2007) The Policy Press.

2. The context

2.1 Employment

Economic activity in all European countries declines as people approach state pension age (SPA) although Britain experiences this phenomenon to a lesser extent than some other states. There are currently 8.9 million people in the UK aged 50 - state pension age. Their employment rate is 72 per cent compared with 82 per cent for 25 - 49 year olds.⁴ The government has declared an aspiration of an overall employment rate of 80 per cent. According to the government, this would require at least one million more people over 50 joining the workplace although this increases depending on the timeframe.

Of the 2.3 million people aged 50 to state pension age who are economically inactive, 47 per cent are inactive due to sickness, disability or injury⁵ and 1.2 million people aged 50 to state pension age (13 per cent of the 50+ section of the working age population) are claiming incapacity benefits.⁶ For disabled older people, the possibilities of being in work are significantly reduced. The employment rate for disabled people in the 50+ age group is only 43 per cent⁷ and for ethnic minority disabled people the rate is only 30 per cent.

2.2 Long-term illness, phased returns and rehabilitation

In the 2001 Census, the proportion of people reporting a long-term illness or disability that limited their daily activity or the work they could do, increased with age. The percentage rose from 21 per cent of 45 to 59 year olds to 40 per cent of 60-74 year olds. According to the Disability Rights Commission (DRC – now absorbed into the Equality and Human Rights Commission) the rates of disability increase with age - from 9 per cent of adults aged 16-24 to 44 per cent in the 50 - to state pension age group.⁸

We believe it is important for all workers to have prompt access to occupational health services and rehabilitation. However, in the case of older workers, this is particularly important. They have less of their working lives ahead of them and the longer they are forced to wait, the more likely they are to retire early.

We are aware that for all workers suffering long term ill health, returning to work can be problematic. A 'one size fits all' solution is not appropriate but we are aware that some company policies minimise the period of time out of the workplace by offering phased returns and rehabilitation opportunities on a very gradual basis. We believe these can be particularly helpful for workers with mental health problems, or indeed others who may lose touch with their work surroundings and begin to feel less confident about their abilities to resume work as time goes by. In a way this may be described as a 'fast track approach' to resuming work, though the essence is gradualism, maintaining contact with the work community and flexibility in the kind of work that is done on resumption of work.

We recognise that in SMEs the small number of employees may make long term absences more difficult to handle. However, given that many organisations, including small and medium sized ones, sometimes have to address problems of long term absenteeism when a staff member falls seriously ill, we do not think the possibility of gradual, rehabilitating approaches should be considered unthinkable merely because the organisation is small.

⁴ Labour Force Survey Quarter 2, 2007

⁵ Labour Force Survey Quarter 2, 2007

⁶ WPLS, DWP, February 2007.

⁷ Select Committee on Work and Pensions, Third Report, February 2007

⁸ Disability Briefing, May 2007

2.3 Extent of work-related ill health

The highest rates for men (ever employed) who report they suffered from a work-related illness are in the 55-64 and 65-74 year age groups. For women, the 55-59 and 45-54 year age groups carry the highest rates.⁹ For men, the estimated rate of days lost per worker due to work-related ill health was higher for the 55+ age group than the average rate for all males and for the youngest age groups. For women, the same estimated rate was higher for 45-54 year age group than for the youngest age groups.

2.4 Early retirement on grounds of ill health

Nearly three-quarters of people who retire early cite ill health as the main cause.¹⁰ It is difficult to assess the extent of genuine ill health early retirement because of pension scheme definitions, the interpretation of health professionals and the 'medicalising' of non-medical problems by individuals. Nevertheless, ill health is clearly a major factor in early retirement. The extent and causes of ill health early retirement need to be better understood, though it seems likely that they link closely to the incidence of ill health generally in the relevant cohorts of the population.

Incapacity benefits figures reveal how many people of working age are unavailable for work because of ill health. In 2006 the two most prevalent types of claim were in respect of those suffering mental health and behavioural disorders, including stress-related problems (40 per cent of all claims) and those suffering diseases of the musculo-skeletal system (18 per cent).¹¹ Precisely how these and other causes of ill-health are reflected in ill-health retirement decisions is not clear, though it would be surprising if the pattern were not closely echoed.

⁹ Self-reported work-related illness and workplace injuries in 2005/06, HSE, 2007

¹⁰ DWP Research Report 200, 2003

¹¹ Reducing dependency, increasing opportunity, DWP 2007

3. Comments on health, work and older people

3.1 Why do older people work?

One of the reasons frequently put forward by older people for remaining in work, is that work itself contributes in some non-financial way to their sense of well-being. An international survey conducted in 2007¹² reported the following reasons people gave for working.

Table 1: Older people’s responses to the question ‘Why work?’

Why work?	Overall	UK Respondents
Need the money	75	82
Need to save money	34	20
Need to support family members	37	37
Enjoy the job or work	30	40
To be productive	16	-
People have obligation to work	-	18

(Figures quoted show percentages of respondents in both samples for whom each given reason appeared as top three choices. The top five reasons are given only.)

Looking at why people *continue* in work beyond retirement gives a somewhat different angle on the rationale of those who chose to continue working, as the following table shows:

Table 2: Older people’s responses to question ‘Why continue in work beyond retirement age?’

Why work?	Overall	UK Respondents
For the extra money	41	45
To support myself	28	-
Stay mentally active	33	49
To stay physically active	27	31
To stay productive	25	-
Because I like work/I want to work	-	31
To have something interesting to do	-	24

¹² American Association of Retired People, ‘Profit from Experience,’ 2007.

The above data bear out the frequent observation that, even though the income from work remains important, people work for more than simply the money. Older people who work appear to make their choices even more for non-financial reasons, concerning the perceived beneficial effects of work itself. However, this observation has to be set against the fact that work can sometimes be damaging to health and there are, of course, other questions which could equally well be asked relating to choices to give up working in mid and later life. The quote in panel 1 (taken from an illuminating paper by Professor Amanda Griffiths, which we are sending with our evidence) summarises what has come to be seen as received wisdom among many working in the field.

Panel 1 : The value of work

“ It is recognised that work can be a source of much satisfaction. It can provide purpose, meaning and challenge, a vehicle for learning, creativity and growth, opportunities to use skills and to demonstrate expertise, to reassert control and achieve success. ”¹³

3.2 Relationship of work and health

TAEN has had the benefit of seeing the TUC's evidence to the review of the health of the working age population. Whilst we feel it is an impressive submission, we are struck by one observation in the TUC's evidence which we do not find expresses the balances between positive and negative health impacts of work. (See Panel 2). We would like now to take the opportunity of developing this discussion in our evidence.

Panel 2 : TUC's comment on health and work

“ Much has been made of the mantra that 'work is good for you'. The reality is that is not the case. While it is true that, for most people, being actively engaged is less likely to lead to serious long-term illnesses than unemployment and inactivity, being in work is, at best, less harmful than not being in work and even then only when it is properly organised, risks are properly managed, and staff are engaged in the work process.”

We have doubts as to whether life's natural and essential activities can really be summarised according to whether or not they cause the individual harm, in this way. We believe it is important neither to exaggerate the health benefits nor minimise the dangers work may pose to health. It is clear that when things go wrong, work can be damaging physically and psychologically. But it also seems clear that the absence of work, particularly to those who feel able and willing to work, is a debilitating and negative experience.

¹³ Csikszentmihalyi, M (1997) *Living Well, the Psychology of Everyday Life*, London, Weidenfeld and Nicholson. Quoted in Griffiths, A (2007) *Healthy Work for Older Workers: Work Design and Management Factors*, in Loretto et al, *The Future for Older Workers* (2007) The Policy Press.

Getting the balance right is important and points to the need for 'good work' for everyone. *Good work* is work which is well designed and executed to avoid health risks, is intellectually challenging and stimulating, involves the individual in the work community and society at large, is rewarded fairly and reasonably and offers opportunities to meet one's broader social and economic needs. It is true that many workplaces, to some extent, can give rise to situations which can be damaging to health, and while analysis and attempted prevention of risks can overcome these problems, few work situations will ever be completely risk free. On the other hand, few situations in life are completely without risk either, including of course, sitting at home without work!

This is not to advocate a blasé or indifferent attitude to the risks associated with work, but in our desire to understand work's riskiness, we should not forget the necessity of it nor the positive enrichment work makes to people's lives. It is our duty to eliminate work risks as far as we are able to do so but a sense of balance in understanding work as a natural, and all things being well, a *health enhancing*, experience is, TAEN believes, important.

3.3 The importance of work for older people

Working to or beyond state pension age can therefore be beneficial to health and well being of everyone, including older and mid life people – providing the work is *good work*. Where this is so, people – including older people - are likely to make valuable contributions and be highly engaged with the success of the organisation. By being economically active, they are more likely to secure their financial futures, remain in contact with other people, and able to engage in intellectual and physical activity that is so essential for the health and well-being of the whole person. In principle, for so long as a person is able and happy to work, he or she should be allowed and encouraged to do so.

In contrast, when work engenders negative feelings, it may be responsible for a range of health problems and a natural feeling of avoidance. This is so for younger people as well as older people, though it seems possible that the negative effects of *bad work* on older people may be more injurious to health than the same *bad work* is to younger people. In these circumstances, it is also likely that the worker will not be giving his or her best to the organisation. Hence the circle can be squared; if work can be designed to be healthy, fulfilling, involving and accompanied by decent conditions, it will probably be health enhancing, productive work, serving the needs of organisations and those who work for them.

The growth in stressful occupations, excessive working time, poor management styles including bullying cultures in some organisations, disruptive and constantly changing shift patterns, insecurity and other contingent or precarious features in work, have been widely commented on as sources of anxiety among workers. There seems little doubt that these negative factors contribute to depression, hypertension and various other illnesses and conditions. According to the Health and Safety Commission, in 2006/07 an estimated 13.8 million working days were lost by UK workers on grounds of work-related stress, depression or anxiety and an estimated 10.7 million days were lost in the same period for work-related musculoskeletal disorders.¹⁴

While there seems to be no convincing evidence that these sorts of problems are more widely experienced by older workers than others, it may well be that as catalysts to decisions to quit the job, they give rise to more profound outcomes than is the case for younger workers. In the latter case, a change of employment may mean that the problem of *bad work* is left behind. For the older worker, the decision to quit may result in permanent worklessness or give rise to a prolonged period of job search, frustration and disappointment as he or she confronts a complex of obstacles to an early return to work.

¹⁴ Health and Safety Statistics 2006/07, HSC/ONS, 2007

4. Pathways to Work

Some 2.7 million UK workers are in receipt of incapacity benefits, 1.2 million of whom are over 50. The government aims to get one million of them back into work, though as is well known, success rates in coming off benefits and returning to work for IB claimants are very low. Pathways to Work offers a new intervention regime which aims 'to activate people's aspirations to return to work.'

However, the proposed expansion of Pathways is only for the *flow* of new claimants onto incapacity benefits, not existing claimants (*the stock*), nearly half of whom are over 50. Switching jobs in a buoyant labour market is for many people, unproblematic. Returning to work after a period of inactivity is more difficult, particularly for older people. Structured advice coupled with a range of supports and suitable training can often help overcome these difficulties.

Pathways is currently rolling out to more than 30 districts across the UK with the aim of making it available everywhere in the country. The idea is to promote sustained employment by providing a programme of staged assistance reflecting thinking characteristic of a '*work first*' approach.

Work first, approaches hold that the key to getting people back into the labour market is to get them into a job first and foremost. It may be contrasted with a *human capital development* approach which essentially emphasises the responsibility of the unemployed person to get a job but also provides a series of holistic interventions to make it more likely that they will be *ready and able* to work. *Work first* seeks to move the individual from unemployment to work as quickly as possible in the belief that this is the best way of avoiding the decline in work ability and employability that sets in as individuals languish unemployed. Some observers criticise *work first* approaches for neglecting to consider the *quality* of the work, while adherents believe that work, *any work*, is probably better than no work.

4.1 Experience of older people in Pathways to Work

A survey of individuals making an initial enquiry about claiming incapacity benefits in 2004 (and who were re-interviewed 18 months later) showed a difference in the impact of Pathways between the over-50s and the under-50s.¹⁵ The findings showed that Pathways has stronger effects on employment and in reducing the probability of claiming benefits among those aged under 50 than with the over-50s. The younger age group was more likely to be in work at the time of the final interview and the estimated effect on IB receipt persisted much longer among them. And while Pathways reduced the probability of people under 50 reporting their ability to carry out every day activities was limited a great deal by their health conditions or disability, there was no such effect among those over 50.

A survey of new and repeat incapacity benefit claimants in the first seven pilot areas¹⁶ showed being aged 30-54 was one of four specific factors most significantly associated with a work outcome. (A fifth of Pathways customers in these pilots were aged 55+).

The adverse situation of the older person does not end there however. Those aged 55+ were more likely to have seen their health worsen over the year to the survey interview than younger age groups (31 per cent worsened compared to 17 per cent among those aged 18 to 29). Those who were older also tended to have a greater degree of limitation due to their conditions. Differences between the other age groups were minimal.

¹⁵ Research Report 453, DWP, 2007

¹⁶ Research Report 456, DWP, 2007

Undoubtedly, older IB claimants are among the hardest to bring back into the workplace. Those in the categories 50-54 and 55+ showed the highest percentages of being 'far from work' compared with other age groups and the lowest percentage for attending three or more Work Focused Interviews.

4.2 Experience of the Condition Management Programme

Part of the Pathways programme includes an optional *condition management programme*. In the first seven pilot areas¹⁷ over half of clients undergoing the condition management programme (CMP) under Pathways presented with mental health problems. Many (the second most numerous category) suffered from musculoskeletal disorders. Smaller proportions presented with cardio-vascular conditions.

Customers over the age of 40 were more likely to have taken part in the Condition Management Programme of Pathways than those who were younger (five per cent in the case of those aged 55+ compared to three per cent of those under 30). Those who took up CMP (in all age groups) were considerably more likely to be in low declining health and thus less likely to achieve favourable health outcomes than those participating in other elements of the Pathways programme.

It will be interesting to see whether the CMP approach laid out and followed in Pathways can help the government to achieve its target of getting a million claimants off incapacity benefits. The DWP Research Report concludes the creation of the CMP would seem to represent a view that at least in the short term positive health outcomes should be pursued as ends in themselves (in expectation they may contribute to work outcomes in the longer term). Our impression is that whatever the merits of a CMP approach for younger people, it may well be insufficient to have a large impact on the older IB claimant.

4.3 Barriers to employment

Older people facing health barriers to employment are likely to have various disadvantages to overcome in regaining work. These might include past neglect of training, lower levels of basic educational attainment, dated skills (particularly in ICT) which are not up to the standards required by modern businesses. Older workers who have spent long periods in manual occupations may well require considerable skills investment before they become 'job ready.'

For those who have serious health conditions or disabilities, the problem of returning is likely to be much greater. Employees with mental health problems are a case in point. One survey¹⁸ reporting on employers' experiences of hiring people with mental illnesses, showed 52 per cent of respondents with no experience of hiring people with such conditions. One in ten employers in the same survey had *withdrawn* an offer of work because someone had misrepresented their condition. A further seven per cent of employers had *dismissed* an employee for the same reason.

Combining lack of skills disadvantages with a degree of age discrimination (which sadly remains widespread, though hard to prove) and the ill health or condition which has caused the person to be on IB in the first instance, can make for an insuperable collection of problems.

¹⁷ Pathways to Work: customer experience and outcomes, DWP Research Report 456, 2007

¹⁸ CIPD Quarterly Survey Report 2007

4.4 The value of preventative approaches

These observations confirm the impression that preventative approaches targeted at existing workers are more likely to succeed than interventions aimed at helping job seekers or IB claimants to recover their places in the labour market. We do not of course disagree that those out of work or claiming IB should be helped to return, but when we look at ill health as a cause of being out of work, we see a cycle of problems causing problems from which it is very difficult indeed for the older worker to break out. It suggests to us that prevention of ill health and decline in one's ability to do the job, should be given the highest priority. The focus therefore should be on maintaining the health, skills and competencies of the worker and his or her employability, rather than to allow him or her to experience the flypaper trap of IB.

5. Occupational health provision

5.1 The role of occupational health services

Occupational health services deal with ill-health conditions early, close to the workplace, and avoid the dilemma of individuals having to decide whether to neglect a health worry by not taking time off work to attend a GP surgery. They can provide a range of health checks and help individuals to extend their own working lives by advising and helping them on issues like alcohol consumption, smoking, other lifestyle issues and so on. OH services should look for the *causes* of ill health and work with employers to provide healthier workplaces.

Hence, occupational health services have a potentially crucial role both in preventing work-related ill health and delivering appropriate and timely diagnoses and treatment.

Again, we have had the benefit of reading the TUC's evidence to Dame Carol's review and we agree with their comments on the need for occupational health physicians to be actively involved. We note the idea that is put forward concerning the possibility of occupational health physicians working in GP surgeries and we agree that this is one of a range of responses that could be tried.

At a seminar TAEN organised for Dame Carol in September 2007, the issue of occupational health provision was discussed and a number of valuable points made. One of the foremost problems appears to be the provision of OH services in small and medium sized enterprises (SMEs). We believe that it is essential that OH services should be provided to all members of society if we are to adequately safeguard their health and well-being. This of course includes those who work for very small employers unable to provide their own OH service, though there is a considerable problem in conceptualising how this might be accomplished.

We suggest that there should be encouragement for health trusts, employers and others, including unions, to collaborate in appropriate health partnerships on a local basis. These would be designed to increase capacity of OH provision in given areas and sectors of the economy. There are a number of possible approaches to making such a system function in the way described. One approach could be the establishment of a fund, which could perhaps be regionally administered, to consider 'partnership proposals,' from groups of organisations. Each proposal would be directed towards some form of OH provision appropriate to the local surroundings, industries and economy. Arrangements might differ from one area to another but experience could hopefully lead towards greater relevance.

5.2 NHS Plus and Workplace Health Connect

Our attention has been drawn to the services offered by NHS Plus and the pilot service Workplace Health Connect, both being occupational health provisions for SMEs. It would appear that the future of Workplace Health Connect, the free advisory pilot service, is under review. Our understanding is that the most relevant provision would be a free, flexible OH service that offers the possibility of some 'first point of contact' informed advice, partly by telephone and web and partly including the possibility of follow up with face to face consultations and, in appropriate cases, workplace visits. The development of services of this kind, would in our view, create an infrastructure within which it would be possible to be far more proactive in advancing health and well-being at work.

5.3 Examples of new approaches to OH provision

We believe there is a need for imaginative and creative solutions to the problem of non-availability of OH services. The following are a few approaches that could be considered:

- GP surgeries including health therapists and physicians could be available in companies and employing organisations as work-world medical services. (We would see this as an alternative route to delivering GP services to the public, more consistent with the needs and time constraints of those who work.)
- GP services (including OH specialists) could be established in a range of busy work transit locations for use on a 'drop in' basis. (Such services have already been established in some central London railway stations and though they appear to offer mainly private medical provision, there seems no reason why they should not be established as an NHS facility.) They could be located in areas where large numbers of people are travelling to and from work, or could leave work for short periods during working hours to attend for medical advice.
- Primary care trusts could consider opening clinics dealing with specialist aspects of work-related ill health (along the lines of the NHS Plus Centre of Excellence being developed in Cambridge to focus on hazards presented by the new technologies and medical research), dealing with workers, wherever possible close to their workplaces but with an industry or occupation specialism so that workers with particular problems might visit an OH specialist knowledgeable in a relevant field. Physicians, besides advising and offering treatment to workers, could build relationships with employers and union health and safety representatives in a given area or sector. Appropriate therapies could be provided or advised to individuals but also preventative seminars and health activities could be promoted, for example, in industries with a particular record of certain forms of ill health.
- Government could give more consideration to how they might provide incentives to employers to make health and well-being facilities available to employees. These might include encouraging the development of programmes advancing health and fitness ranging from healthy eating to running and other sporting activities.
- Employers (in particular HR practitioners, but hopefully operational managers too) could work with representatives of employees, including union representatives, to examine ways in which individuals could be helped to review their own lifestyles, health and fitness as key aspects of their *work ability*, and consider adopting fitness plans commensurate with their realistic aspirations. We realise that this would require development of substantial capacity in the form of knowledge and active engagement with fitness trainers and others. We think there is scope here for health and fitness issues to be addressed in management and union training courses. Not every manager and not every union representative will be interested or able to take such issues on board, but having people on both sides in organisations who can champion the issue of employee health and well-being, could make a significant difference over a period of time.

Whilst there is general recognition of the health beneficial effects of exercise, control of diet, healthy living (including getting enough rest), attention to consumption of alcohol and the elimination of smoking, it is important that individuals are encouraged and helped to address these issues rather than them being made into prescriptive rules in organisations. Providing advice and help in the sorts of ways illustrated here, could, we believe, have an impact on the choices individuals make. Applying such lifestyle changes over a life-course would have important benefits to all workers and would make a large contribution to older workers remaining fit and able to work.

6. The Finnish work ability model

6.1 What is meant by work ability?

Appendix 1 to this submission outlines the Finnish *work ability* model, developed within the Finnish Institute of Occupational Health. A *work ability* index has been adapted and used in other countries as well as Finland – for example it is currently being used in Australia in trials by Swinburne University of Technology, based in Melbourne, in a research programme involving partners in Australian industry under the ambit of the Business Work and Ageing Research Centre. It has also been used in a number of other European countries and some Asian countries too. The *work ability index* (WAI) is explained in more detail in appendix 1. A quotation from this appendix is reproduced below in Panel 3 for convenience.

The concept of the *maintenance of work ability* (MWA) has become familiar in Finland during the past decade. MWA has now become a part of daily routines that have been adopted in many Finnish workplaces. The Occupational Health Service system has taken initiatives to develop the forms and contents of MWA. Gradually, the complexity of the activities and the need for good collaboration in the MWA have increased. Nowadays, maintaining work ability is a task of both the human resources manager, line management, and of the occupational health and safety services.

Panel 3 : What is work ability?

“ Work ability is a measure of an inter-relationship between *the work capacity of the worker* and *the work he or she does*. It takes into account all the factors that might influence that capacity, and make the job more or less do-able.

Poor work ability might be caused by poor health, poor work competence, skills or knowledge, inappropriate values and attitudes, poor working conditions or management. The individual’s personal circumstances, the nature of the work, the working environment and other factors can intervene.

Work ability is not separated from life outside work. Family and the close community to which an individual belongs can all have an impact. “

The practical benefits of using a concept such as work ability, would seem to include focusing on a 'prevention rather than cure' approach. We are convinced that there is much of value in this systematic analysis of work and the condition of the worker. If we seek to keep people in work, we need to be mindful of their changing abilities throughout their life-courses. Every individual is different and it is not necessarily the case that the natural changes in human minds and bodies over a life time in work, will in each case, impact on their abilities to work.

Equally however, it is pointless and some cases, plainly wrong to pretend that *some individuals* doing *some sorts of work* do not experience a decline in their *work ability*. The idea of measuring such changes, feeding back the evidence to the individuals concerned and working with them and their managers to *maintain* their work ability, seems to make a great deal of sense.

If individuals can be helped to remain in work, by attending to their own health and well-being as well as their skills and career expectations, this clearly offers them better life chances. If companies can be encouraged to keep their skills, know-how and talents by providing health and other interventions, considering flexible ways of working, undertaking ergonomic assessments, re-designing work in appropriate cases and using other approaches that have been tried and tested, this seems to offer the universally desired *win-win* solution.

To develop the work ability model in the UK requires growing knowledge and experience of it. Clearly, an instrument of this kind needs to be understood, examples need to be developed and experience needs to be disseminated. The Finnish government sponsored a massive education and training approach to ensure that the work ability approach was adopted in Finnish work places. There seems no reason why the UK government should not look closely at this example and seek to apply any lessons it can usefully learn.

7. Towards gendered approaches to health, age and work

7.1 Note on accompanying documents

While many of the health benefits and risks of work are the same for men and women, and for older and younger workers, there are also significant age and gender differences. These important differences should be taken into consideration in Dame Carol's review.

Our two publications, *Older Women, Work and Health*, and *Older Men Work and Health*, make an important contribution towards a gendered approach to age and health and we are indebted to our partner charity Help the Aged and the authors. We believe that these two documents merit full consideration as comprehensive literature reviews. The following points are of particular importance.

7.2 Older Women, Work and Health

Older Women, Work and Health (Doyal and Payne, 2006), a literature review commissioned by Help the Aged and TAEN, highlighted the paucity of studies exploring the impact of work on the health and well-being of older women and their occupational health needs. Most occupational health research has focused on men; and in the case of studies on women, the focus has tended to be on younger women and hazards to the reproductive system.

Key findings of the review:

- Although many occupational health risks are the same for men and women, there are also significant differences in the hazards facing the two groups. Some reflect biological differences and others consequences of different lifestyles.
- Women are concentrated in certain areas of employment and in low-status jobs with less control.
- Women's lack of autonomy and low status are likely to affect mental health.
- Women workers often have greatest burden of domestic labour, especially in older age groups.
- Women aged 45-65 are most likely to combine work with care of dependants.
- Burn-out is more common amongst those directly responsible for others and these are usually women.
- Many studies show women are more likely than men to report MSDs including RSI and back pain, reflecting the fact that women's 'light work' is often physically demanding, involving repetitive tasks.
- Workplace health promotion programmes often fail to meet needs of older workers, especially women.
- There is a need to consider access (in small as well as large workplaces) and the possibility of single sex provision for workplace health promotion programmes.

The review recommended:

- Greater age and gender sensitivity from HSE and associated bodies.
- More appropriate indicators for monitoring the occupational health of older women.
- Better knowledge is needed with research including appropriate numbers of men and women.
- OH and safety standards and workplace design should reflect the diversity of employees.

7.3 Older Men, Work and Health

Older Men, Work and Health (Granville and Evandrou), a literature review commissioned by Help the Aged and TAEN, is to be published in January 2008 and an advance copy is provided for Dame Carol's review.

Findings:

- Few studies examine the effects of health among older people within a gendered perspective.
- There is little empirical evidence on the cumulative effect of working lives on the health of men (and women) as they age.
- Compared to those aged 25-49, older male workers are three times more likely to report ill-health and disability.

- As men grow older they report a higher prevalence of limiting long-term illness, whilst below 60, there are similarities between men and women.
- One in five older male workers leaves the labour market as result of sickness or disability.
- Studies show men in manual jobs may be more readily accepting of physical decline and a loss of functioning while professionals tend to be more anxious about their ageing bodies and try to combat and control the ageing process. (The need for tailored interventions is suggested.)
- Work plays a central role in men's lives with paid work more salient for men's well-being with stronger health effects for men than women. Presence or absence of work can thus be a key source of health problems.
- Evidence linking job strain and cardio-vascular disease was strongest and most consistent in men aged 40-64 years – and the links between job strain and blood pressure was greater in those over 50.
- Men are more likely to be involved in potentially dangerous work environments with more men than women suffering work-related mortality and injury.
- Men are more likely to face structural barriers in accessing health care.
- Occupying a parental role during mid-life either alone or in combination with other roles appears to have negative health consequences for men.
- Many older men are self-employed contractors (taxi and lorry drivers eg) so they present challenges as far as any engagement on health promotion is concerned. In the construction industry, three in ten workers are self-employed older men and they may not have participated in the appropriate health and safety training.

Recommendations:

More research is needed on:

- The cumulative effects of working lives on the health of people as they age to increase understanding of the implications of an ageing workforce.
- The impact of work on health amongst older workers within a gendered perspective.
- The impact of work on health amongst older workers from different ethnic groups.
- Types of programmes that support behaviour change in the workplace and what is effective in particular circumstances with particular groups of people.

8. Additional comments

We recognise that a government priority must be to reduce numbers dependent on welfare benefits. Much of our discussion in this document has been around this objective, with particular reference to the known and understood desire to reduce the numbers of IB claimants.

However, it should not be forgotten that 45 per cent of non-working people of working age are not on benefits. The reasons for people giving up work in their 50s, early 60s or even late 40s are many and varied, but as we have seen, there is a link between health and work that cannot be ignored. We believe that this is so, regardless of whether or not the individual is claiming benefits from the state.

Failing to consider those outside the labour market but not receiving benefits is a potential waste of an important resource. More relevantly perhaps, for the purposes of Dame Carol's review, the evidence of work's generally beneficial effects, both in generating personal income and providing life interest and fulfilment, suggest to us that an injustice would be done were the 'out of work off benefits,' category of older people not to be considered.

TAEN – The Age and Employment Network

30 November 2007

Appendix 1

The Finnish Concept of Maintaining Work Ability

Background to work ability

The idea of measuring the ability of an individual to sustain a working life, emerged during the early 1980s in Finland. In turn it arose from concerns that Finland's ageing population and early departures from the workforce, were seriously damaging the economic success of the country. It seems possible that the concept of work ability could be very relevant to the UK's situation as government pursues the target of extending working lives.

What is work ability?

The work ability concept is credited to Professor Juhani Ilmarinen, Director of the Department of Physiology in the Finnish Institute of Occupational Health (FIOH). Ilmarinen and co-workers studied the ability of municipal workers to overcome a variety of problems causing early departures from the workforce. They came up with a paradigm of good practice covering line and personnel management and occupational health and safety services.

Work ability is a measure of an inter-relationship between *the work capacity of the worker* and *the work he or she does*. It takes into account all the factors that might influence that capacity, and make the job more or less do-able.

Poor work ability might be caused by poor health, poor work competence, skills or knowledge, inappropriate values and attitudes, poor working conditions or management. The individual's personal circumstances, the nature of the work, the working environment and other factors can intervene.

Work ability is not separated from life outside work. Family and the close community to which an individual belongs can all have an impact.

Promoting or maintaining work ability

A key idea is that whilst work ability appears to decline naturally as people age, various interventions can be introduced to *enhance* or *maintain work ability*. Research has shown how a decline in work ability can be slowed down, halted or reversed by the choice of timely interventions.

Maintaining work ability (MWA) as a means of keeping people from early retirement through ill health and other reasons has developed into a central aspect of the HR and manpower approaches adopted by Finnish organisations.

The *maintenance and promotion* of work ability requires good cooperation between supervisors and employees and the whole work community. Central roles are played by the occupational health and occupational safety functions in the organisation.

Work ability index

A work ability index has been devised and widely used in Finland. It is based on a self-completion questionnaire. Elements in the calculation of the index are:

- An individual's current work ability compared with their lifetime best.
- Their work ability in relation to the demands of the job.
- The number of diagnosed illnesses or limiting conditions from which they suffer.
- Their estimated impairment due to diseases/illnesses or limiting conditions.
- The amount of sick-leave they have taken during the last year.
- Their own prognosis of their work ability in two years time.
- An estimate of their mental resources.

Poor scores are a predictor of early retirement among other outcomes unless interventions are introduced.

Building capacity to apply the MWA concept

The skills and knowledge used to apply the work ability concept, evolved with active contributions from government agencies and the social partners. These were administered in a series of training and other campaigns that engaged the vast majority of Finnish workplaces.

Through collective agreements encouraging employers and unions to collaborate locally, flesh has been put on the bones in most workplaces. Projects proliferate. For example, 'Work Ability Tomorrow,' sponsored by the Association of Finnish Pension Institutions and the FIOH, has trained all full time occupational health professionals in the application of work ability. 5,000 worker representatives from workplaces attended the same training events.

Costs and benefits of maintaining work ability

The pay-off of MWA includes retention of skilled workers who can contribute to the organisation. Improvements in productivity and quality are claimed too.

Impact on Finnish workplaces

The concept of the maintenance of work ability (MWA) has become familiar to all Finns during the past decade. MWA has now become a part of daily routines that have been taken into use in most Finnish workplaces.

The Occupational Health Service system has been very active and taken initiatives to develop the forms and contents of MWA at the beginning of the 1990s. Gradually, the complexity of the activities and the need for good collaboration in the MWA have increased. Nowadays, the MWA is a task of both the personnel administration and the line management, and of the occupational health and safety services.

