Taking the strain: The impact of musculoskeletal disorders on work and home life

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## Contents

1. Executive summary .......................................................................................................................... 4

2. Introduction .................................................................................................................................... 7
   2.1 The policy context .......................................................................................................................... 9
   2.2 Objectives .................................................................................................................................. 10
   2.3 Methodology .............................................................................................................................. 11
   2.4 Research findings ....................................................................................................................... 12

3. Impact of MSDs on individuals and households .............................................................................. 15
   3.1 Impact of health condition on quality of life ............................................................................. 15
   3.2 Impact on employment status ..................................................................................................... 17
   3.3 Loss of working time and productivity ....................................................................................... 22
   3.4 Impact on households .................................................................................................................. 24
   3.5 Summary .................................................................................................................................... 26

4. Experiences of support in maintaining employment ........................................................................... 27
   4.1 Health care experiences .............................................................................................................. 27
   4.2 Management of work outcomes in the clinical setting ............................................................... 30
   4.3. Employment experiences .......................................................................................................... 31
   4.4 Summary .................................................................................................................................... 34

5. Conclusions and recommendations ................................................................................................. 35

Appendix 1. Sample ............................................................................................................................ 39

Appendix 2. Participating patient organisations .................................................................................... 41

Appendix 3. Questionnaire .................................................................................................................. 42
1. Executive summary

The Government’s welfare reforms, spearheaded by the Department for Work and Pensions and set to affect thousands more benefits claimants in the coming years, are underpinned by a belief that work is both good for you, and is the best route to wellbeing. While the aim of returning people to employment is universally welcomed, the methods deployed – the new Work Capability Assessment, the introduction of stricter entry criteria for Employment and Support Allowance, and greater use of the private sector to deliver a Work Programme based on the principle of ‘Payment by Results’ – have proven controversial.

In particular, public attention has focused on the reported negative impact of the reforms upon people with disabilities and long-term health conditions. Here is a group of people who want to work, but as this report shows, are too often dropping out of the labour market early without appropriate support from employers, line managers or health care professionals.

The Work Foundation is a founding member of Fit for Work UK – a campaigning coalition established in 2011 with the aim to shift the treatment and care of musculoskeletal disorders (MSDs) from being disabling conditions to manageable conditions. Drawing on a new study of 809 people diagnosed with an MSD, published for the first time here, we urge concerted action from policymakers, health care professionals, commissioners, employers, and individuals, both to stop people with long-term conditions losing their jobs in the first place, and to help them return to work.

Headline findings from our new survey include:

- **Delays in diagnosis and treatment:** It took an average of 4.22 years to diagnose a MSD. Even with the diagnosis, 11.4 per cent of respondents had to wait more than a year to receive an intervention.

- **Health care professionals failing to discuss employment with their patients:** Despite ‘Employment of people with long-term conditions’ being listed as an indicator of the NHS Outcomes Framework, only half of respondents had discussed employment or return-to-work with health care professionals.

- **A danger of impoverished old age, as people with MSDs face premature retirement:** Three quarters of respondents who were retired said their condition had influenced their decision to retire, the majority of whom left the labour market before reaching the age of fifty-five.
Whole households financially affected by MSDs: More than half (57.4 per cent) of respondents who were not in work had been primary income earners before leaving their job.

We conclude that for the Government’s welfare reforms to succeed in adequately supporting people with long-term health conditions, all the interested stakeholders need to take concerted action to improve the support and treatment of MSDs:

Health care professionals should seek training and development opportunities in MSDs to improve their expertise in identifying early symptoms, enabling swift diagnosis and referral of patients to appropriate treatment. They should consider the impact of MSDs on their patients’ ability to work, and make appropriate recommendations for workplace adjustments in the Fit Note. They should help educate patients on the impact an MSD may have on ability to work, as the condition progresses, and signpost them to support groups.

Commissioners of health services should collect data on diagnosis and treatment times, and ensure these meet NICE clinical guidance and support early intervention. Commissioners should take into account the well-evidenced link between employment and health outcomes, and ensure the services they commission include the provision of employment advice and are designed to support patients at work (for example by ensuring speedy access in case of disease flare-up and appointments outside of patients’ working hours). Health and Wellbeing Board members should ensure their local Health and Wellbeing Strategy addresses the employment of people with long-term conditions, and should collaborate with local employers, as supporting individuals in employment can prevent exacerbation of negative public health outcomes.

Employers should create a climate where people with long-term conditions feel empowered to disclose their condition, confident their needs for simple workplace accommodations will be met. In addition, employers should support workplace adjustments where these benefit employee and employer alike, for example, by following NICE public health guidance on workplace health. Flexible working requests should be considered with due diligence, to avoid exit of valuable skills and expertise from the workforce. Employers should train line managers on the impact and appropriate management of MSDs in the workplace. A number of employer charters are available to provide guidance in best practice.

2 See Department for Business, Innovation and Skills http://www.bis.gov.uk/assets/biscore/employment-matters/docs/e/employerscharter
**Line managers** should have open conversations with affected employees about the impact of their MSD, and offer necessary workplace adjustments. They should remember that the intrinsic quality of jobs must be preserved, even where change of duties or working patterns is introduced, in order to avoid the consequences of underemployment.

**Individuals** living with MSDs should take a proactive approach to self-management of their condition and recognise that informed communications between their health care professionals and their employer is in everyone’s interest. They should seek advice from patient support groups and make use of their rights under the NHS Constitution and Equalities legislation.

**Policymakers** should join up policymaking across the Department of Health, the Department of Work and Pensions, the Department for Business and the Treasury, to ensure public services are coordinated in their approach to employment of people with long-term conditions. Having included ‘work’ as an outcome in the NHS Outcomes Framework, the Government should now agree an indicator to enable measurement at the level of clinical commissioning groups, and incentivise the system to record appropriate data to meet this outcome.

Furthermore, the government should agree to a recommendation made by Professor Dame Carol Black and David Frost CBE in ‘Health at work – an independent review of sickness absence’ and fund a new Independent Assessment Service, which would provide an evaluation of an individual’s physical and mental function after four weeks of sickness absence with the purpose of encouraging early intervention and optimising the individual’s opportunities of returning to meaningful employment.

Our research shows clearly that, despite having a chronic health condition in the volatile labour market, holding down a fulfilling job should be a realistic aspiration for many people living with even severe forms of MSDs. The evidence base for the array of interventions to make this happen is well known and not in dispute. All that is missing is a combination of political will and some cross-agency collaboration based on the principle that job retention and sustained return to work should be a high priority outcome in the UK. Fit for Work UK believes that the evidence presented in this report adds further weight to the already compelling case for change.

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2. Introduction

Ill health associated with high mortality is rightly seen as a priority for the UK’s health system; however, chronic diseases with lower mortality but high morbidity may have an even higher impact on individuals’ productivity at work and likelihood of early retirement. Given the centrality of productivity and availability of workforce skills in achieving economic growth, decision makers need to consider how health and employment policies can better support people with chronic conditions in the labour market.

The disabilities and comorbidities that result from musculoskeletal disorders (MSDs) have some of the highest indirect health and social care costs in high-income countries.4 The impact MSDs have on individual’s ability to work has implications for health and welfare spending. Yet, the burden of MSDs is poorly recognised, and the need to support people with MSDs in the workplace is rarely addressed.

This report is part of a major study – *Fit for Work Europe* – conducted by The Work Foundation globally across over 30 countries, looking at the impact that MSDs have on the working lives of workers, the adequacy of the treatment and support they receive and the human and financial costs of these conditions. Research on MSDs in the UK5 has highlighted that:

- Musculoskeletal conditions and common mental health problems are the major causes of absence from work and benefit claims due to ill health. Musculoskeletal conditions comprise about 55 per cent of all work-related illness (compared to stress being responsible for 30 per cent of work-related illness).
- Amongst manual workers, acute back pain was the second most highly ranked cause of short-term absence (54 per cent, after the common cold) followed by other musculoskeletal disorders – problems with the movement of muscles and limbs – identified by nearly half (49 per cent) of respondents.

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- Musculoskeletal disorders were the second most commonly identified cause of long-term absence for manual workers (44 per cent) closely followed by chronic back pain (42 per cent). Amongst non-manual employees musculoskeletal disorders were the third most identified cause (31 per cent).\(^6\)
- Around 580,000 people in England (or 690,000 adults in the UK) have rheumatoid arthritis (RA), with 26,000 new cases reported each year.\(^7\) Within 3 years of diagnosis half of people with RA are registered as work disabled.\(^8\)
- Ankylosing spondylitis (AS) is a progressive and chronic rheumatic disorder that mainly affects the spine, but can also affect other joints, tendons and ligaments. In the UK over 200,000 people have AS. AS is a condition which is most often diagnosed among men in their early twenties and, in the most serious cases, can severely curtail the working lives of people living with the condition. Reported unemployment rates are three times higher among people with AS than in the general population.

These figures, together with new data presented in this report, point to the devastating impact of MSDs on individuals’ ability to maintain employment. With the challenges of rising job instability and the growing burden of chronic disease on the UK’s health and welfare systems, it is essential that the impact of MSDs on workers’ productivity is managed better, so that MSDs do not lead to unnecessary job loss and early retirement. Since chronic illness reduces an individual’s chances to remain in work\(^9\) and people not in employment are more likely to be socio-economically disadvantaged,\(^10\) this issue has important implications for health inequalities and public health outcomes. Furthermore, the impact of MSDs on individuals’ opportunities for independent living can affect the work outcomes of informal carers, as well as the financial situation of entire households.

'Good' work, characterised by job security, control and autonomy, is associated with better health, both physical and mental, compared to worklessness.\(^11\) Employment also provides an important source of income for individuals and households. Supporting more individuals

with MSDs to remain in or return to work, when they are able and willing to do so, would improve individual social and wellbeing outcomes, allow their informal carers to return to paid employment, and additionally support the needs of the economy as a whole by retaining skills, knowledge and experience.

2.1 The policy context

In 2008 Dame Carol Black’s report\textsuperscript{12} called for better work outcomes for individuals with chronic disease. Since then, work has been included in the first NHS Outcomes Framework, aiming to prioritise employment outcomes in the clinical settings.\textsuperscript{13} In addition, several initiatives have aimed to provide guidance and support for employers of people with long-term conditions.\textsuperscript{14}

Ongoing welfare reform in the UK, spearheaded by the Department for Work and Pensions, aims to return more people to work, by disincentivising prolonged reliance on welfare benefits through greater ongoing assessment, the introduction of stricter entry criteria to these benefits, and ensuring that claimants always earn more if they work in some capacity. The Work Foundation has already expressed concerns that these assessments may be failing to take into account the fluctuating nature of many chronic conditions, including MSDs.\textsuperscript{15} As part of an independent review by Professor Malcolm Harrington in 2011, several charities, including Arthritis Care, highlighted that the Work Capability Assessment cannot differentiate in the day-to-day variation in individuals’ work ability, for example, in the case of RA where pain and stiffness may be more prominent in the early part of the day.\textsuperscript{16}

It appears that this welfare policy is not sufficiently complemented by the performance indicators of the health care system, or by incentives for employers to support employees with MSDs to continue in their jobs. For example, although the Government’s mandate to the NHS Commissioning Board\textsuperscript{17} lists ‘employment of people with long-term conditions’ among its desired outcomes, there is no indicator for measuring whether or not the health services

\textsuperscript{12}Ibid.

\textsuperscript{13}See Department of Health


\textsuperscript{14}See Department of Health

http://responsibilitydeal.dh.gov.uk/2012/02/07/h1-factsheet/


\textsuperscript{16}Employment and Support Allowance Work Capability Assessment review. (2011). \textit{Making it work for fluctuating conditions}. Retrieved on 18 November 2012 from


help to achieve this. Similarly, there is scant evidence of individual’s work outcomes being a priority for the health service commissioners, since the latest Commissioning Outcomes Framework does not encourage commissioners to consider work as an outcome for patients of working age.

As a result, people with chronic MSDs may be disproportionately affected by reforms that intend to return people to work, but do not accommodate the specific needs of those with chronic musculoskeletal disease. As such, those with an MSD may lose welfare support, but not be supported back into employment, lacking appropriate management of their condition in either clinical or employment setting.

Considering a lack of reliable data on the impact of MSDs in the UK and the practices surrounding management of these conditions, this study aims to shed some light on what is happening ‘on the ground’ and encourage a full assessment of the impact of ongoing health and welfare reforms. Our aim through the Fit for Work Programme is to gather new and comprehensive data that can inform the design and execution of practical methods that will support job retention, promote return to work and ensure more fulfilling employment experiences for people with MSDs.

### 2.2 Objectives

The objectives of this study were:

1. To collect data on individuals’ experiences of living and working with their MSD.
2. To collect data on onset, timing of diagnosis, treatment, condition severity, comorbidity, functional limitations, impact on daily living, family.
3. To identify which aspects of the health care system support or hinder participation of these individuals at work.
4. To examine their employment experiences (eg working conditions and work environment, workplace relationships, job satisfaction, impact of the condition on attendance and productivity).
5. To collect data on demographic characteristics, which may help explain differences in perceptions, experiences or outcomes.
6. To provide recommendations for policymakers, health care professionals and employers on the support required by individuals living with MSDs to return to and remain in work in the UK.
2.3 Methodology

In order to explore individuals’ experiences of living and working with MSDs, we launched an EU-wide survey of individuals with a range of MSDs. We have collected 809 valid responses in the UK. Mean age of the sample was 49.75 years old (SD = 11.52),\(^\text{18}\) with the minimum reported age of 19, and the maximum reported age of 89. Please see Appendix 1 for the basic profile of the sample, including respondents’ gender, age, employment status and the number of survey respondents with no formal qualifications.

The research was conducted through the use of an online questionnaire, which was circulated to members of selected patient groups with doctor-diagnosed MSDs in the UK. Please see Appendix 2 for the list of patient organisations and Appendix 3 for the description of the questionnaire we used. Because the total population, which accessed the online questionnaire, is unknown, it was not possible to calculate response rates. The sampling method we utilised – namely publicising the survey via patient groups – allows us to target individuals with the type of conditions we are interested in. However, this sample may not be representative of the general population of individuals with MSDs for several reasons.

First, large patient group approach makes it more difficult to target people with rare MSDs, such as Osteogenesis Imperfecta or Ehlers-Danlos Syndrome, who are likely to be members of smaller patient groups. Equally, individuals with non-specific conditions, such as back pain or neck pain, are less likely to be part of a patient group, as these conditions are episodic and can abate for long periods of time.

Secondly, due to the sampling method, the data is heavily skewed to the female and older population: over 83.6 per cent of respondents were female and 37.9 per cent were aged 55 and above. This may be due to women being more likely to participate in patient groups than men.\(^\text{19}\) However, we also know that some MSDs, such as RA, are more common among women and among people of older age.

Although accessible, easy to use and targeting the right individuals, the population of patient groups appears to be skewed towards better educated and female participants. While this may be representative of the total population of people with certain MSDs, concerns around representative potential of patient groups remain. To target respondents outside the patient

\(^{18}\) Here and below 95% confidence level is applied.

groups we asked the users of social media platforms, where the survey was advertised, to share the link with other potential respondents.

2.4 Research findings

As indicated above, the survey specifically targeted individuals who had experienced pain in their joints and/or muscles in the previous four weeks and been given a diagnosis of an MSD by a doctor. This analysis only includes the individuals who had received such a diagnosis. Figure 2.1 below describes the distribution of various types of diagnoses among the respondents.

Figure 2.1. Distribution of the sample by main diagnosis received

It is unclear whether this distribution accurately reflects the true representation of various MSDs in the UK. For example, it is understood that osteoarthritis is the most common MSD in the European population.\textsuperscript{20} Similarly, back pain appears under-represented, given that it affects between 12-30 per cent of working age people in Europe at any time. However, we also know that chronic muscular pain is undiagnosed in 42 per cent of cases.\textsuperscript{21} The distribution of this sample is therefore likely to be a reflection of the specific population of the


patient groups (which tend to include individuals with inflammatory MSDs), and also of the fact that many people live with and manage non-specific MSDs without receiving a diagnosis.

As much of the impact of MSDs on individuals’ quality of life and their productivity results from pain associated with these conditions, we asked respondents to indicate whether they felt muscle or joint pain at any of the specific body sites. Table 2.1 below explains the prevalence of pain experienced by the respondents.

Table 2.1. Prevalence of muscle and/or joint pain by body site, per cent indicating

<table>
<thead>
<tr>
<th>Site of pain</th>
<th>In the past 4 weeks</th>
<th>Problem lasting 3 months or longer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>36.8</td>
<td>37.7</td>
</tr>
<tr>
<td>Shoulder(s)</td>
<td>38.1</td>
<td>39.2</td>
</tr>
<tr>
<td>Upper back</td>
<td>21.0</td>
<td>24.7</td>
</tr>
<tr>
<td>Elbow(s)</td>
<td>24.0</td>
<td>25.7</td>
</tr>
<tr>
<td>Wrist(s)</td>
<td>35.4</td>
<td>37.7</td>
</tr>
<tr>
<td>Hand(s)</td>
<td>39.9</td>
<td>40.5</td>
</tr>
<tr>
<td>Low back</td>
<td>38.6</td>
<td>40.6</td>
</tr>
<tr>
<td>Hip(s)/Thigh(s)</td>
<td>35.0</td>
<td>36.7</td>
</tr>
<tr>
<td>Knee(s)</td>
<td>40.9</td>
<td>43.1</td>
</tr>
<tr>
<td>Ankle(s)</td>
<td>30.4</td>
<td>34.1</td>
</tr>
<tr>
<td>Foot/feet</td>
<td>37.9</td>
<td>40.7</td>
</tr>
</tbody>
</table>

As can be seen from the table, although only just over 3 per cent of respondents received a diagnosis of back/neck pain, a much higher proportion had experienced pain in the previous four weeks, and an even higher proportion of respondents indicated that the problem lasted for three months or longer. In total, almost 95 per cent of respondents said they had experienced pain in more than one site in the previous four weeks. This is likely to have added to the impact of MSD on the individuals’ lives, both in and outside work.

In addition, the health state of individuals with MSDs is likely to be affected by the presence of physical and psychological comorbidities, which may include other MSDs. While the prevalence of comorbidity is difficult to establish, estimates suggest that at least a quarter of people with physical long-term conditions have a mental health comorbidity.²²

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The survey found that 53.4 per cent of participants had another health condition in addition to their MSD; this was consistent across all the age groups we surveyed. Of those with comorbidities:

- 36.6 per cent named mental health conditions;
- 21.1 per cent – respiratory conditions;
- 25.5 per cent – diabetes, Crohn’s disease or IBS;
- 8.8 per cent – cardiovascular conditions
- 3.2 per cent – neurological conditions (eg multiple sclerosis);
- 1.9 per cent – immune deficiency (eg HIV/AIDS).

The next sections of this report present the findings of our survey of individuals diagnosed with MSDs in the UK. We discuss the impact of these conditions on the ability of the individual to perform work and non-work activities, assess the level of support currently available to them via the health care system and employers, and make recommendations for better management of the work outcomes of those living with MSDs.
3. Impact of MSDs on individuals and households

There is growing evidence that the effects of illness extend beyond the individual to include carers, parents of ill children, and family and household members.

This section describes the effect that living with an MSD can have on individuals’ daily lives and work, and on the people around them.

3.1 Impact of health condition on quality of life

Survey respondents were asked to estimate the severity of their condition, on a scale of 0 (no impact) to 10 (very significant impact). Figure 3.1 presents the distribution of the responses by the severity of the impact of the condition.

Figure 3.1. Subjective severity of the health condition in general, n = 807
On average, the respondents indicated the severity of their condition at 6.59 (SD = 1.96), which corresponds to above average severity. The severity of the condition did not correlate with the respondents' age, nor with the number of years lived with the condition. However, those with a comorbidity were slightly more likely to report a greater severity of their health condition in general (6.42, SD = 1.93 vs. 6.22, SD = 1.92)**.\(^{23}\)

Such level of severity is unlikely to be characteristic of the entire population of individuals with MSDs, and this feature of the sample may reflect the fact that the respondents in a survey had lived with the disease a fairly long time: mean number of years lived with the symptoms was 15.09 (SD = 12.07).

For further analysis purposes we split the respondents into four quartiles according to the severity of their condition. Table 3.1 lists the number of respondents in each category of impact.

**Table 3.1. Proportion of respondents by severity of MSD impact**

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Mean impact (SD)</th>
<th>Number of respondents</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 2 (mild impact)</td>
<td>1.90 (0.31)</td>
<td>29</td>
<td>3.6</td>
</tr>
<tr>
<td>3 – 5 (moderate impact)</td>
<td>4.29 (0.79)</td>
<td>190</td>
<td>23.5</td>
</tr>
<tr>
<td>6 – 8 (severe impact)</td>
<td>7.17 (0.79)</td>
<td>485</td>
<td>60.1</td>
</tr>
<tr>
<td>9-10 (near complete loss of function)</td>
<td>9.42 (0.50)</td>
<td>103</td>
<td>12.8</td>
</tr>
</tbody>
</table>

We also asked the respondents to indicate the impact of the condition on physical activities (eg cleaning the house, shopping, walking, participation in sports), social activities (eg visiting friends and family, social or cultural outings, undertaking voluntary work), as well as the impact of the condition at work on a scale of 1 (no impact) to 5 (a great deal of impact). All four of these scales correlated well with each other (p = 0.01), for example, the greater was the overall impact of the condition, the greater was its impact on physical activities. Similarly, the more severe the condition, the more likely it was to impact on various spheres of individuals' lives, for example, social activities and work.

\(^{23}\) Here and below the following levels of statistical significance are applied: ≤0.05*; ≤0.01**; ≤0.001***.
While we suspected that the degree of impact would differ by the respondent’s age, the only age group that stood out in terms of severity of the condition was the 45-54 years old group, which is likely to be linked to the fact that this was the largest group of respondents, with the highest ratio of women to men. Table 3.2 below compares the overall impact of MSDs, as well as the impact of the conditions on physical, social and work activities between the age groups.

### Table 3.2. Comparison of mean (SD) impact of MSDs by activity and age group

<table>
<thead>
<tr>
<th>Age</th>
<th>Overall state of condition (1 – least impact; 10 – worst impact)</th>
<th>Impact on physical activities (1 – least impact; 5 – worst impact)</th>
<th>Impact on social activities (1 – least impact; 5 – worst impact)</th>
<th>Impact whilst at work (1 – least impact; 5 – worst impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>5.88 (2.09)</td>
<td>3.67 (0.92)</td>
<td>3.67 (1.01)</td>
<td>2.53 (1.19)</td>
</tr>
<tr>
<td>26-34</td>
<td>6.61 (1.96)</td>
<td>3.72 (1.11)</td>
<td>3.62 (1.28)</td>
<td>2.97 (1.04)</td>
</tr>
<tr>
<td>35-44</td>
<td>6.66 (2.01)</td>
<td>3.83 (0.98)</td>
<td>3.70 (1.14)</td>
<td>2.95 (1.12)</td>
</tr>
<tr>
<td>45-54</td>
<td>6.79 (1.99)</td>
<td>4.00 (0.99)</td>
<td>3.75 (1.14)</td>
<td>3.09 (1.21)</td>
</tr>
<tr>
<td>55-64</td>
<td>6.55 (1.83)</td>
<td>3.85 (1.03)</td>
<td>3.57 (1.22)</td>
<td>2.93 (1.18)</td>
</tr>
<tr>
<td>65 and over</td>
<td>6.04 (1.98)</td>
<td>3.67 (1.07)</td>
<td>3.27 (1.23)</td>
<td>2.57 (0.98)</td>
</tr>
<tr>
<td>Total</td>
<td>6.59 (1.96)</td>
<td>3.87 (1.02)</td>
<td>3.63 (1.19)</td>
<td>2.97 (1.16)</td>
</tr>
</tbody>
</table>

The relatively lower impact of the condition on work activities, compared to other types of activities may point to the fact that those individuals with MSDs who report lower condition severity are more likely to be in work. As the impact of a chronic condition on work may contribute to the individual’s decision to withdraw from the labour market or to reduce their work participation, we explore this impact on work further.

### 3.2 Impact on employment status

MSDs can result in prolonged periods of sickness absence and lost productivity at work, having a dramatic impact on the individual’s ability to stay in the labour market and remain productive. For example, one of the most disabling MSDs, rheumatoid arthritis (RA) is a chronic progressive autoimmune disease that causes pain and swelling in the joints of hands, wrists and feet. It is estimated that 70 per cent of individuals will have irreversible joint destruction in the first year of being diagnosed. With 80 per cent of those of working age have disabling pain and stiffness, which reduces their functional abilities.24 Individuals living

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with RA have significant levels of absenteeism and employment status changes, which all usually precede exit from the workforce.

For disabling MSDs early diagnosis and treatment can lessen the disabling effects of these conditions. A recently developed Work Instability Scale (AS-WIS) designed to detect work instability for ankylosing spondylitis (AS), which usually precedes partial or full withdrawal from the work force, found that self-reported disease severity (global assessment) predicted work instability for patients in a large UK hospital. This suggests that appropriate management of the disease symptoms may improve employment outcomes of individuals with MSDs. Table 3.3 explores the severity of the health condition among people of different employment status.

Table 3.3. Proportion of individuals with various severity levels of the condition, by employment status

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Severity of condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 – 2</td>
</tr>
<tr>
<td>In paid work, n = 371</td>
<td>5.1%</td>
</tr>
<tr>
<td>In education, n = 8</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unemployed and actively looking for a job, n = 15</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unemployed, wanting a job but not actively looking for a job, n = 28</td>
<td>0.0%</td>
</tr>
<tr>
<td>Permanently sick or disabled, n = 210</td>
<td>2.9%</td>
</tr>
<tr>
<td>Retired, n = 113</td>
<td>0.9%</td>
</tr>
<tr>
<td>In unpaid work (volunteering, home working), n = 16</td>
<td>6.3%</td>
</tr>
<tr>
<td>Other, n = 46</td>
<td>4.3%</td>
</tr>
<tr>
<td>Total</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

The table shows that being in paid work was associated with lower degree of severity of the condition (6.14, SD = 1.97 in work vs 6.98, SD = 1.85 not in work).*** The analysis of the degree of impact on physical activities and social activities has highlighted similar significant differences (3.68, SD = 1.02 in work vs 4.03, SD = 0.99*** not in work for physical activities, and 3.36, SD = 1.21 in work vs 3.87, SD = 1.12*** not in work for social activities). While there is ample evidence that work is therapeutic to recovery and rehabilitation it is more likely that those with less severe forms of the condition maintain active employment status. As such, the differences in the severity scores were reversed when we compared permanently sick and disabled with other groups: 7.48, SD = 1.75 vs 6.28; SD = 1.93*** for general health state; 4.27, SD = 0.93 vs 3.73, SD = 1.01*** for impact on physical activities and 4.28, SD = 0.86 vs 3.41 SD = 1.20*** for impact on social activities. No significant differences were found between those retired and other groups, although almost three quarters of the retirees said the condition influenced their decision to retire. Given the progressive nature of the disease, early intervention for preventing the negative outcomes of MSDs is required.

Similarly, those unemployed and not actively looking for a job have higher disease severity, which may prevent them from being employed. When we asked all the respondents who were disabled, unemployed, or in education about their reasons for not having a job, an overwhelming majority of them indicated that their condition prevented them from working. Figure 3.2 illustrates this and other reasons for being outside work.
Of those employed, 61.5 per cent worked full-time and 38.5 per cent worked part-time. Over 44 per cent of the respondents had managerial duties. More than a fifth (23.1 per cent) of employed respondents worked in manual jobs with the remaining 76.9 per cent holding non-manual jobs. Of the employed respondents, 35.5 per cent worked in the private sector, 42.0 in the public sector, and 10.4 per cent were self-employed. These proportions are broadly representative of the UK workforce in general and no significant differences were found in the severity of the disease between groups with various types of job characteristics. There were no significant differences in the reported severity of the condition between the groups of respondents with different job characteristics.

Nevertheless, individuals with MSDs reported a significant impact of the MSDs on their job opportunities and career choices. For example, 68.8 per cent said their condition affected their job satisfaction, and 51.9 per cent believed it affected their choice of job, while 68.2 per cent feel they cannot change jobs because of the condition.

Equally, it was clear that people with MSDs experienced concerns over job security because of their condition. An overwhelming 93.5 per cent agreed that they sometimes go to work despite not feeling well because of their condition. High tendency to go to work when ill (presenteeism) among those with MSDs suggests that many employees may experience pressure – either from themselves or from their management – to downplay the effect of their condition, as almost 26.1 per cent of working respondents feared losing their job. Such
behaviours may contribute to the delay in identifying and managing the condition in the workplace context, and lead to actual job loss. Figure 3.3 illustrates this, and other workplace concerns of individuals with MSDs.

**Figure 3.3. Work-related concerns associated with having an MSD, n = 372**

As Figure 3.3 shows, inadequate performance and job loss were the top concerns among those with MSDs with regard to their work ability. Further analysis indicated that those with mild disease severity scores were mostly concerned about management of symptoms (36.8 per cent of respondents), while those with moderate and severe forms of disease were mostly concerned with their performance (45.9 per cent and 33.0 per cent respectively). Finally, job loss, was the major concern for those with severe and most severe forms of disease (28.4 per cent and 52.0 per cent respectively).

It is clear that, as the condition progresses, individuals with MSDs experience growing impact of the disease on their ability to perform at work, with increasing concerns over eventual job loss. Indeed, the survey highlighted that individuals’ experience of MSDs may have led to increased sickness absence and productivity. Temporary work incapacity, as well as inability to perform to the full potential, increases the risk of withdrawal from work and partial or full loss of earnings. The next section looks at this risk in more detail.
3.3 Loss of working time and productivity

MSDs are the leading cause of temporary and permanent incapacity across Europe. Already MSDs account for 49.9 per cent of all absences from work lasting 3 days or longer and for 60 per cent of permanent work incapacity.\(^\text{26}\) In this survey the respondents lost an average of 4.11 hours of work in the week preceding their response. With an average working week of 31.9 hours, this represents a loss of just under 13 per cent of their working time.

Often the periods of absence associated with MSDs can last several days or weeks. While 85 per cent of people who take sick leave due to back pain have fewer than seven days off, the other 15 per cent are absent for over a month.\(^\text{27}\) Research carried out by the National Rheumatoid Arthritis Society found that individuals with RA have, on average, 40 days’ sick leave a year compared to 6.5 days for the average person.\(^\text{28}\)

We know that prolonged sickness absence can eventually lead to workers dropping out of the labour market. Someone who is off work for 6 months or longer is 80 per cent more likely to be out of work for 5 years.\(^\text{29}\) In many cases, it is barriers at work that prevents or delays a return to work.\(^\text{30}\) Better support within the workplace is required to support positive work outcomes for individuals with MSDs.

In this survey, 80 individuals of 113 who classified themselves as retired (70.8 per cent) left the labour market before they turned 60 years old. Similarly, 132 of 210 respondents who were permanently sick or disabled (62.9 per cent) were younger than 55 years old. With better support to manage their conditions in clinical and workplace settings, some of these withdrawals from the labour market could be prevented.

In addition to reducing the size of the workforce, disability and early retirement also reduce the pool of skills available to the UK employers. Of those permanently sick/disabled and retired 62.5 per cent held some form of vocational or professional qualifications. Again, these skills could potentially be redeployed in the labour market and are not easily replaced by employers.

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27 Bevan et al. (2007).
Another type of indirect cost associated with chronic disease, including MSDs, is the loss of productivity whilst at work, or presenteeism. Chronic conditions – when not managed properly – may contribute to the workers not performing to their full capacity.

Productivity loss is difficult to measure, and the available instruments are mainly based on self-reported data. One of the measures of the impact of health state specifically on the productivity of employees at work is the Work Productivity and Activity Impairment scale (WPAI), developed as a patient-reported quantitative assessment of the amount of absenteeism, presenteeism and daily activity impairment attributable to general health (WPAI:GH) or a specific health problem (WPAI:SHP). The WPAI:GH and the WPAI:SHP were created simultaneously and use the same template, but in the GH version the subject is instructed to respond with reference to general health status while in the SHP version, the subject responds with reference to a specified health problem, disease or condition.\(^{31}\)

In this analysis, the self-reported WPAI-SHP was used to investigate the impact of MSD on a person’s total work productivity. It is an internationally validated instrument that assesses the impact of health on work and activity during the last 7 days. It collected information on the hours of work missed because of MSD; hours missed because of other reasons e.g. holiday; hours actually worked; the degree to which MSD has affected productivity while working from 0 (no effect) to 10 (maximum impairment); and the degree to which MSD affected other (non-work) regular activities (0–10). We found that on average the respondents experienced 43.9 (±26.8) per cent productivity loss at work.\(^{32}\) The productivity loss did not differ for those performing manual and non-manual jobs.

On average, 61.0 (±23.4) per cent productivity were lost in daily activities by those in paid work, compared to 73.2 (±21.0) per cent among those not in paid work. Perceived severity of the respondents’ condition correlated both with the productivity loss at work (r = 0.350**, n = 235) and productivity loss in daily activities (r = 0.574**, n = 802).

Ultimately, staying active in the labour market is important for the financial wellbeing of the individuals with MSDs and their families. Worryingly, 51.8 per cent of respondents in this survey said that having the condition has impacted their earnings, which can spill over into the financial wellbeing of families and households, as well as present a strain on the UK welfare system. The next section explores this problem in more detail.

\(^{31}\) See Reilly Associates [http://www.reillyassociates.net/WPAI_General.html]

\(^{32}\) The respondents indicated they spent an average of 30.88 hours (full-time) and 12.53 hours (part-time) at work in the previous week.
3.4 Impact on households

Financial wellbeing, linked to the employment status, is likely to be a particular concern among those with long-term conditions. As illustrated above, the likelihood of being out of work increases with the progress of the disease, either due to the mobility limitations associated with the disease, or an inability to accommodate the chronic condition in the workplace. Once those with chronic conditions are out of work, and the longer they are inactive, they are increasingly less likely to find another job. This is a concern for several reasons.

First, financial problems associated with loss of income result in lower living standards, which may in turn reduce social integration and lower self-esteem. Second, unemployment can trigger distress, anxiety and depression, exacerbating the state of individuals’ health and having a spillover impact on families and households. Third, unemployment has been linked to poor lifestyle choices, such as increased smoking and alcohol consumption and decreased physical exercise, and may lead to further or additional health problems.

In this survey 263 of the 266 respondents not in employment or education indicated that they have previously been in paid employment; 57.4 per cent of them had been primary earners of their households before leaving a paid job. Equally, 58.5 per cent of those employed and living with MSDs in the survey are the primary income earners.

Job loss, therefore, risks sudden detrimental impact on the income of these households. If individuals, who are primary income earners, stop working, the impact of the income loss affects both these individuals and their households. In the survey a large proportion of the respondents were aged 35 years old and over, and therefore likely to have caring responsibilities for children or ageing parents. At the same time, 26.8 per cent of those employed were concerned about retaining their job, highlighting the instability of employment associated with having an MSD. Interestingly, those individuals with MSDs who were self-treating in addition to receiving treatment in the clinical settings were less concerned about job retention, suggesting that self-management of MSDs may have a positive impact on individual employment outcomes.

If a significant proportion of the household income is lost, individuals and families may have to rely heavily on welfare payments, and a lower household income. Figure 3.4 compares the main sources of income in respondents’ households between those in paid work and the rest of the sample.

**Figure 3.4. Main source of income in the household**

More specifically, over 64 per cent of those permanently sick or disabled and just under 80 per cent of those retired relied on social support as the main source of income for their household. Almost 80 per cent of all respondents said they regularly received physical, emotional or financial help from their friends and family. This was even more common among those who reported their MSD to be more severe overall, as well as those who experience greater impact of the condition on their ability to work.

Many individuals with MSDs would prefer to stay in work, and those who do stay in work report that it has had a positive affect on their physical and mental health. As well as the financial benefits of staying in work, people with RA, for example, also say that work gives them the opportunity to be productive and provides social interactions, which have benefits for their psychological wellbeing. Supporting people with disabling MSDs to stay in work would have benefits for the individual, but it would also have benefits for society as there would be less pressure on welfare systems.

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35 Bevan et al. (2009).
Considering that dependency on welfare benefits is less likely to support individuals' social status, action is required on behalf of the health care system, employers and policymakers to redeploy those individuals with MSDs who are willing and able to work in the labour market, and to provide measures to support those with mild and moderate cases of MSDs in retaining their jobs as their condition progresses.

3.5 Summary

In this section we described the impact of MSDs on individuals and households. We found that having an MSD impacts individuals' lives in and outside work. Those with less severe forms of the condition are more likely to be physically and socially active and maintain active employment status. Almost three quarters of those not in paid employment were prevented from working or looking for a job by their condition. However, even among those with jobs, over a quarter were worried about remaining in work.

Whilst unemployment is associated with negative health outcomes, it also undermines the financial wellbeing of individuals and their families. Over 64 per cent of those permanently sick or disabled, and just under 80 per cent of those retired relied on welfare support as the main source of income for their household. Equally, 58.5 per cent of those employed provide the main source of earnings for their families; this hints at the potential spillover effect on households if those individuals lose their job when their condition worsens.

The respondents highlighted their increasing concerns with management of their symptoms and maintaining adequate performance levels as their condition progressed. This finding calls for better support for individuals with MSDs in work, as their disease progresses, highlighting the importance of having early conversations with health care professionals and line managers about workplace adjustments necessary to accommodate the course of disease and retain active employment status as long as the individual is willing and capable to do so. The next section will discuss the support available for individuals with MSDs to stay in or return to work.
4. Experiences of support in maintaining employment

As described above, a number of policy measures have been put in place to support those with chronic conditions in maintaining jobs, or returning to work. On the other hand, Employer’s Charter\(^37\) developed by the Department for Business, Innovation and Skills provides basic guidance for good practice of management employee health conditions in the workplace. This section will examine the extent to which these policy measures for improving work outcomes of people with chronic conditions have translated into clinical and workplace management practice.

4.1 Health care experiences

Early diagnosis and appropriate management of the disease symptoms and progress is critical to the work outcomes of individuals with chronic – particularly inflammatory – MSDs. Early diagnosis is essential to start managing MSDs as effectively as possible and to lessen the disabling effect of these conditions.\(^38\) According to the survey respondents, it took an average of 4.22 years, and up to 65 years, to diagnose the condition from the onset of symptoms, although the time of diagnosis differed by condition.

Time of diagnosis might be one of the key obstacles to effective management of MSDs and may be more challenging for some types of MSDs than for others: as highlighted above, chronic muscular pain isundiagnosed in 42 per cent of cases because individuals do not tend to seek medical help for this condition; on the other hand, spondyloarthropathies (SpAs) are often misdiagnosed as sports injuries due to a lack of experience among general practitioners to recognize these MSDs.\(^39\) The survey found that it took an average of 2.32 years to diagnose RA, and an average of 8.56 years to diagnose SpAs. It is essential to improve clinicians’ expertise in diagnosing MSDs, so that appropriate interventions can begin as early as practicable.

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\(^{37}\) See Department for Business, Innovation and Skills http://www.bis.gov.uk/assets/biscore/employment-matters/docs/e/employerscharter

\(^{38}\) Bevan et al. (2009).

\(^{39}\) Ibid.
Even when the diagnosis is made, access to treatment can be delayed. Where early intervention is recognised as having potential benefit, it is often the case that the health care system or the welfare system (and often both) are under-resourced or required to prioritise the kinds of early interventions which, in some cases, are likely to be easy and inexpensive to administer and can have both clinical and work-related benefits. Figure 4.1 below illustrates the time it took individuals living with MSDs to access interventions.

**Figure 4.1. Timing of intervention**

![Pie chart showing the time it took individuals to access interventions.]

Although almost two-thirds of all respondents received treatment within a three month time frame, a significant proportion (11.4 per cent) had to wait more than a year. In addition, subjective ease of access to treatment varied. Figure 4.2 below highlights subjective ease of access to treatment.

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40 Ibid.
Interventions for managing MSDs and their symptoms include drugs, walking programmes, education about condition management, clinical treatments, work place adjustments, work counselling, cognitive behavioural therapy and work place visits by clinicians. The most effective interventions are the ones that combine treating the physical and emotional wellbeing of individuals. These interventions resulted in increased work participation and lower stress levels for individuals coping with their conditions, work and personal life roles. Work and community interventions need to have a holistic approach to help people living with MSDs manage their conditions and work and personal lives.

Over 88 per cent of respondents were receiving some form of treatment for their MSDs. Of those, 98.2 per cent were receiving treatment through their GP, of those 29.1 per cent of them were self-treating as well. Whilst the majority received drug therapy (96.6 per cent), the findings on the timing of diagnosis and intervention above suggest that for some individuals this treatment may have come later than recommended for prevention of disease progress. In addition, 29.1 per cent received physiotherapy, and 10.9 per cent – psychological therapy. Individuals with more severe forms of disease were significantly more likely to receive psychological therapy (which is an important practice for managing mental health comorbidities of MSDs), but not other types of therapies. Other forms of treatment included alternative therapies, pilates and other types of exercise, for example, water sports.

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4.2 Management of work outcomes in the clinical setting

In this survey only 11.4 per cent of respondents received occupational therapy (although including a proportion of those unemployed, permanently sick or disabled). Considering the evidence on the instability of employment among individuals with MSDs, this is a concerning finding. Further exploration of management of work outcomes in clinical settings has shown that very few health care professionals prioritised active employment status as an outcome of treatment of MSDs.

Overall, more than half of all respondents (51.3 per cent) did not have a conversation with a GP or another health care professional about managing their condition in the workplace. There were no significant differences here between those in employment or out of work. Respondents were even less likely to have a return-to-work conversation with a GP. Overall, less than a third of respondents (31.8 per cent), and only 35.6 per cent of those not in work had a return-to-work conversation with their doctor.

Where the evidence above suggests some good practice among clinicians in terms of discussing work outcomes with their patients, there is still some way to go before the therapeutic benefits of work are embraced in clinical practice in the UK. Figure 4.3 below summarises the extent to which work is considered as an outcome of treatment.

Figure 4.3. Work considered as an outcome of clinical treatment
Even where clinical practice attempts to manage individuals’ work ability, support of individuals with MSDs must continue in the employment context. Employers also have a key part to play in supporting people with MSDs in and back into work. The next section will discuss the impact of work conditions and environment on the individuals’ ability to manage their MSDs more effectively.

4.3. Employment experiences

As discussed above, the impact of MSD on individuals’ health may affect the length and the intensity of work that they do. In our study those citing a greater perceived impact of their condition on their performance in the job worked fewer hours the respondents per week \( r = -0.183^{***}, n = 356 \), when controlled for employment status (full-time vs part-time work).

Whilst treating MSDs with clinical interventions is undoubtedly important and effective, comprehensive work interventions may also have positive effects on the conditions and improve job retention.\(^{42}\) For example, studies into absenteeism, presenteeism and productivity in RA have shown that work characteristics, such as physically demanding work, high job strain, and low support from co-workers, affect an individual’s ability and decision to remain in work.\(^{43}\)

Even where an occupational health professional is not present, accommodating the needs of a worker with an MSD in the workplace should occur via the support of a line manager and colleagues. Of the employed respondents, 82.5 per cent told their line manager about the condition, and 83.5 per cent told their co-workers. The main reasons for non-disclosure to the line manager were: fear of losing their job (29.7 per cent) and disbelief that managers or co-workers could help manage the MSD better (under 22 per cent). At the same time more that two-thirds of those who had disclosed their MSD felt comfortable discussing their condition at work.

Just under 74 per cent of the respondents said their manager was supportive of their condition, when they disclosed it, and in over two-thirds of cases they received some form of adjustment to their work conditions and environment in order to manage their MSD better.

\(^{42}\) Ibid.

For over a quarter of respondents this was an adaptation to the number or pattern of working hours, and over half received equipment, transport, or workstation adaptation.

These simple changes to working conditions and work environment can make a real difference to the ability of individuals with MSDs to stay in work. In the survey provision of any of the following forms of support – flexible working, ergonomic assessments and adjustments, attendance policies (eg time off for medical appointments) – was associated with fewer concerns regarding potential job loss and income maintenance among the respondents. Employers and individuals with MSDs should refer to government schemes, such as Access to Work,\textsuperscript{44} to put workplace adjustments in place.

Employers should bear in mind that, when such changes to the working patterns of people with MSDs are made, it is important to preserve the quality of work that these individuals do. It is often assumed that in the context of job scarcity, any job is good enough. However, the Marmot Review finds that it is ‘good’ work that is beneficial for your physical and mental health and well-being, whilst work that is insecure and low-paid typically fails to protect employees from ill health and results in common mental health problems and musculoskeletal disorders.\textsuperscript{45} Furthermore, a recent survey of more than 7,000 respondents in Australia has confirmed that poor-quality jobs, characterised by excessive demands, low autonomy, high job insecurity and significant effort-reward imbalance, were more detrimental to employees’ mental health than unemployment.\textsuperscript{46}

Linear regression analysis of the factors impacting work productivity has revealed that greater loss of productivity at work predicted greater compound score for the degree of impact of the condition on the quality of work outcomes (job satisfaction, access to career development and training, satisfaction with earnings, job security) at \(-.479^{***}, R^2 = 0.229\) (see Figure 4.4 below). Evidently, the fact of living with a condition may compromise the job quality of individuals with MSDs, which highlights the need for appropriate management practices in accommodating the effect of the condition on workers’ productivity and in supporting their job quality.

\textsuperscript{44} See Gov.uk \url{https://www.gov.uk/access-to-work/overview}
\textsuperscript{45} The Marmot Review (2010).
Unfortunately, people with disabilities are more likely to be in low-paid, poor quality jobs with fewer opportunities for advancement, often working in conditions that are harmful to health.  

Exposure to stresses such as physically demanding or dangerous work, long or irregular hours, sedentary or repetitive work, conflicts within the workplace, discriminatory practices, low worker control, low wages and low job security are more prevalent among workers with chronic disease and contribute to general ill health, depression and MSDs. In this survey, we found evidence that workers with MSDs believed that the condition affected their career development opportunities: 34.7 per cent said it affected their access to training and development; just under 60 per cent felt the condition prevented them from reaching their full potential at work.

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48 Ibid.
4.4 Summary

In this section we explored the likelihood of early diagnosis and treatment for MSD, and found there are still some gaps in the delivery of timely interventions for those individuals who require some sort of therapy to support their physical, psychological and work functioning. Notably, there was some good practice in providing treatment that included psychological support and complementary therapies to manage MSDs and associated comorbidities in an integrated approach.

However, only some health care professionals were likely to manage work outcomes as part of treatment in the clinical setting. As shown above, the ability of individuals with MSDs to stay in work depended on their health and their ability to manage their condition in the workplace. Nevertheless, only few clinical practitioners included advice on management of MSDs in the workplace, or considered work as a clinical outcome. Inclusion of stay-in and return-to-work advice in clinical practice is a simple and cost-effective intervention to help individuals with MSDs manage their condition better and retain active employment status.

With the introduction of ‘work’ as an outcome into the NHS Outcomes Framework there is a theoretical incentive for clinicians to change their approach and improve the way in which they support individuals to return to or remain in work. However, these principles are not yet widely adopted in practice. Considering the importance of work for the financial wellbeing of individuals living with MSDs and their households, it is essential that these theoretical outcomes become a reality through measuring and monitoring the extent to which clinicians discuss employment with their patients.

We have also described the workplace experiences of people with MSDs, and found that having the condition may compromise the quality of jobs for these individuals. A high proportion of respondents also indicated that their condition may have impacted on their development opportunities at work. Employers should bear in mind that when changes to the working patterns of people with MSDs are made, it is important to preserve the quality of work that these individuals do.

Many respondents chose to disclose their condition at work when it impacted their performance, and the majority received workplace interventions to better accommodate their conditions. Simple changes to work conditions and work environments, such as flexible working, ergonomic assessments and adjustments, attendance policies (eg time off for medical appointments), were associated with fewer concerns regarding potential job loss and income maintenance among the respondents.
5. Conclusions and recommendations

Already MSDs cost the UK billions of pounds in direct health care costs and indirect costs of lost working time and productivity. This study highlights their devastating impact on the quality of life both of individuals and their households and their effect on MSDs on individuals’ ability to work, and on the financial wellbeing of people with MSDs and their families.

This survey of more than 800 individuals living and working with MSDs in the UK has confirmed that, as these conditions progress, the ability to maintain performance at work diminishes, bringing an increased risk of job loss and consequent financial hardship. Urgent action is required by practitioners and decision-makers in the NHS, by employers and policymakers in the welfare system to return individuals with MSDs, who are willing and able to work, back into the labour market, and to support those with mild and moderate MSDs in retaining their jobs as their condition progresses.

Despite evidence showing the benefits of work for individuals’ health and wellbeing, the management of work outcomes for those diagnosed with MSDs is poor both in clinical and employment settings. The survey findings highlight large variations in the time it takes to receive a diagnosis and treatment, as well as variations in the management of comorbidities and individuals’ participation in management of their condition. Furthermore, clear gaps in practice are observable, where clinicians fail to discuss work with their patients despite this requirement featuring in the NHS Outcomes Framework.

In the workplace, disclosing a chronic condition to line managers and co-workers and gaining access to flexibility in working conditions seemed to help many individuals to stay in work. Nonetheless, it is not evident that job quality is preserved for workers diagnosed with MSDs. Disincentives that can exist to return to work (low job satisfaction, low social support among colleagues and occupational aspects such as an unclear return-to-work policy) all work against job retention. Management of MSDs in the workplace can be improved via simple workplace adjustments during and after treatment in clinical settings, and appears to be an essential part of reducing the negative impact of these conditions on an individual’s wellbeing.
The Fit for Work Programme has continuously shown that individuals with MSDs value work and are often willing to play an active role in improving their work outcomes. This research has highlighted that simple practices that clinicians and employers could adopt for early and appropriate management of MSDs are likely to help reduce the negative effect of the condition on individuals’ health state, allowing them to stay productive in work and prevent unnecessary or premature early retirement.

More specifically we recommend that, if the impact of these conditions on both clinical and work outcomes is to be optimised, the prioritisation of work outcomes for those diagnosed with MSDs should occur as early as practicable, with better coordination between clinical and employment settings.

**Health care professionals** should consider the impact of MSDs on individuals’ ability to stay in and return to work at the point at which diagnosis and treatment is decided, and make appropriate recommendations for workplace adjustments in the Fit Note. They should help to educate individuals on the impact that an MSD may have on ability to work, as the condition progresses, identify and prevent development of mental health comorbidities. Referring the individuals to patient groups and social services can help provide the necessary support. Clinicians should make themselves aware of the health benefits to be derived from individuals with MSDs being in work. From the clinical perspective of managing MSDs, they should also seek training and development opportunities to improve their expertise in diagnosis and appropriate treatment of MSDs to prevent exacerbation of symptoms.

**Commissioners** of health services should take into account the well-evidenced links between employment and public health outcomes, and consider work as an indicator in selecting cost-effective health services. They should establish practical measures that would enable them to collect and monitor the employment outcomes of various types of treatment. In addition, commissioners and Health and Wellbeing Boards should consider ways of collaborating with local employers to ensure that the effect of workplace interventions is aligned with the health needs of the working population.

Employers should create a climate where people with chronic conditions feel empowered to disclose their condition in the confident hope that their needs for understanding and for simple workplace accommodations will be met. In addition, employers should ensure that they support workplace adjustments if these would benefit the individual worker and the employer alike, for example, by following NICE public health guidance on workplace
health. Timely referral to occupational health professionals and other expertise (physiotherapy, occupational therapy) may ensure that appropriate support is accessed as early as required. Flexible working requests should be considered with due diligence, to avoid exit of valuable skills and expertise from the workforce.

Specifically in relation to the management of MSDs, employers should take a more prominent role in supporting public health outcomes, by monitoring early signs of chronic conditions, and referring individuals to the appropriate health care and patient support groups. They should raise awareness of line managers and other employees about the impact and appropriate management of MSDs in the workplace. A number of employer charters are available to provide guidance in best practice of managing the workforce.

**Line managers** should acknowledge that many employees with valuable skills and experience may have MSDs that impact their ability to work. They should have open conversations with individuals about this impact and offer necessary workplace adjustments, which are often a cost-effective intervention to support individuals’ active employment status and productivity, without discounting the career ambitions of individuals living with MSDs. For example, flexible working options to provide for training would support those employees to continue development of their skills, and enable them to compete for progression opportunities. They should also remember that the intrinsic quality of jobs for those with MSDs must be preserved even where change of duties or working patterns is introduced, in order to avoid the consequences of underemployment.

**Individuals** living with MSDs should take a proactive approach to the self-management of their condition and to ensuring coordination between their health care professional and their employer. They should seek out timely, appropriate and integrated care for managing the impact of MSDs on their lives both in and outside of work. Individuals should consider seeking advice from patient communities to prevent the negative impact of job loss on the financial wellbeing of their households, and make use of their rights under the NHS Constitution and Equalities legislation.

**Policymakers** should promote measures that avert health-related early retirement, productivity loss and unemployment among people with MSDs who wish to work, and the resulting impact on the health and financial wellbeing of individuals and their families. They should facilitate the coordination of those stakeholders responsible for early diagnosis and management of MSDs in both clinical and employment settings. At a national level, they

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Taking the strain: The impact of musculoskeletal disorders on work and home life

should drive joined-up policymaking across the Department of Health, the Department of Work and Pensions, the Department for Business and the Treasury, to this end. In particular, Government should agree to a recommendation made by Professor Dame Carol Black and David Frost CBE in ‘Health at work – an independent review of sickness absence’\(^\text{50}\) and fund a new Independent Assessment Service, which would provide an evaluation of an individual’s physical and mental function after four weeks of sickness absence with the purpose of encouraging early intervention and optimising the individual’s opportunities of returning to meaningful employment.

Furthermore, having included ‘work’ as an outcome in the NHS Outcomes Framework, the Government should now agree an indicator to enable measurement of this across the NHS, and incentivise the system to record the appropriate data and meet this outcome. Following on from the Government’s mandate to the NHS Commissioning Board, employment outcomes of people with long-term conditions should become an indicator in the Commissioning Outcomes Framework, to ensure availability of health services that maximise those work outcomes. Lastly, policymakers should work to maintain existing schemes that provide support for individuals and organisations to access workplace adjustments for individuals with chronic disease.

This research shows clearly that, despite their chronic health condition and the volatility of the labour market, remaining attached to the labour market and holding down a fulfilling job should be a realistic aspiration for many people living with a musculoskeletal disorder – even with severe symptoms. The evidence base for the array of interventions to make this happen is well known and is not in dispute. All that is missing is a combination of political will and some cross-agency collaboration based on the principle that job retention and sustained return to work should be a high priority clinical outcome in the UK. The Fit for Work UK Coalition believes that the evidence presented in this report adds further weight to the already compelling case for change.

\(^{50}\) Black and Frost (2011).
Appendix 1. Sample

This survey drew on a non-random sample of members of MSD patient groups in the UK, to a specification that was designed by The Work Foundation. It was specified that the respondents were 16 years old or over at the time of the survey, had experienced pain or discomfort affecting their muscles, joints, neck or back which affected their ability to carry out activities of daily living within the previous four weeks, and had been diagnosed with an MSD by a medical doctor. Table A describes the demographic characteristics of the sample.

Table A. Demographic characteristics of the sample.

<table>
<thead>
<tr>
<th>Achieved responses</th>
<th>Male</th>
<th>Female</th>
<th>FT/ PT Employees</th>
<th>Permanently sick or disabled</th>
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<td>16-17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18-25</td>
<td>24</td>
<td>2</td>
<td>22</td>
<td>13/3</td>
</tr>
<tr>
<td>26-34</td>
<td>61</td>
<td>8</td>
<td>53</td>
<td>29/11</td>
</tr>
<tr>
<td>35-44</td>
<td>150</td>
<td>31</td>
<td>129</td>
<td>62/38</td>
</tr>
<tr>
<td>45-54</td>
<td>267</td>
<td>37</td>
<td>230</td>
<td>78/54</td>
</tr>
<tr>
<td>55-64</td>
<td>237</td>
<td>47</td>
<td>188</td>
<td>50/33</td>
</tr>
<tr>
<td>65+</td>
<td>70</td>
<td>16</td>
<td>54</td>
<td>3/8</td>
</tr>
</tbody>
</table>
| Total             | 809  | 131    | 676              | 235/147                     | 210
The chart below presents the country where the respondents lived. For analysis purposes we treated all the respondents as one sample.

**Figure A. Distribution of the sample by country of residence.**
Appendix 2. Participating patient organisations

Several patient organisations have participated in the survey. An advance email was circulated to members of each of the participating patient groups. This email introduced the survey and directed respondents to the URL address where the questionnaire could be completed.

- Arthritis Care
- The Arthritis and Musculoskeletal Alliance
- Chronic Pain Policy Coalition, which includes:
  - Action on Pain
  - BackCare
  - FMA UK
  - National Osteoporosis Society
  - Pain Alliance Northern Ireland
  - Pain Association Scotland
- National Ankylosing Spondylitis Society (NASS)
- National Rheumatoid Arthritis Society (NRAS)
- National Voices
- UK Gout Society

We relied on an open distribution of the survey, where it was up to the patient groups to decide how to contact their members. Some of them shared the link to the survey as part of their regular newsletter, while others published it on their website, or relevant social media platforms (e.g. Facebook, Twitter).

The link to the survey has also been advertised on the online and social media platforms (e.g. website, Twitter) belonging to The Work Foundation and Fit for Work Europe. Any individual could access those links, even if they did not belong to a patient organisation. The respondents were screened out of the survey if they indicated that they had not received a diagnosis of an MSD.
Appendix 3. Questionnaire

The questionnaire was developed and piloted by the Work Foundation in 2011/2012. The draft of the questionnaire has been peer-reviewed by Professor Anthony Woolf of EUMUSC.net, Prof Ingemar Petersson of Epi-centrum Skåne and Maarten de Wit of Stichting Tools. The questionnaire and the survey method were reviewed and adjusted after the completion of the pilot phase in spring 2012.

The structure of the questionnaire and individual modules were as follows from the chart below.

**Figure B. Questionnaire structure**

Responses were collected between 24 July 2012 and 17 September 2012. The questionnaire length was between 10 and 20 minutes depending on the answers given. Most questions were closed questions, with multiple choice answers. However, there were some open questions available to respondents throughout the questionnaire. These were recoded into a numeric format for the statistical analysis purposes.
All survey responses were automatically forwarded to a designated mailbox, belonging to The Work Foundation. The responses were collected with the SNAP survey software and were consequently exported into SPSS software for statistical analysis purposes.

Please see the full questionnaire below.
About the survey
The Work Foundation is conducting this survey, on behalf of the Fit for Work Europe Coalition - a major European initiative, which aims to help people with Musculoskeletal Disorders (MSDs) to play a full and active part at work.

Your participation in this survey is extremely important to us.

Who should complete the questionnaire?
We wish to hear from as many people as possible who have a musculoskeletal condition and are 16 years old or older. We want to find out about your experiences with doctors and other healthcare professionals, with employers and, if relevant, with parts of the benefits system.

The success of the survey is dependent on the number of people who take part. The more people who take part, the more useful the results will be as we will have a much better understanding of your experiences and those of other people with MSDs.

The results of this research will be made available to senior clinicians, governments and to the European Commission. Our aim is that the survey findings will help improve the support which people living with MSDs receive to stay at, or return to, fulfilling work.

A short summary of the findings will also be available on the Fit for Work Europe Website at the end of the year.

How do I fill in the questionnaire?
Most of the questions can be answered by selecting the option next to the answer that applies to you, however, with a few questions you may also be asked to type a short answer into a box underneath it.

Depending on your answers, the questionnaire will take about 15 minutes to complete.

As you complete each page of the questionnaire, click the Next button to go to the next page. If you want to change your answers please click the Reset button.

When you have completed the questionnaire please click the Submit button. Your responses will then be directly sent to The Work Foundation.

Is the survey confidential?
The Work Foundation takes every care to protect the confidentiality of the information you give us.

Your answers to this survey will be completely anonymous and the results will not be presented in anyway that can identify you as an individual.

What if I have a question?
If you have any other questions or concerns about the survey, please contact Ksenia Zheltoukhova at kzheltoukhova@theworkfoundation.com

Thank you very much for your help with this survey.
**BACKGROUND INFORMATION**

A1. What country do you live in?
- Belgium
- Bulgaria
- Ireland
- Netherlands
- Portugal
- Spain
- Sweden
- France
- UK

A2. What is your gender?
- Male
- Female

A3. What is your current age?


B1. Which of these descriptions best applies to what you were doing in the past 7 days?

*Please select one answer only*
- In paid work (employee, self-employed, working for your family business, or on leave)
- In education (not paid for by employer)
- Unemployed and actively looking for a job
- Unemployed, wanting a job but not actively looking for a job
- Permanently sick or disabled
- Retired
- In unpaid work (volunteering, home working)
- Other

B2. Do you work full-time or part-time?

*(FULL TIME = MORE THAN 30 HOURS, PART-TIME = 30 HOURS OR LESS)*
- Full-time
- Part-time

B3. What type of organisation do you work for?

*Please select one answer only.*
- Private sector
- Public sector
- Not-for-profit sector, NGO
- Self-employed
- Other
- Don’t know
B4. What type of work do you do?  
*Please select the category you think best fits.*

- Manual
- Non-manual

B5. Do you have managerial duties?  
- Yes
- No

B6. Including yourself, how many people are employed by your organisation/company in your country?  
- 1-10
- 11-50
- 51-250
- 251+

B7. Does your employer provide, or give access, to any of the following through your place of work?  
*Please select all that apply.*

- Health insurance e.g. BUPA, SalusAnsvar, Menzis
- Occupational health specialists, counsellors or psychologists
- Flexible working arrangements e.g. working from home
- Ergonomic assessments and adjustments e.g. workstation assessments, specialised equipment
- An employee assistance programme e.g. confidential telephone helpline
- Attendance policies e.g. time off for medical appointments, long/short term sick leave
- Other
- None of these
- Don't know

B8. What else does your employer provide, or give access to, through your place of work?  
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
## MUSCULOSKELETAL CONDITIONS

*(INCLUDING RHEUMATIC DISORDERS AND PAIN IN THE MUSCLES AND JOINTS)*

C1. In the past 4 weeks have you had any pain or discomfort affecting your muscles, joints, neck or back which affected your ability to carry out your activities of daily living?

- [ ] Yes
- [ ] No

C2. Has this problem lasted for 3 months or more?

- [ ] Yes
- [ ] No

C3. Please select where you felt the pain:

a) in the last 4 weeks
b) if the problem has lasted for 3 months or more

<table>
<thead>
<tr>
<th></th>
<th>a) Pain during last 4 weeks</th>
<th>b) Problem lasted for 3 months or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Shoulder(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Upper back</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Elbow(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Wrist(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hand(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Low back</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hip(s)/Thigh(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Knee(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ankle(s)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Foot/feet</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

C4. For this problem, have you been told by a medical doctor what the diagnosis is?

- [ ] Yes
- [ ] No
C5. Please select the diagnosis you were given. If you have been given a diagnosis of more than one musculoskeletal condition, please select other.

- Rheumatoid arthritis (inflammation of the joints)
- Osteoarthritis (arthrosis, joint degeneration, "wear and tear")
- Gout
- Fibromyalgia
- Sprain or strain
- Spondyloarthritis
- Dorsopathy or dorsalgia
- Osteoporosis
- Upper-limb disorders (hand, wrist, arm, shoulder)
- Back/neck pain
- Other

C6. Please state what other diagnosis(s) you were given

___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

E1. At what age did you first start experiencing symptoms of your condition?

_______________

E2. Are you currently receiving any kind of treatment for your condition? For example drug therapy or physiotherapy.

- Yes
- No

E3. Are you receiving this treatment through your GP or healthcare professional (e.g. physiotherapist, rheumatologist, etc) or are you self-treating?

- Through my GP or healthcare professional
- Self-treating
- Both

E4. Which of the below treatments are you receiving? Please select all that apply.

- Drug therapy
- Physiotherapy
- Occupational therapy
- Psychological therapies (e.g. cognitive behaviour therapy, talking therapies)
- Other
E5. Which other treatments are you receiving?

________________________________________________________________________

________________________________________________________________________

F1. In your own opinion, please indicate on the scale below which number best describes your condition currently - that is, on average, over the past month?

0 = the best possible state

10 = the worst possible state

![Scale 0 to 10]

F2. Still thinking about the past month, other than when at work, have you had to cut down on any usual physical activities because of your condition?

Examples of physical activities include things such as cleaning the house, shopping for food and walking to work as well as physical sports such as swimming, aerobics and tennis etc.

☑ Not at all
☑ Very little
☑ Somewhat
☑ Quite a lot
☑ A great deal

F3. (Still thinking about the past month), other than when at work, have you had to cut down on any usual social activities because of your condition?

Examples of social activities include attending a club or organisation, visiting friends or relatives, undertaking voluntary work, going to the theatre etc.

☑ Not at all
☑ Very little
☑ Somewhat
☑ Quite a lot
☑ A great deal

F4. (Still thinking about the past month), have you had to cut down on any usual activities whilst at work because of your condition?

☑ Not at all
☑ Very little
☑ Somewhat
☑ Quite a lot
☑ A great deal
F5. Do you ever receive any help from family members or friends because of your condition? This could include physical, emotional or financial help.

☐ Yes
☐ No

G1. Do you have any other health conditions that affect your activities of daily living, including work?

☐ Yes
☐ No

G2. If yes, which of the following do you have?

Please select all that apply.

☐ Mental health condition e.g. depression, bipolar disorder
☐ Respiratory condition e.g. asthma, emphysema, chronic bronchitis
☐ Cardiovascular condition e.g. angina, heart attack
☐ Metabolic condition e.g. diabetes, crohn's disease, IBS
☐ Neurological condition e.g. multiple sclerosis (MS), huntington's disease
☐ Immune deficiency e.g. HIV/AIDS
☐ Other long term condition not listed here
☐ I don't have any other conditions

G3. Please state what other long term condition you have

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

HEALTH CARE AND WELFARE SUPPORT

H1. At what age did a general practitioner (GP) or a healthcare professional first diagnose you with your condition?

_______________

H2. How long after your diagnosis did you receive your first treatment (e.g. drug therapy or physiotherapy) for your condition?

☐ Less than 2 weeks
☐ 2 weeks or more but less than 1 month
☐ 1 month or more but less than 3 months
☐ 3 months or more but less than 6 months
☐ 6 months or more but less than 12 months
☐ More than 12 months
☐ I haven't received any treatment
H3. Overall, in your opinion, how easy has it been to access treatment for your condition?

- Very easy
- Quite easy
- Neither easy nor difficult
- Quite difficult
- Very difficult

H4. Have you ever had a conversation with your GP or a healthcare professional about managing your condition in the workplace, even if you are not currently working?

- Yes
- No
- Don't know

H5. Have you ever received information from a support service (e.g. national health agency, a charity or advice centre) to help you better manage your condition in the workplace, even if you are not currently working?

- Yes
- No
- Don't know

H6. Have you ever had a return-to-work conversation with your GP or a healthcare professional, even if you are not currently working?

- Yes
- No
- Don't know

H7. To what extent has your GP or healthcare professional considered your ability to stay-in or return-to-work a successful outcome of your treatment?

- A great deal
- Quite a bit
- Somewhat
- Very little
- Not at all

H8. Do you have access to an occupational health professional through your place of work?

- Yes
- No
CURRENT EMPLOYMENT EXPERIENCES

J1. Have you told your employer or line manager about your musculoskeletal condition?

☐ Yes
☐ No
☐ Self-employed

J2. Which of the following best describes why you have not told your employer or line manager?

☐ My symptoms are under control
☐ I’d prefer them not to know
☐ There is no point as no-one can help
☐ It might put me at risk from losing my job
☐ Something else
☐ None of these

J3. Why else have you not told your employer or line manager?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

K1. How supportive is your employer/line manager of your musculoskeletal condition?

☐ Very supportive
☐ Somewhat supportive
☐ Not very supportive
☐ Not at all supportive

K2. Have your employer or line manager discussed or offered any of the options below to help you better manage your condition in the workplace?

Please select all that apply.

☐ Change of duties
☐ Change to the number of hours worked
☐ Change to the pattern of hours worked
☐ Increase in use of home working
☐ Option to take emergency leave as needed
☐ Provision of equipment or workstation adaptations
☐ Other changes
☐ No changes discussed or offered
K3. Which, if any, of these changes has your employer or line manager actually made to help you better manage your condition in the workplace? Please select all that apply.

- Change of duties
- Change to the number of hours worked
- Change to the pattern of hours worked
- Increase in use of home working
- Option to take emergency leave as needed
- Provision of equipment or workstation adaptations
- Other changes
- No changes made

K4. Do you think any of these changes might help you to better manage your condition in the workplace?

- Yes
- No
- Don't know

L1. Have you told your co-workers about your condition?

- Yes
- No
- Don't have co-workers

L2. Which of the following best describes why you have not told your co-workers?

- My symptoms are under control
- I'd prefer them not to know
- There is no point as no-one can help
- It might put me at risk from losing my job
- Something else
- None of these

L3. Why else have you not told your co-workers?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

M1. How comfortable have you felt discussing your musculoskeletal condition at work with your line manager/employer and/or co-workers?

- Very comfortable
- Somewhat comfortable
- Neither comfortable nor uncomfortable
- Somewhat uncomfortable
- Very uncomfortable
The next few questions are about the past seven days, not including today.

N1. During the past seven days, how many hours did you miss from work because of problems associated with your musculoskeletal condition?

Include hours you have missed on sick days, times you went in late, left early etc, because of your problem.

Hours __________

N2. During the past seven days, how many hours did you miss from work because of any other reason, such as a vacation or holiday?

Hours __________

N3. During the past seven days, how many hours did you actually work?

Hours __________

N4. During the past seven days, how much did your condition affect your productivity while you were working?

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If your condition affected your work only a little, choose a low number. Choose a high number if your condition affected your work a great deal.

0 = condition had no effect on my work
10 = condition completely prevented me from working

N5. During the past seven days, how much did your condition affect your ability to do your regular activities, other than work at a job?

By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If your condition affected your activities only a little, choose a low number. Choose a high number if your condition affected your activities a great deal.

0 = condition had no effect on my daily activities
10 = condition completely prevented me from doing my daily activities
N6. Which of the following do you worry about most in the workplace as a result of your musculoskeletal condition?

Please select one answer only.

- [ ] Managing my symptoms
- [ ] Not being able to carry out my work responsibilities adequately
- [ ] Losing my job
- [ ] My employer not being flexible to my needs
- [ ] Not being able to find a job that fits around my condition
- [ ] Being discriminated against
- [ ] Something else

N7. What do you most worry about in the workplace as a result of your musculoskeletal condition?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

N8. Below are some statements. Thinking about your job, how much does each one reflect your current situation?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Completely agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Completely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes I go to work even though I don't feel well enough because of my condition.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>My condition affects my job satisfaction.</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>My condition has limited my access to workplace training and development.</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>My condition has prevented me from reaching my full potential in the workplace.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>My condition has had an impact on my career progression.</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>My condition has prevented me from pursuing my preferred choice of job.</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>My condition prevents me from looking for a different job.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>I am earning less as a result of my condition.</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>I find it difficult to remain employed because of my condition.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
FOR THOSE NOT IN PAID EMPLOYMENT

P1. Which of the following best describes the reason you are not currently in paid employment? Please select one option only.

- My condition makes it hard for me to work at all
- My condition makes it difficult for me to find a suitable job
- I could work, but I chose not to
- I cannot find a job that matches my skills and requirements
- My treatment makes it hard for me to get through the process of applying for jobs
- None of these

P2. Have you ever been in paid employment?

- Yes
- No

P3. When you were in paid employment, were you the primary earner in your household?

- Yes
- No

Q1. What age did you retire from work?

- Under 40 years old
- 40-49
- 50-59
- 60-65
- Over 65 years old

Q2. To what extent did your condition play a part in your decision to retire when you did?

- A great deal
- A moderate amount
- Just a little
- Not at all
A FEW FINAL QUESTIONS

S1. What is your highest level of education?

- No formal qualifications
- GCSE/O-Level/CSE
- Vocational qualifications (e.g. NVQ1, NVQ2)
- A Level/Scottish Higher or equivalent (e.g. NVQ3)
- Bachelor Degree or equivalent (e.g. NVQ4)
- Masters/PHD or equivalent
- Other (e.g. professional qualifications)

S2. What is the main source of income in your household?

Please select one option only.

- Wages or salaries
- Income from self-employment
- Pensions
- Unemployment/redundancy benefit
- Any other social benefits or grants
- Income from investments, savings, insurance or property
- Income from other sources
- Prefer not to say
- Don’t know

S3. Are you the primary income earner in your household?

- Yes
- No

If we wanted to talk to you further about your health in the future, may we contact you to see if you are willing to help?

- Yes
- No

Please provide us with the following details:

Forename _______________________________________
Surname _______________________________________
Email address ____________________________________
Telephone number (optional) _______________________

Thank you very much for your time and participation in this survey.

Please click the Submit button below.
Taking the strain: The impact of musculoskeletal disorders on work and home life
About The Work Foundation

The Work Foundation aims to be the leading independent, international authority on work and its future, influencing policy and practice for the benefit of society. Through its rigorous research programmes targeting organisations, cities, regions and economies, The Work Foundation is a leading provider of research-based analysis, knowledge exchange and policy advice in the UK and beyond. Organisations from across all industry sectors can sign up as partners to gain access and active involvement in research, thinking and practice emerging from its work. The Work Foundation is part of Lancaster University – an alliance that enables both organisations to further enhance their impact.
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