¹ Institute of Health and Wellbeing
University of Glasgow, Glasgow, UK

² University of Wolverhampton,
Wolverhampton, UK

³ University of Glasgow, Glasgow, UK

⁴ University of Oxford, Oxford, UK

Correspondence to: E Macdonald
ewan.macdonald@glasgow.ac.uk

Cite this as: *BMJ* 2020;370:m3600

<http://dx.doi.org/10.1136/bmj.m3600>

Published: 21 September 2020

Safely returning clinically vulnerable people to work

Widespread unemployment would be worse for population health than covid -19

Ewan Macdonald,¹ John Middleton,² Drushca Lalloo,³ Trisha Greenhalgh⁴

The covid-19 pandemic has seen record numbers of people off work. With lockdown eased, the challenge is to get as many of them as possible back to work safely.

The UK has roughly 43 million people of working age. Around 33 million were working before the covid-19 crisis. Of those, 9.4 million employees were furloughed (mandatory suspension supported financially by government) and 2.6 million self-employed people were claiming financial support.¹ Some were in vulnerable groups that required “shielding” at home. Others chose to isolate at home because of real or perceived increased risk. Individuals were selected for shielding based on routinely collected health data and single diagnoses and treatments. Selection did not account for people with multimorbidities.²

Poor shape

The country’s working population is not in great shape. Thousands have been unwell with covid-19, and many survivors are experiencing post-acute symptoms, including breathlessness, fatigue, headaches, concentration difficulties, and anxiety. The deconditioning effects of not working include obesity, declining physical and cognitive fitness, and worsening mental ill health.³ The importance of work as a health outcome has been highlighted,⁴ and the longer someone is off work, the less likely they are to return.³ Almost 700 000 jobs have disappeared to date in the UK, with many more people facing long term unemployment and associated debt.⁵

Complicating the situation, is our ageing population and workforce. Over half of adults stop working—often for health reasons^{6,7}—between the age of 50 and statutory retirement age. People with disabilities looking for work will also have reduced employment prospects.⁸

Before covid-19, an estimated 140 million working days were lost each year to sickness absence, costing the UK £22bn (€24bn; \$28bn) each year on health related costs and sick pay.⁹ The pandemic could push these figures much higher—potentially up to 15% of gross domestic product, which is clearly unsustainable.¹⁰

It is essential to help clinically vulnerable people get back to work, whether that be homeworking or in their workplaces. Clinicians must take a holistic approach, recognising the wide range of clinical and social interventions that may be needed, particularly by those with multiple health problems.

A recent *BMJ* editorial suggested a personalised approach to managing risk of covid-19 and risk of poor outcomes.¹¹ The concept is already being used

in occupational health to inform a safe return to work.¹² Based on the findings from the OpenSAFELY study,¹³ the Covid-age tool converts individual demographic and clinical risk factors—such as sex, ethnicity, diabetes, or asthma—into a number of years.¹² These are added to (or subtracted from) a person’s age to give a “covid age,” indicating a person’s risk of developing severe covid-19 relative to a healthy white man of the same age. For example, a body mass index above 40 adds 10 years, while female sex subtracts five years.

While not everyone returning to work needs a formal risk assessment, it is important to consider the risk of workplace exposure to covid-19 when advising patients whether and how to return to work.¹⁴ Employers should have implemented infection control measures, including social distancing, improved hygiene, screens, virtual meetings, and personal protective equipment.¹⁵ However, some employers have not, and many occupations are known to be high risk.^{16,17} Particular problems are faced by workers in low wage, poorly regulated jobs, including those in meat plants¹⁷ and the care industry.

Psychological barriers

Much emphasis has been placed on the psychological effect of returning to work after extended periods away, including employees’ fears of workplace transmission.⁸ Exploring and addressing these psychological barriers is critical during discussions with patients, particularly those who are clinically vulnerable. Observational research from China suggests that organisational measures to reduce risk, including improved workplace hygiene, and employers who prioritise workers’ health are both associated with a lower risk of psychiatric symptoms among returning employees.¹⁸

In the UK, the task of assessing clinical vulnerability and supporting millions of people anxious about returning to work is likely to fall to general practitioners (GPs) and occupational health specialists. But GPs will have to do the heavy lifting as only 50% of the working population have access to occupational health services.⁹ There is a strong economic case for improving access to occupational health, as bridging the health and workplace divide will help reduce the health effects of a recession.¹⁹

The financial, social, and health consequences of large numbers of people not returning to work could be devastating. Clinicians, employers, and politicians must recognise that the effects of widespread worklessness and long term unemployment could be worse for population health than covid-19.

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Not commissioned; externally peer reviewed.

- 1 UK Government. Coronavirus job retention scheme statistics: July 2020. <https://www.gov.uk/government/publications/coronavirus-job-retention-scheme-statistics-july-2020/coronavirus-job-retention-scheme-statistics-july-2020#main-points>
- 2 Cassell A, Edwards D, Harshfield A, et al. The epidemiology of multimorbidity in primary care: a retrospective cohort study. *Br J Gen Pract* 2018;68:e245-51. doi: 10.3399/bjgp18X695465doi: 10.3399/bjgp18X695465 pmid: 29530918
- 3 Black C, Frost D. *Health at work—an independent review of sickness absence*. Stationery Office, 2011.
- 4 Thakrar S. Promoting work as a health outcome: Summary of the conference Good work is good for you. Academy of Medical Royal Colleges, 2019. https://www.aomrc.org.uk/wp-content/uploads/2019/05/Good_work_is_good_for_you_summary_0519.pdf
- 5 Office for National Statistics. *Labour market overview, UK: September 2020. Estimates of employment, unemployment, economic inactivity and other employment-related statistics for the UK* 2020. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employment-andemployeetypes/bulletins/uklabourmarket/september2020#main-points>
- 6 CIPD. Avoiding the demographic crunch: Labour supply and the ageing workforce. Policy report. June 2015. https://www.cipd.co.uk/Images/avoiding-the-demographic-crunch-labour-supply-and-ageing-workforce_tcm18-10235.pdf
- 7 Parker M, Bucknall M, Jagger C, Wilkie R. Population-based estimates of healthy working life expectancy in England at age 50 years: analysis of data from the English Longitudinal Study of Ageing. *Lancet Public Health* 2020;5:e395-403. doi: 10.1016/S2468-2667(20)30114-6 pmid: 32619541
- 8 Shaw WS, Main CJ, Findley PA, Collie A, Kristman VL, Gross DP. Opening the workplace after covid-19: what lessons can be learned from return-to-work research? *J Occup Rehabil* 2020;30:299-302. doi: 10.1007/s10926-020-09908-9 pmid: 32562129
- 9 Nicholson PJ. *Occupational health: the value proposition*. Society of Occupational Medicine, 2017. https://www.som.org.uk/sites/som.org.uk/files/Occupational_health_the_value_proposition_0.pdf
- 10 Fernandes N. Economic effects of coronavirus outbreak (covid-19) on the world economy, 22 March 2020. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3557504
- 11 Smith GD, Spiegelhalter D. Shielding from covid-19 should be stratified by risk. *BMJ* 2020;369:m2063. doi: 10.1136/bmj.m2063 pmid: 32467287
- 12 Coggon D, Croft P, Cullinan P, Williams A. Assessment of workers' personal vulnerability to covid-19 using 'covid-age'. *Occup Med (Lond)* 2020;kqaa150. doi: 10.1093/occmed/kqaa150 pmid: 32761080
- 13 Williamson EJ, Walker AJ, Bhaskaran K, et al. Factors associated with COVID-19-related death using OpenSAFELY. *Nature* 2020;584:430-6. doi: 10.1038/s41586-020-2521-4 pmid: 32640463
- 14 Barnes M, Sax PE. Challenges of "return to work" in an ongoing pandemic. *N Engl J Med* 2020;383:779-86. doi: 10.1056/NEJMs2019953 pmid: 32558484
- 15 UK Government. Working safely during coronavirus (COVID-19). <https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/updates>.
- 16 Koh D. Occupational risks for COVID-19 infection. *Occup Med (Lond)* 2020;70:3-5. doi: 10.1093/occmed/kqaa036 pmid: 32107548
- 17 Middleton J, Reintjes R, Lopes H. Meat plants—a new front line in the covid-19 pandemic. *BMJ* 2020;370:m2716. doi: 10.1136/bmj.m2716 pmid: 32646892
- 18 Tan W, Hao F, McIntyre RS, et al. Is returning to work during the COVID-19 pandemic stressful? A study on immediate mental health status and psychoneuroimmunity prevention measures of Chinese workforce. *Brain Behav Immun* 2020;87:84-92. doi: 10.1016/j.bbi.2020.04.055 pmid: 32335200
- 19 Godderis L, Luyten J. Challenges and opportunities for occupational health and safety after the COVID-19 lockdowns. *Occup Environ Med* 2020;77:511-2. doi: 10.1136/oemed-2020-106645 pmid: 32513831

This article is made freely available for use in accordance with BMJ's website terms and conditions for the duration of the covid-19 pandemic or until otherwise determined by BMJ. You may use, download and print the article for any lawful, non-commercial purpose (including text and data mining) provided that all copyright notices and trade marks are retained.