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Ewan Macdonald,[1] John Middleton, [2] Drushca Lalloo, [3] Trisha Greenhalgh, [4]

Author affiliations

[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

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

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 plants[17] 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.

Footnotes

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