

ERGONOMIC ANALYSIS IN CHRONIC LOW BACK PAIN WORKERS

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Background

Based on a new policy for managing work-related diseases, the Belgian government has launched, starting March 1st 2005, an evidence-based program to promote an early return to work and to prevent chronic low back pain (LBP). To enter this program coordinated and funded by the Belgian Fund for Occupational Diseases (FOD), target workers must be off work due to LBP for at least 4 weeks and maximum 3 months, and are offered a standardised multidisciplinary back rehabilitation program in more than 50 rehabilitation centres across the country, and an ergonomics intervention to be carried out in the worker company by the OH prevention service (see www.fmp-fbz.fgov.be). The medical component of the program is based on the rehabilitation nomenclature INAMI-RIZIV n° 558994. More than 2000 back pain workers have entered the program since 2005 (more than 600 workers in 2009). Since the pioneering work of Loisel and co-workers [1], workplace based RTW interventions targeting LBP workers have shown to be effective in comparison to usual care, on return to work rate and reduction of the number of days of absence from work at short and medium terms, even if improvements in workers' functional status or pain are not often observed [2, 4]. The design of the Belgian program has thus mostly been based on the Sherbrooke model [1] and on its recent application in the Netherlands by Anema and his colleagues [3].

Ergonomic intervention

Within the Belgian project, an ergonomics intervention is stimulated in the worker enterprise. With the employer agreement, this intervention will be carried out by the ergonomist or the occupational physician of the prevention service in charge of the company. Most Belgian occupational prevention services collaborate to the project. Depending on the context, the workplace intervention may involve an ergonomic analysis with the participation of the sick-listed worker, a larger group-based ergonomics redesign, or temporary change in the worker duty or work schedule in order to facilitate his/her return to work. The employer gets a financial incentive (350 €) from the FOD when he agrees to such an intervention.

Why could an ergonomic intervention have an impact on return to work?

In fact the intervention may allow to identify and to address two types of barriers experienced by the patient. Concern about returning to work with residual symptoms is often expressed by the workers themselves, but also primary care health professionals, medical advisers and occupational health professionals as well as supervisors and management. Networking between the health care professionals and the workplace may be very helpful, if the patient is involved, in lessening these worries and showing the patient that he/she will get help and support from the supervisor and co-workers. A symbolic exchange of goodwill can also take place between the workplace often considered responsible for the health problem but showing its recognition of the worker difficulties, and the worker who will be ready to make efforts to return despite persisting symptoms.

Another lever to help the back pain worker returning to its usual duties is to provide him/her with a work accommodation. In practice, there is substantial variation in the content of a "modified work". The three predominant categories are: (1) light duty or work restriction or adapted job tasks; (2) reduction in the working hours/day and/or working days/week and (3)

ergonomic changes to the workplace. In some countries, modified work can also involve 'therapeutic return to work' (as in Quebec) or 'work trial'.

Results of the Belgian program

Various assessment surveys show that the program has been consistently applied in its medical component, but much less in its ergonomics component. This is partly related to the difficulties encountered in networking the curative and the preventive sector. For more than 40 years, caring physicians have been encouraged not to come into contact with OH physicians and such behaviours cannot be changed in a few months.

Several other barriers to an efficient collaboration between curative and prevention services have been identified: concurrence between health professionals has had a negative influence in some areas; entering the program implies a visit by the occupational health physician (OP) during the sick leave, a new procedure still largely unknown from the treating physician; arising from wrong beliefs about back pain, some treating physicians are not keen to see their patients participating to such an active program.

Other barriers are related to the role given in the program to the OPs. The OP actual commitment to the program is influenced also by his/her personal representations regarding his/her professional role. A stronger commitment for promoting the program has been observed among Dutch speaking OPs ($p < 0.001$) and more senior OPs ($p = 0.019$). However those Dutch- versus French-speaking differences in commitment seem to be related in part to similar differences in program adherence among the rehabilitation centers.

Discussion

The project being completely innovative in the Belgian context, it implies deep changes in the traditional interactions between different health professionals and it requests altering very common beliefs about back pain. Such beliefs or behaviours cannot be changed in a few months! More fundamentally this project shows that there is long way to go before implementing with success at a national scale, interventions originally developed and tested in well controlled conditions and in a selected number of settings.

References

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